Attachment B – DPP BHS Question 8

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

Community Mental Health Centers (CMHCs) will be eligible for payments under two components.

Component 1 is uniform dollar increase based on SFY19 (September 2018 – August 2019) units and will be paid prospectively on a monthly basis, (equal to 1/12 of the annual amount) based on the historic utilization of the 20 most utilized CMHC procedure codes from SFY19 increased by 7% to account for projected SFY19 to SFY22 enrollment growth among the three (3) Medicaid managed care programs (STAR, STAR+PLUS, and STAR Kids). An annual reconciliation will be calculated for individual providers with a 10% variance from actual SFY22 utilization compared with the SFY19 projections.

Component 2 will apply a uniform percentage increase to the 15 most utilized CCBHC procedure codes as claims are adjudicated by the MCOs for the STAR, STAR+PLUS and STAR Kids programs. Procedure codes include: H2014, T1017, H2017, 99214, H2011, 99213, 90837, 90792, 90791, H0034, 90834, H0020, 99215, 96372, and H0005. Component 2 is targeted to further incentivize uncertified CMHCs to obtain Certified Community Behavioral Health Clinic (CCBHC) certification, and, for those CMHCs that already received certification – to maintain it. As such, crisis services, speech therapy services, and therapeutic activities codes will be excluded as they are outside of the CCBHC model. Providers will qualify to receive the Component 2 rate enhancement based upon achievement of quality improvement measures. In Component 2, providers are required to report baselines for improvement-over-self (IOS) measures as a condition of participation in the program. For benchmark measures, providers must meet or exceed national benchmarks to be eligible for payment. Only providers with the required minimum volume in measure denominators will earn payment for achievement on those measures.

Component 3 will be quality payments for unearned Component 2 funds for both - CCBHC certified and non-certified CMHCs. Providers successfully achieving quality metrics for full distribution of Component 2 (Uniform Percentage) payments will qualify for Component 3 payments. Component 3 payments will be redistributed amounts from providers unsuccessful in achieving Component 2 quality goals.

Component 3 payments for qualifying providers will be calculated based upon the allocation formula:

(Qualifying Component 2 Individual Provider Payments)/(Qualifying Component 2 Total Provider Payments) *Undistributed Component 2 Provider Payments