Attachment E – DPP BHS Question 19 a, b, c and d.

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a X uniform dollar amount or a X uniform percentage increase?

The state is selecting both boxes: a uniform dollar amount and a uniform percentage increase. The state is utilizing different payment requirements for the respective components of the program. The uniform dollar amount in Component 1 is intended to function as a prospective payment in similar fashion to the CCBHC model Prospective Payment System-2 (monthly) (PPS-2) Rate. The uniform rate increase in Component 2 will be applied specifically to the top 15 CCBHC codes. Payment in Component 2 will be triggered by demonstrating quality measure achievement.

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

Component 1: $23.77 per unit;
Component 2: 52.7% per claim for CMHCs without CCBHC certification status
57.7% per claim for CMHCs that are CCBHC certified.

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

A. Component 1 (65% of total program value; up to $107.6 million) under this preprint will be a uniform dollar increase. All CMHC providers, with and without CCBHC certification status, will receive a uniform dollar increase for the top 20 procedure codes, excluding procedure code Q3014 (telehealth origination site fee). Payments will be 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 historical utilization of the codes from the same SFY19 increased by 7% to account for projected SFY19 to SFY22 enrollment growth among the 3 Medicaid managed care programs (STAR, STAR+PLUS, and STAR Kids), and trended forward with anticipated membership growth to SFY22. An annual reconciliation will be calculated for individual providers with a 10% variance from actual SFY22 utilization compared with the SFY19 projections. Top 20 procedure codes were determined using SFY19 MCO claims payments for the STAR/STAR+PLUS/STAR Kids programs.

   A uniform dollar increase of $23.77 will be added to the top 20 procedure codes described above. (See Attachment F for listing of top 20 codes)

   The $23.77 uniform dollar increase was calculated by dividing the SFY22 projected billable units into the $107.6 million available funds. The top 20 codes were analyzed based upon service acuity and billable time components to establish a uniform billable unit of measure (analogous to RBRVS reimbursement methodology). The analysis established a fifteen-minute billable unit of measure. The billable unit of measure was developed juxtaposing MCO paid units and defined service minutes. All codes demonstrated congruence with this method except these three:
   1. 90839, Psychotherapy For Crisis; First 60 Minutes
   2. 92523, Speech Sound Production And Language Evaluation
   3. H0005, Alcohol And/Or Drug Services; Group Counseling By A Clinician With (Hf) Substance Abuse Program

   Reasonable billable units were developed for these three codes after additional review.

Attachment E – DPP BHS Question 19 a, b, c and d.

B. Component 2 (35% of total program value; up to $59 million) will be a uniform percent increase for the top 15 procedure codes from the Component 1 list, excluding crisis services, speech therapy services, and therapeutic activities, for the STAR/STAR+PLUS/STAR Kids programs. Component 2 is targeted to further incentivize the remaining uncertified CMHCs to obtain certification and CMHCs that obtained such 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. For Component 2, the uniform percent increase will be 52.7% for CMHCs without CCBHC certification status and 57.7% for CMHCs who are CCBHC-certified. The uniform percent increase will be applied to the top 15 procedure codes and earning the increased rate will be contingent upon achievement of quality metrics. Providers must meet or exceed the benchmark for at least one benchmark measure to earn payment for Component 2. Certified CMHCs receive a higher percentage increase compared to non-certified CMHCs, as the CCBHC model has additional costs related to providing whole person care. Payments will be made as part of MCO processing the initial claim, and thus will be based on SFY22 claims.

C. Component 3 will be quality payments for unearned Component 2 funds for both - CCBHC certified and non-certified CMHCs. Providers successfully reporting Component 1 metrics and 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 1 and Component 2 Individual Provider Payments)/(Qualifying Component 1 and Component 2 Total Provider Payments) *Undistributed Component 2 Provider Payments

   Please see Attachment F for Component 1 codes and associated units and Component 2 codes.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The top 20 codes represent nearly 95% of SFY19 MCO claims for all CMHCs. Concentrating on the top 20 codes will make the payments easier to operationalize. As noted above in question 19c, for Component 2, crisis services, speech therapy services, and therapeutic activities codes will be excluded from the top 20 list, as these codes are outside of the CCBHC model. The CCBHC cost-report rate methodology that establishes the PPS-2 rate is the CMS approved methodology for payment for CCBHC services. Thus, the program targets to reimburse the participants working toward or maintaining CCBHC certification, the difference between the PPS-2 rates and MCO payments.

The integration of behavioral and physical health is a priority for Texas. In 2018, the external quality review organization (EQRO) for Texas Medicaid reported that co- occurring Behavioral Health (BH)/Physical Health (PH) conditions accounted for the majority of potentially preventable events (PPEs) in STAR+PLUS. In the second report, the EQRO noted that behavioral health providers had relatively lower PPE actual-to-expected (A/E) ratios compared to other providers; promoting integration practices that focus on BH providers (e.g., encouraging BH providers to screen and monitor for chronic PH conditions) may further reduce PPEs among members with co-occurring conditions[i].

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[i] https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/medicaid-chip-qei/ppe-co-occurring-conditions-exec-summary-2018.pdf