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.