TO: Medical Care Advisory Committee

DATE: February 11, 2021

FROM: Emily Sentilles, Director, Healthcare Transformation Waiver

SUBJECT: Community Mental Health Center Directed Payment Program

Agenda Item No.: 14

New Rules: §353.1320, Directed Payment Program for Behavioral Health Services; and §353.1322, Quality Metrics for the Directed Payment Program for Behavioral Health Services

BACKGROUND: ☐ Federal Requirement ☐ Legislative Requirement ☒ Other: Delivery System Reform Incentive Payment Transition Plan

The Texas Health and Human Services Commission (HHSC) proposes new §353.1320, concerning Directed Payment Program for Behavioral Health Services, and new §353.1322, concerning Quality Metrics for the Directed Payment Program for Behavioral Health Services, in Texas Administrative Code Title 1, Part 15, Chapter 353, Subchapter O.

The purpose of the proposed new rules is to describe the circumstances under which HHSC will direct a Medicaid managed care organization (MCO) to provide a uniform percentage rate increase and a uniform dollar increase in the form of prospective monthly payments to community mental health centers (CMHCs) in the MCO's network in a participating service delivery area (SDA) for the provision of services by CMHCs. The proposed rules also describe the methodology used by HHSC to determine the amounts of the percentage rate and dollar increases.

HHSC is encouraging CMHCs to earn certification as Certified Community Behavioral Health Clinics (CCBHC) to implement processes and delivery of care that are consistent with the CCBHC model. Currently, Medicaid payments to CMHCs that are either certified CCBHC entities or in the process of getting certified, made through either the fee-for-service (FFS) or managed care models, may not cover all costs of Medicaid allowable services provided by CMHCs. HHSC is proposing these rules to establish a new program developed under the Delivery System Reform Incentive Payment (DSRIP) program Transition Plan.

HHSC anticipates that the increased payments to participating CMHCs will sustain access to services, promote better health outcomes, and increase focus on improving quality goals that are established as part of the Texas Medicaid program.

In May 2016, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that allows a state to direct expenditures under its contract with MCOs under certain limited circumstances. Under the federal rule, a state may direct an MCO to

raise rates for a class of providers of a particular service by a uniform dollar amount or percentage, or as a performance incentive, subject to approval of the contract arrangements by CMS. To obtain approval, the arrangements must be based on the utilization and delivery of services; direct expenditures equally, and using the same terms of performance, for a class of providers of a particular service; advance at least one of the goals and objectives of the state's Medicaid quality strategy and have an evaluation plan to measure the effectiveness of the arrangements at doing so; not condition provider participation on an intergovernmental transfer (IGT); and not be automatically renewed.

These proposed rules authorize HHSC to use IGTs from sponsoring governmental entities to support MCO capitation payment increases in one or more SDAs. Each MCO within the SDA would then be contractually required by the state to increase payments by a uniform percentage and dollar amount for the applicable component, respectively, for one or more classes of CMHCs that provide services within the SDA.

Conceptual Framework

Eligibility

HHSC determines eligibility for payments by CMHC class. The SDA must have at least one sponsoring governmental entity willing to provide IGT to support increased payments. Also, to be eligible for the reimbursement increase, a CMHC must be within a class designated by HHSC to receive the increase.

HHSC proposes two classes of CMHCs: CMHCs that have attained certification as a CCBHC and those that have not. The classifications allow HHSC to direct reimbursement increases where they align with the quality goals of the program. The reimbursement increase will be uniform for all CMHCs within each class.

Services subject to rate or dollar increase

HHSC may direct rate increases for all or a subset of services provided by CMHCs. The services subject to the rate increase will focus on CCBHC procedure codes, in an effort to advance the goals and objectives of HHSC's managed care quality strategy and continue best practices identified in DSRIP.

Determination of rate and dollar increase

HHSC will consider several factors in determining the percentage rate increase that will be directed for one or both classes of CMHCs within an SDA, including the amount of available funding; the class or classes of CMHCs eligible to receive the increase; the type of service subject to the increase; budget neutrality; and the actuarial soundness of the capitation payment needed to support the increase.

Reconciliation and recoupment

HHSC will follow the methodology described in Texas Administrative Code Title 1 §353.1301 to reconcile the amount of non-federal funds expended under this section and to authorize recoupments of overpayment or disallowance amounts.

ISSUES AND ALTERNATIVES:

HHSC currently operates the DSRIP program, which provides incentive payments to participating providers to support their efforts to enhance access to health care, the quality of care, and the health of patients and families served. There are 39 CMHCs participating in DSRIP with a total valuation of over $401.8 million in demonstration year (DY) 10, Federal Fiscal Year (FFY) 2021. Program funding is ending in FFY 2022 (DY 11).

As part of DSRIP Transition, HHSC worked across HHS to develop new program options. The Directed Payment Program for Behavioral Health Services includes quality components and incentivizes the transition to the Texas Certified Community Behavioral Health Clinics (CCBHC) model of care. The goal of the CCBHC initiative is to transform service delivery to improve the lives and health outcomes of vulnerable populations by creating a more efficient and coordinated system. Currently, 18 CMHCs have become certified CCBHCs with several other CMHCs in queue for certification.

HHSC engaged key CMHC stakeholders to discuss the program option. Discussions focused on the design of the current DSRIP program, quality objectives of a new program, and structure options. A CMHC class structure that comprises two classes was also considered, one where the CMHC is a CCBHC and one that is not a CCBHC. A CMHC must be within one of the designated classes to be eligible for a payment increase. The workgroup discussed different options for a payment methodology and agreed on a two-component structure to allocate funds across qualifying CMHCs.

HHSC discussed quality metrics with stakeholders as well, including possible metrics that could be designated for each funding component. As all CMHCs have been participants in DSRIP, the ability to demonstrate achievement on selected measures is well established. Many CMHCs were already reporting on certain CCBHC measures as part of the DSRIP program; these will be the starting point for determining the pay-for-reporting and pay-for-performance measures. HHSC will publish a notice of the proposed metrics and their associated performance requirements for public comment on the HHSC web site.

STAKEHOLDER INVOLVEMENT:

As mentioned above, HHSC engaged external stakeholders to get specific feedback on the development of the proposed program. Stakeholders that participated in the workgroup include the Texas Council of Community Centers and Integral Care.

In addition, under the DSRIP Transition Plan, HHSC created a workgroup of DSRIP-specific stakeholders to inform new program proposals. This Best Practices Workgroup provided survey responses ranking the measures that were key in driving improvements in the health outcomes of clients served in DSRIP and the interventions or practices that were key to improving health outcomes of clients. These insights and key measures were utilized in the development of the DPP for Behavioral Health Services. HHSC considered stakeholders' feedback and recommendations when drafting the program and rules.

The proposal will be presented to the HHSC Executive Council meeting on February 18, 2021. Additionally, HHSC held a public hearing to receive public comments following the publication of the proposed rules.

FISCAL IMPACT:

HHSC anticipates there will be no fiscal impact to state government because the non-federal share of the increase in capitation rates will be funded with IGTs from non-state governmental entities. There may be a fiscal impact to local governments, but there is insufficient information to provide an estimate because HHSC does not know which non-state governmental entities will choose to sponsor rate increases under this section or at what level of funding.

RULE DEVELOPMENT SCHEDULE:

January 2021	Publish proposed rules in *Texas Register*
February 11, 2021	Present to the Medical Care Advisory Committee
February 18, 2021	Present to HHSC Executive Council
March 2021	Publish adopted rules in *Texas Register*
March 2021	Effective date

REQUESTED ACTION: (Check appropriate box)

☐ The MCAC recommends approval of the proposed rules for publication.

☒ Information Only

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER O DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes new §353.1320, concerning Directed Payment Program for Behavioral Health Services; and new §353.1322, concerning Quality Metrics for the Directed Payment Program for Behavioral Health Services.

BACKGROUND AND PURPOSE

The purpose of the proposed new rules is to describe the circumstances under which HHSC will direct a Medicaid managed care organization (MCO) to provide a uniform percentage rate increase and a uniform dollar increase in the form of prospective monthly payments to community mental health centers (CMHCs) in the MCO's network in a participating service delivery area (SDA) for the provision of services by CMHCs. The proposed rules also describe the methodology used by HHSC to determine the amounts of the rate and dollar increases.

HHSC is encouraging CMHCs to earn certification as Certified Community Behavioral Health Clinics (CCBHC) to implement processes and delivery of care that are consistent with the CCBHC model. Currently, Medicaid payments to CMHCs that are either CCBHC entities or in the process of getting certified, made through either the fee-for-service (FFS) or managed care models, may not cover all costs of Medicaid allowable services provided by CMHCs. HHSC is proposing these rules to establish a new program developed under the Delivery System Reform Incentive Payment program (DSRIP) Transition Plan.

HHSC anticipates that the increased payments to participating CMHCs will sustain access to services, promote better health outcomes, and increase focus on improving quality goals that are established as part of the Texas Medicaid program.

In May 2016, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that allows a state to direct expenditures under its contract with MCOs under certain limited circumstances. Under the federal rule, a state may direct an MCO to raise rates for a class of providers of a particular service by a uniform dollar amount or percentage, or as a performance incentive, subject to approval of the contract arrangements by CMS. To obtain approval, the arrangements must be based on the utilization and delivery of services; direct expenditures equally, and using the same terms of performance, for a class of providers of a particular service; advance at least one of the goals and objectives of the state's Medicaid quality strategy and have an evaluation plan to measure the effectiveness of the arrangements at doing so; not condition provider participation on an intergovernmental transfer (IGT); and not be automatically renewed.

These proposed rules authorize HHSC to use IGTs from sponsoring governmental entities to support MCO capitation payment increases in one or more SDAs. Each MCO within the SDA would then be contractually required by the state to increase payments by a uniform percentage and dollar amount for the applicable component, respectively, for one or more classes of CMHCs that provide services within the SDA.

Conceptual Framework

Eligibility:
HHSC determines eligibility for payments by CMHC class. The SDA must have at least one sponsoring governmental entity willing to provide IGT to support increased payments. Also, to be eligible for the reimbursement increase, a CMHC must be within a class designated by HHSC to receive the increase.

HHSC proposes two classes of CMHCs: CMHCs that have attained certification as a CCBHC and those that have not. The classifications allow HHSC to direct reimbursement increases where they align with the quality goals of the program. The reimbursement increase will be uniform for all CMHCs within each class.

Services subject to rate or dollar increase:
HHSC may direct rate increases for all or a subset of services provided by CMHCs. The services subject to the rate increase will focus on CCBHC procedure codes in an effort to advance the goals and objectives of HHSC's managed care quality strategy and continue best practices identified in DSRIP.

Determination of rate and dollar increase:
HHSC will consider several factors in determining the percentage rate increase that will be directed for one or both classes of CMHCs within an SDA, including the amount of available funding; the class or classes of CMHCs eligible to receive the increase; the type of service subject to the increase; budget neutrality; and the actuarial soundness of the capitation payment needed to support the increase.

Reconciliation and recoupment:
HHSC will follow the methodology described in Title 1 of the Texas Administrative Code (TAC), §353.1301 to reconcile the amount of non-federal funds expended under this section and to authorize recoupments of overpayment or disallowance amounts.

SECTION-BY-SECTION SUMMARY

Proposed new §353.1320(a) establishes the Directed Payment Program for Behavioral Health Services and describes the goals of the program. Subsection (b) defines key terms used in the section. Subsection (c) describes the CMHC classes that may participate in the program. Subsection (d) describes the data sources that will be used to determine the estimated distribution of program funds. Subsection (e) describes the participation requirements of the CMHCs that wish to participate in the program, including the application process and timing. Subsection (f) describes how percentage rate and dollar increases will be determined. Subsection (g) identifies the services subject to percentage rate and dollar increases. Subsection (h) describes the value and allocation of the program's capitation rate components. Subsection (i) describes the timing and basis for the distribution of program payments. Subsection (j) describes the process for collecting the non-federal share of the program funding. Subsection (k) describes the effective date of the percentage rate and dollar increases. Subsection (l) describes the notice requirements if there are changes in operation of the CMHC. Subsection (m) refers to 1 TAC §353.1301(g) for the description of the reconciliation authority. Subsection (n) refers to 1 TAC §353.1301(j) and (k) for the description of the recoupment authority.

Proposed new §353.1322 describes the quality metrics associated with the Directed Payment Program for Behavioral Health Services. Subsection (a) establishes the purpose of the section. Subsection (b) defines key terms used in the section. Subsection (c) describes the quality metrics HHSC can designate for each of the program's capitation rate components. Subsection (d) discusses the performance requirements that will be associated with the designated quality metrics. Achievement of performance requirements will trigger payments for the program's capitation rate components as described in §353.1320 of this subchapter. Subsection (e) provides that HHSC will publish notice of the proposed metrics and their associated performance requirements no later than January 31 that precedes the first month of the program period. The notice will be published on HHSC's website or in the *Texas Register*. Subsection (f) provides that final quality metrics and performance requirements will be provided on HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period.

FISCAL NOTE

Trey Wood, HHSC Chief Financial Officer, has determined that for each year of the first five years the proposed rules are in effect, there will be no fiscal impact to state government because the non-federal share of the increase in capitation rates will be funded with IGTs from non-state governmental entities. There may be a fiscal impact to local governments, but there is insufficient information to provide an estimate because HHSC does not know which non-state governmental entities will choose to sponsor rate increases under this section or at what level of funding.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

(1) the proposed rules will create a government program;
(2) implementation of the proposed rules will not affect the number of HHSC employee positions;
(3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;
(4) the proposed rules will not affect fees paid to HHSC;
(5) the proposed rules will create a new rule;
(6) the proposed rules will not expand, limit, or repeal existing rules;
(7) the proposed rules will increase the number of individuals subject to the rules; and
(8) the proposed rules will positively affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro businesses, or rural communities. CMHCs eligible for the reimbursement increases will not be required to alter their current business practices.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules. The anticipated public benefit will be improved quality and stability in access to CMHCs as a result of funding flowing through the MCOs.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because the rules do not impose any additional fees or costs on those who are required to comply. Participation in the program is optional.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that this proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government

action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC HEARING

HHSC will conduct a public hearing on February 5, 2021, at 11:00 a.m. (Central Standard Time) to receive public comments on the proposal. Persons requiring further information, special assistance, or accommodations should email: TXHealthcareTransformation@hhsc.state.tx.us.

Due to the declared state of disaster stemming from COVID-19, the hearing will be conducted online only. No physical entry to the hearing will be permitted.

Persons interested in attending may register for the public hearing at:

https://attendee.gotowebinar.com/register/4533537542099112975

After registering, a confirmation email will be sent with information about joining the webinar.

HHSC will broadcast the public hearing. The broadcast will be archived for access on demand and can be accessed at https://hhs.texas.gov/about-hhs/communications-events/live-archived-meetings.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4900 North Lamar Boulevard, Austin, Texas 78751; or emailed to Kimberly Tucker, Senior Analyst, Medicaid and CHIP Services, Healthcare Transformation Waiver Unit, at TXHealthcareTransformation@hhsc.state.tx.us.

During the current state of disaster due to COVID-19, physical forms of communication are checked with less frequency than during normal business operations. Therefore, please submit comments by email if possible.

To be considered, comments must be submitted no later than 15 days after the date of this issue of the *Texas Register*. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be post-marked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 21R038" in the subject line.

STATUTORY AUTHORITY

The new rules are proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code, Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The proposed new rules implement Texas Human Resources Code, Chapter 32; Texas Government Code, Chapter 531; and Texas Government Code Chapter 533. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 923-0644.

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language
(No change.) = No changes are being considered for the designated subdivision

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER O DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

§353.1320. Directed Payment Program for Behavioral Health Services.

(a) Introduction. This section establishes the Directed Payment Program for Behavioral Health Services. This program is designed to incentivize community mental health centers (CMHCs) to improve quality, access, and innovation in the provision of medical and behavioral health services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1322 of this subchapter (relating to Quality Metrics for the Directed Payment Program for Behavioral Health Services).

(1) Average Commercial Reimbursement (ACR) gap--The difference between what an average commercial payor is estimated to pay for the services and what Medicaid actually paid for the same services.

(2) Certified community behavioral health clinic (CCBHC)--A clinic certified by the state in accordance with federal criteria and with the requirements of the Protecting Access to Medicare Act of 2014 (PAMA).

(3) CCBHC cost-reporting gap--The difference between what Medicaid pays for services and what the reimbursement would be based on the CCBHC cost-reporting methodology.

(4) Community mental health center (CMHC)--An entity that is established under Texas Health and Safety Code §534.0015 and that:

(A) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility.

(B) Provides 24-hour-a-day emergency care services.

(C) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(D) Provides screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission.

(5) Program period--A period of time for which the Texas Health and Human Services (HHSC) contracts with participating managed care organizations (MCOs) to pay increased capitation rates for the purpose of provider payments under this section. Each program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year. A CMHC that is unable to participate in the program described in this section beginning September 1 may apply to participate beginning March 1 of the program period and ending August 31. Participation during such a modified program period is subject to the application and intergovernmental-transfer (IGT) deadlines described in subsection (j) of this section.

(6) Total program value--The maximum amount available under the Directed Payment Program for Behavioral Health Services for a program period, as determined by HHSC.

(c) Classes of participating CMHCs.

(1) HHSC may direct the MCOs to provide a uniform percentage rate increase or a uniform dollar increase to all CMHCs within one or more of the following classes of CMHCs with which the MCO contracts for services:

(A) CMHCs that are certified CCBHCs; and

(B) CMHCs that are not certified CCBHCs.

(2) If HHSC directs rate or dollar increases to more than one class of CMHCs within the service deliveray area (SDA), the rate or dollar increases directed by HHSC may vary between classes.

(d) Data sources for historical units of service. Historical units of service are used to determine the estimated distribution of program funds across eligible and enrolled CMHCs.

(1) HHSC will use encounter data and will identify encounters based upon the billing provider’s national provider identification (NPI) number.

(2) The most recently available Medicaid encounter data for a complete state fiscal year will be used to determine the distribution of program funds across eligible and enrolled CMHCs.

(3) In the event that the historical data are not deemed appropriate for use by

actuarial standards, HHSC may use data from a different state fiscal year at the discretion of the HHSC actuaries.

(4) The data used to estimate distribution of funds will align to the extent possible with the data used for purposes of setting the capitation rates for MCOs for the same period.

(5) HHSC will calculate the estimated rate that an average commercial payor or Medicare would have paid for similar services or based on the CMS approved CCBHC cost report rate methodology using either data from Medicare cost reports or collected from providers.

(e) Participation requirements. As a condition of participation, all CMHCs participating in the program must allow for the following.

(1) The CMHC must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period must be no less than 21 calendar days, and the final date of the enrollment period will be at least nine calendar days prior to the IGT notification.

(2) The entity that bills on behalf of the CMHC must certify, on a form prescribed by HHSC, that no part of any payment made under the program will be used to pay a contingent fee, consulting fee, or legal fee associated with the CMHC's receipt of program funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(3) The entity that bills on behalf of the CMHC must submit to HHSC, upon demand, copies of contracts it has with third parties that reference the administration of, or payments from, the program.

(f) Determination of percentage of rate and dollar increase.

(1) HHSC will determine the percentage of rate or dollar increase applicable to CMHC by program component.

(2) HHSC will consider the following factors when determining the rate increase:

(A) the estimated Medicare gap for CMHCs, based upon the upper payment limit demonstration most recently submitted by HHSC to the Centers for Medicare and Medicaid Services (CMS);

(B) the estimated Average Commercial Reimbursement (ACR) gap for the class or individual CMHCs, as indicated in data collected from CMHCs;

(C) the estimated gap for CMHCs, based on the CCBHC cost-reporting methodology that is consistent with the CMS guidelines;

(D) the percentage of Medicaid costs incurred by CMHC in providing care to Medicaid managed care clients that are reimbursed by Medicaid MCOs prior to any rate increase administered under this section; and

(E) the actuarial soundness of the capitation payment needed to support the rate increase.

(g) Services subject to rate and dollar increase. HHSC may direct the MCOs to increase rates or dollar amounts for all or a subset of CMHC services.

(h) Program capitation rate components. Program funds will be paid to MCOs through two components of the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of program funds to the enrolled CMHCs will be based on each CMHC's performance related to the quality metrics as described in §353.1322 of this subchapter. The CMHC must have provided at least one Medicaid service to a Medicaid client for each reporting period to be eligible for payments.

(1) Component One.

(A) The total value of Component One will be equal to 65 percent of toal program value.

(B) Allocation of funds across all qualifying CMHCs will be proportional, based upon historical Medicaid utilization.

(C) Monthly payments to CMHCs will be triggered by achievement of requirements as described in §353.1322 of this subchapter.

(D) The interim allocation of funds across qualifying CMHCs will be reconciled to the actual Medicaid utilization across these CMHCs during the program period, as captured by Medicaid MCOs contracted with HHSC for managed care 180 days after the last day of the program period. This reconciliation will only be performed if the absolute values of percentage changes between each CMHC’s proportion of historical Medicaid utilization and actual Medicaid utilization is greater than 10 percent.

(2) Component Two.

(A) The total value of Component Two will be equal to 35 percent of total program value.

(B) Allocation of funds across all qualifying CMHCs will be based upon historical Medicaid utilization.

(C) Payments to CMHCs will be triggered by achievement of performance requirements as described in §353.1322 of this subchapter.

(3) Non-disbursed funds. Funds that are non-disbursed due to failure of one or more CMHCs to meet performance requirements will be distributed across all qualifying CMHCs based on each CMHC's proportion of total earned program funds from Components One and Two combined at the end of the year.

(i) Distribution of the Directed Payment Program for Behavioral Health Services payments.

(1) Prior to the beginning of the program period, HHSC will calculate the portion of each payment associated with each enrolled CMHC broken down by program capitation rate component, quality metric, and payment period. For example, for a CMHC, HHSC will calculate the portion of each payment associated with that CMHC that would be paid from the MCO to the CMHC as follows.

(A) Monthly payments in the form of a uniform dollar increase for Component One will be equal to the total value of Component One attributed based upon historical utilization of the provider divided by twelve.

(B) Ongoing rate increases from Component Two will be paid as performance requirements are met and will be a uniform percentage rate increase on applicable services calculated based on the total value of Component Two for the CMHCs divided by historical utilization of the respective services.

(C) For purposes of the calculation described in subparagraph (B) of this paragraph, a CMHC must achieve a minimum number of measures as identified in §353.1322 of this subchapter to be eligible for full payment.

(2) MCOs will distribute payments to enrolled CMHCs based on criteria established under paragraph (1) of this subsection.

(j) Non-federal share of program payments. The non-federal share of all program payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support the Directed Payment Program for Behavioral Health Services.

(1) HHSC will share suggested IGT responsibilities for the program period with all program eligible and enrolled CMHCs at least 10 calendar days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars available under the program for the program period as determined by HHSC, plus 10 percent; forecasted member months for the program period as determined by HHSC; and the distribution of historical Medicaid utilization across CMHCs, plus estimated utilization for eligible and enrolled within the same SDA, for the program period. HHSC will also share estimated maximum revenues each eligible and enrolled CMHC could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled CMHCs will meet 100 percent of their quality metrics. The purpose of sharing this information is to provide CMHCs with information they can use to determine the amount of IGT they wish to transfer.

(2) CMHCs will determine the amount of IGT they wish to transfer to HHSC for the entire program period and provide a declaration of intent to HHSC 15 business days before the first half of the IGT amount is transferred to HHSC.

(A) The declaration of intent is a form prescribed by HHSC that includes the total amount of IGT the sponsoring governmental entity wishes to transfer to HHSC.

(B) The declaration of intent is certified to the best knowledge and belief of a person legally authorized to sign for the sponsoring governmental entity but does not bind the sponsoring governmental entity to transfer IGT.

(3) HHSC will instruct sponsoring governmental entities as to the required IGT amounts. Required IGT amounts will include all costs associated with the CMHC rate increase, including costs associated with MCO (Capitation) premium taxes, risk margin, and administration, plus 10 percent.

(4) CMHCs will transfer the first half of the IGT amount by a date determined by HHSC, but no later than June 1. The second half of the IGT amount will be transferred by a date determined by HHSC, but no later than December 1. The IGT deadlines and all associated dates will be published on the HHSC Provider Finance webpage by March 15 of each year.

(k) Effective date of rate and dollar reimbursement increases. HHSC will direct MCOs to increase reimbursements under this section beginning the first day of the program period that includes the increased capitation rates paid by HHSC to each MCO pursuant to the contract between them.

(l) Changes in operation. If an enrolled CMHC closes voluntarily or ceases to provide Medicaid services, the CMHC must notify the HHSC Provider Finance Department by electronic mail to an address designated by HHSC, by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide Medicaid services. Notification is considered to have occurred when HHSC receives the notice.

(m) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter and, as applicable, subsection (h)(1)(D) of this section.

(n) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) - (k) of this subchapter.

§353.1322. Quality Metrics for the Directed Payment Program for Behavioral Health Services.

(a) Introduction. This section establishes the quality metrics and required reporting that may be used in the Directed Payment Program for Behavioral Health Services.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this section may be defined in §353.1301 (relating to General Provisions) or §353.1320 (relating to Directed Payment Program for Behavioral Health Services) of this subchapter.

(1) Baseline--An initial standard used as a comparison against performance in each metric throughout the program period to determine progress in the program's quality metrics.

(2) Benchmark--A metric-specific initial standard set prior to the start of the program period and used as a comparision against a community mental health center's (CMHC's) progress throughout the program period.

(3) Measurement period--The time period used to measure achievement of a quality metric.

(c) Quality metrics. For each program period, the Texas Health and Human Sevices Commission (HHSC) will designate quality metrics for each of the program's capitation rate components as described in §353.1320(h) of this subchapter.

(1) Each quality metric will be identified as a structure measure, a pay-for-reporting (P4R) measure, or a pay-for-performance (P4P) measure.

(2) Each quality metric will be evidence-based and will be presented to the public for comment in accordance with subsection (e) of this section.

(d) Performance requirements. For each program period, HHSC will specify the performance requirement that will be associated with the designated quality metric that is expected to advance at least one of the goals and objectives in the Medicaid quality strategy. Achievement of performance requirements will trigger payments for the program's capitation rate components as described in §353.1320(h) and be used to evaluate the degree to which the arrangement advances at least one of the goals and objectives that are incentivized by the payments described under §353.1320(h) of this subchapter. For some quality metrics, achievement is tested merely on whether a CMHC meets or does not meet the established requirement. The following performance requirements are associated with the quality metrics described in subsection (c) of this section.

(1) Reporting of quality metrics. All quality metrics must be reported for the CMHC to be eligible for payment.

(2) Achievement of quality metrics.

(A) The achievement of a structure measure is tested on whether a CMHC

meets the established requirement.

(B) The achievement of a P4R measure is based on reporting data for a specified measurement period.

(C) The achievement of a P4P measure is based on meeting or exceeding the goal for a measurement period. Goals will be determined by either improvement over self or performance above a benchmark as specified by the metric and determined by HHSC.

(3) Reporting frequency. Achievement will be reported semi-annually, unless otherwise specified by the metric.

(4) Other metrics related to improving the quality of care for Texas Medicaid beneficiaries. If HHSC develops additional metrics for inclusion in the Directed Payment Program for Behavioral Health Services, the associated performance requirements will be presented to the public for comment in accordance with subsection (e) of this section.

(e) Notice and hearing.

(1) HHSC will publish notice of the proposed metrics and their associated performance requirements no later than January 31 of the calendar year that precedes the first month of the program period. The notice must be published either by publication on HHSC's website or in the *Texas Register*. The notice required under this section will include the following:

(A) instructions for interested parties to submit written comments to the HHSC regarding the proposed metrics and performance requirements; and

(B) the date, time, and location of a public hearing.

(2) Written comments will be accepted for 15 business days following publication. There will also be a public hearing within that 15-day period to allow interested persons to present comments on the proposed metrics and performance requirements.

(f) Publication of final metrics and performance requirements. Final quality metrics and performance requirements will be provided through HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period. If the Centers for Medicare and Medicaid Services requires changes to quality metrics or performance requirements after February 28 of the calendar year but before the first month of the program period, HHSC will provide notice of the changes through HHSC’s website.