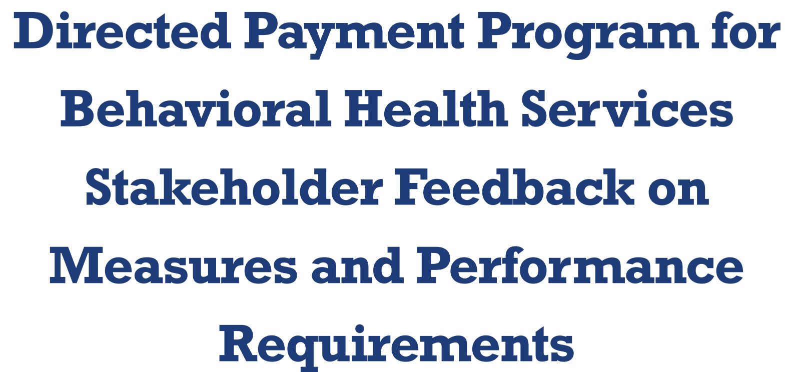

Directed Payment Program for Behavioral Health Services Stakeholder Feedback on Measures and Performance Requirements

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1. Overview

On January 25, 2021, HHSC released the draft measures and performance requirements for a directed payment program (DPP) for Behavioral Health Services (BHS) for stakeholder feedback. The documents included measure specifications, attribution methodology, reporting requirements, achievement goals, and CPT codes for focused rate enhancements. HHSC hosted a webinar on January 29, 2021 to provide an overview of the proposed measures and performance requirements and answer questions. Stakeholders submitted feedback through an online survey that closed on February 17, 2021.

This document summarizes the stakeholder feedback HHSC received through the 8 respondents to the survey. The DSRIP team reviewed stakeholder comments, grouped similar comments together, drafted responses, and determined changes through internal discussion and guidance from leadership. Changes made based on stakeholder feedback are reflected in the updated *DPP for BHS Measure Specifications*, *DPP for BHS Requirements,* and are noted in the responses herein.

HHSC will include the measures and performance requirements in the DPP for BHS state directed payment preprint submitted to the Centers for Medicare & Medicaid Services (CMS) in February 2021. All DPP for BHS requirements are subject to CMS approval. HHSC will post any changes requested by CMS as required in TAC §353.1322.

2. Component 1 Measures

B1-102: Provide patients with services by using remote technology including audio/video, client portals and apps for the provision of services such as telehealth, assessment collection and remote health monitoring/screening

1. A stakeholder asked for the definition of remote technology.

   HHSC Response: Remote technology is the use of telemedicine services to provide preventive and follow-up care to patients. This may include a wide variety of services, and providers are encouraged to report on all remote technology services provided.

2. A respondent asked what supporting documentation/attestation will be necessary to show provision of services. Another stakeholder asked if the structure measures will be reported as a yes/no and once implementation is reported, whether payment would be based on maintenance.

   HHSC Response: There are not any prescribed requirements for B1-102. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. CMHCs that have not implemented a structure measure will report on progress and any future planning for implementation.

B1-103: Provide integrated physical and behavioral health care services to children and adults with serious mental illness

3. Multiple stakeholders were concerned with reporting on this structure measure due to not currently having integrated physical and behavioral care services. Another stakeholder asked if the structure measures will be reported as a yes/no and once implementation is reported whether payment would be based on maintenance.

   HHSC Response: There are not any prescribed requirements for B1-103. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. CMHCs that have not implemented a structure measure will report on progress and any future

planning for implementation. It should be noted that the CCBHC model required coordination of care and integration of care is one way to achieve that objective and is a best practice of DSRIP.

B1-104: Participate in electronic exchange of clinical data with other healthcare providers/entities

~~4.~~ A respondent asked what supporting documentation/attestation will be necessary to show provision of services. Another stakeholder asked if the structure measures will be reported as a yes/no and once implementation is reported, whether payment would be based on maintenance.

HHSC Response: There are not any prescribed requirements for B1-104. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. CMHCs that have not implemented a structure measure will report on progress and any future planning for implementation.

5. A stakeholder asked for clarification on whether this electronic exchange is with other providers through an HIE or just electronic exchange of information?

HHSC Response: This structure measure is directly tied to Strategy 1 of the Texas Health IT Strategic Plan which encourages the use of Health Information Technology (HIT) and Health Information Exchange (HIE) to streamline patient care, eliminate waste, and improve care coordination, with the goal of ultimately improving patient health outcomes. HITs may include electronic medical/health record systems, local HIEs, statewide HIEs, and e-prescribing capabilities.

Suggestions for Component 1 structure measures

6. A respondent suggested the addition of a structure measure for engaging in Value Based Care with MCOs.

HHSC Response: HHSC may consider a similar measure for inclusion in Year 2 of the program and will begin stakeholder engagement in fall 2021.

3. Component 2 Measures

B2-105: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

7. A stakeholder asked whether the Denominator Exclusion for *Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling* would be changed to allow telehealth.

    HHSC Response: CMS is the measure steward of *Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling.* CMS did not identify this measure as having new CY2020 telehealth related specifications and thus the measure is not included as a DSRIP Optional Telehealth Measure. The measure will continue to exclude telehealth services unless updated by the measure steward.

8. A stakeholder asked if alternative methods can be used to determine the eligible numerator and denominator inclusions if billing codes are not available to CMHCs (i.e., "G-codes").

    HHSC Response: Per the additional information tab in the DPP Specs file, providers may include individuals in reporting even if billing codes (i.e., "G-codes") are not available to the CMHC. Providers are responsible for adhering to measure specifications and in cases where a variance from a designated measure source is required due to variances in data sources, providers should keep a record of such variances to ensure consistency, and make a note of such variances when reporting each measurement year. Providers may opt to use local or proprietary codes or values mapped to the standard codes included in the DPP for BHS measure specifications. Providers that use local or proprietary codes must maintain documentation that includes a crosswalk of relevant codes, descriptions, and clinical information if applicable.

B2-106: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

9. A respondent requested clarification on the different ages listed in the measure specifications.

    HHSC Response: For Chi*ld and Adolescent Major Depressive Disorder (MDD) Suicide Risk Assessment*, the denominator range is limited to patients who are six years or older to patients who are younger than 17 years old at the start of the measurement period (6≤ and <17). Patients who are 17 years old at the beginning of the measurement period are not included in this

measure but are included in *B2-107: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment*.

10. A stakeholder asked if alternative methods can be used to determine the eligible numerator and denominator inclusions if billing codes are not available to CMHCs (i.e., "G-codes").

    HHSC Response: Per the additional information tab in the DPP Specs file, providers may include individuals in reporting even if billing codes (i.e., "G-codes") are not available to the CMHC. Providers are responsible for adhering to measure specifications and in cases where a variance from a designated measure source is required due to variances in data sources, providers should keep a record of such variances to ensure consistency and make a note of such variances when reporting each measurement year. Providers may opt to use local or proprietary codes or values mapped to the standard codes included in the DPP for BHS measure specifications. Providers that use local or proprietary codes must maintain documentation that includes a crosswalk of relevant codes, descriptions, and clinical information if applicable.

B2-107: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

11. A respondent requested clarification on the different ages listed in the measure specifications.

    HHSC Response: The logic statement for the age requirement, as written, captures patients who turn 18 years old during the measurement period so that these patients are included in the measure. For this reason, the initial population at the start of the measurement period is those who are 17 years and older.

12. A stakeholder asked if alternative methods can be used to determine the eligible numerator and denominator inclusions if billing codes are not available to CMHCs (i.e., "G-codes").

    HHSC Response: Per the additional information tab in the DPP Specs file, providers may include individuals in reporting even if billing codes (i.e., "G-codes") are not available to the CMHC. Providers are responsible for adhering to measure specifications and in cases where a variance from a designated measure source is required due to variances in data sources, providers should keep a record of such variances to ensure consistency and make a note of such variances when reporting each measurement year. Providers may opt to use local or proprietary codes or values mapped to the standard codes included in the DPP for BHS measure specifications. Providers that use

local or proprietary codes must maintain documentation that includes a crosswalk of relevant codes, descriptions, and clinical information if applicable.

B2-108: Follow-Up After Hospitalization for Mental Illness 7-Day (discharges from state hospital) and B2-109. Follow-Up after Hospitalization for Mental Illness 30-Day (discharges from state hospital).

13. Multiple stakeholders asked if the metrics should also include contracted beds, in addition to discharges from state hospitals.

    HHSC Response: HHSC has discussed this issue with the Texas Council. Most contracted beds are used to serve individuals who are uninsured and not the Medicaid population. For this reason, the measures will be limited to discharges from state hospitals.

14. Multiple respondents asked who would qualify as a mental health practitioner for the purposes of meeting numerator eligibility.

    HHSC Response: National Committee for Quality Assurance (NCQA) measure steward recently replaced “mental health practitioner” with “mental health provider” and included CMHCs as an eligible provider. HHSC has included the definition of a mental health provider in the Additional Information section of the measure specifications. Providers should use their clinical discretion in determining the appropriate professional under this definition as long as they are operating within their scope of practice. These should be professionals licensed or approved to perform the type of follow-up visit required for numerator inclusion.

15. A stakeholder asked if alternative methods can be used to determine the eligible numerator and denominator inclusions if billing codes are not available to CMHCs (i.e., “G-codes”).

    HHSC Response: Per the additional information tab in the DPP Specs file, providers may report based on whether the individual is discharged from a state hospital even if billing codes are not available to the CMHC. Providers should keep record of any individuals being discharged from a state hospital and may opt to use local or proprietary codes or values mapped to the standard codes as appropriate. Please note that providers that use local or proprietary codes must maintain documentation that includes a crosswalk of relevant codes, descriptions, and clinical information if applicable.

16. A respondent requested clarification on inconsistent usage of codes in the numerator descriptions and numerator inclusions sections.

HHS Response: HHSC has updated measure B2-108: *Follow-Up After Hospitalization for Mental Illness 7-Day* to reflect the correct code for follow-up within 7 days (G9405). HHSC has updated measure B2-109: *Follow-Up After Hospitalization for Mental Illness 30-Day* to reflect the correct code for follow-up within 30 days (G9402).

4. Quality Requirements

Attribution Methodology

17. A few stakeholders suggested that the attribution methodology include an active enrollment criterion to ensure clients will continue follow-up services. A respondent stated that the current methodology of one encounter may pull in clients who receive a single outreach service. Instead, a suggestion was made to change the attribution to one billable service.

    HHSC Response: After applying the attribution methodology, providers limit the denominator eligibility according to the specific measure's denominator criteria. These criteria include office visit or hospital discharge codes. Individuals who meet denominator encounter requirements are considered part of the attributed population of the CMHC.

18. A respondent asked whether providers will define a system of care that allows them to select which programs to include in reporting.

    HHSC Response: Providers will not need to define a system beyond DPP for BHS eligibility requirements. Individuals who meet attribution and measure denominator inclusion requirements regardless of the individual's program utilization should be included in reporting.

Improvement Over Self (IOS) Measures

19. A few stakeholders requested information on calculations for IOS goals for future reporting years.

    HHSC Response: In Year 1, DPP for BHS IOS measures are reporting on baselines. Goals for future years have not been determined. HHSC will begin engaging stakeholders in fall 2021 on measures and goals for Year 2.

20. A respondent asked whether CY2021 would be appropriate for setting accurate baselines given the COVID-19 pandemic.

    HHSC Response: HHSC will continue to work with CMS to align COVID-19 impacts on quality measurement and will inform stakeholders of any changes.

Benchmark Measures

21. A respondent requested the benchmark goals for the proposed benchmark measures.

HHSC Response: Providers can find benchmark information for measures in the measure specifications Excel file under columns AA-AC. The benchmarks have also been included below.

Measure ID	Measure Name	National Benchmark Source	25th Percentile National Benchmark	50th Percentile National Benchmark
B2-108	Follow-Up After Hospitalization for Mental Illness 7-Day (discharges from state hospital)	NCQA Quality Compass HEDIS 2020 (2019)	NA	59.38
B2-109	Follow-Up after Hospitalization for Mental Illness 30-Day (discharges from state hospital)	NCQA Quality Compass HEDIS 2020 (2019)	NA	36.78
B2-110	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	NCQA Quality Compass HEDIS 2020 (2019)	86.13	NA

22. A few stakeholders requested information on whether HEDIS benchmark goals are appropriate CMHC goals, especially during the COVID-19 pandemic.

    HHSC Response: Texas CMHCs generally outperform HEDIS benchmarks. In addition, the goals for B2-108: *Follow-Up After Hospitalization for Mental Illness 7-Day and* B2-109: *Follow-Up after Hospitalization for Mental Illness 30-Day* have been proposed at the 50th percentile of the national benchmark, and B2-110: *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan* has been proposed at the 25th percentile of the national benchmark. These three benchmark goals have been set at reasonable performance targets given that the median CMHC rates are well above these rates for all three benchmark measures. HHSC will continue to work with CMS to align COVID-19 impacts on quality measurement and will inform stakeholders of any changes.

Minimum Denominator Volume

23. Multiple stakeholders indicated that some CMHCs will not meet the minimum Medicaid denominator volume of 30 for measures *B2-108: Follow-Up After Hospitalization for Mental Illness 7-Day (discharges from state hospital)* and *B2-109: Follow-Up after Hospitalization for Mental Illness 30-Day (discharges from state hospital).*

    HHSC Response: HHSC acknowledges that smaller CMHCs maybe have difficulty meeting a Medicaid minimum denominator of 30 for measures B2-108 and B2-109. To mitigate this issue, measure *B2-110: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up* has been

added as a benchmark measure. Providers must report all measures and meet or exceed at least one benchmark to earn payment for component 2.

Reporting Requirements

24. A few stakeholders had concerns regarding the burden of new measure standards and reporting for the new DPP while DSRIP reporting is still required.

    HHSC Response: The DPP for BHS program is a voluntary program that aligns Texas quality measurement with the CCBHC program using nationally recognized quality metrics. Program measures reflect the most recent measure specifications as released by the measure stewards. Although there will be an overlap for DPP for BHS and DSRIP reporting, this will only be for one reporting period.

25. A respondent requested that the program reporting be required on an annual basis instead of semi-annually.

    HHSC Response: HHSC did not make any changes in response to this comment. The twice per year reporting provides an opportunity for HHSC to track progress and collect data for evaluation purposes.

26. One stakeholder requested clarification on the reporting payer type stratifications.

    HHSC Response: Based on stakeholder feedback regarding the challenges of stratifying by Medicaid managed care vs. Medicaid, HHSC has updated the requirements for reporting and performance achievement to be based on Medicaid patients. Providers will also be required to report measures stratified by uninsured and other payer types.

Targeted Codes for Component 2

27. One stakeholder suggested the addition of code 90832, which is 30 minutes of psychotherapy instead of code for 45 minutes (90834) so that more individuals will have access to needed services under the code that will provide a rate increase.

    HHSC Response: HHSC included proposed codes based on the analysis of SFY2019 claims data. A majority of CMHCs were utilizing 90837 as their primary psychotherapy code and 90834 as their secondary code. Both codes (90837 and 90834) are included on the list of Component 2 codes eligible for a rate increase.

28. One stakeholder requested to clarify if these codes allow for group and other modifiers based on measures and appropriateness.

HHSC Response: The modelling did not apply any modifier exclusions, so claims with the listed procedure codes and modifiers would be eligible for the rate increase.

29. One stakeholder suggested for consideration an inclusion of codesH0038 Mental Health Peer Specialist (Authentic Peer Support) and H0047, H0048, H0049, and H0050 Substance Use codes.

    HHSC Response: HHSC included proposed codes based on the analysis of SFY2019 claims data. The most frequently utilized and billed 15 CCBHC codes were selected for Component 2. The stakeholder's proposed codes did not have a significant utilization in SFY19, therefore were excluded from the rate increase codes.

5. General Comments Related to Measure Specifications

30. One stakeholder requested information on how the Component 2 rate increase codes were selected.

    HHSC Response: DPP for BHS financial modelling is based on the largest total payments and most frequently used CMHC codes, which were 20 codes comprising 95% of the Medicaid managed care paid claims. The 15 most frequently utilized and billed CCBHC codes were selected for Component 2.

31. A respondent asked why measures are not focused on treatment rather than just screening.

    HHSC Response: The measures in component 2 are quality measures that align with the CCBHC program as developed by Substance Abuse and Mental Health Services Administration (SAMHSA). Although three measures are process measures that incentivize improvements in care delivery, they are validated and are nationally recognized as tools for healthcare transformation.

32. A stakeholder asked about the allowances that will be made related to COVID-19 and how these allowances may impact future performance.

    HHSC Response: HHSC will continue to work with CMS to align COVID-19 impacts on quality measurement and will inform stakeholders of any changes. HHSC will also continue to monitor measure steward updates to measure specifications.

33. A respondent requested that HHSC confirm that DPP for BHS measures have the same value sets as the corresponding CCHBC program measures.

    HHSC Response: The DPP for BHS measures specifications are pulled directly from the defined measure specifications source. The value sets used to determine denominator and numerator eligibility are consistent with the measure steward requirements and updated annually.

34. A respondent asked whether these measures would be reported for a 10-year period and how goals will be determined after year 1.

HHSC Response: DPP for BHS is currently being proposed for CMS approval as the first-year of a three-year program. Goals for future years have not been determined. HHSC will begin engaging stakeholders in fall 2021 on measures and goals for Year 2.

35. Comment: One commenter recommended aligning DPP BHS measures with current MCO and Alternative Payment Model (APM) measures to avoid further confusion among providers. The commenter also recommended aligning DPP BHS measures with the same P4Q measures that MCOs are financially at risk to achieve.

    HHSC Response: Measures proposed for inclusion in the DPP for BHS align with the CCBHC program and take into consideration the services provided by and the data available to a CCBHC. Since the DPP for BHS uses provider reporting, E.H.R./chart abstracted measures are appropriate for inclusion which includes measures outside the P4Q measures. Ultimately, the measures proposed for inclusion in the DPP for BHS align with the quality initiatives and goals that may lead to improvement in outcomes like potentially preventable ED visits and potentially preventable admissions. For example, screening and intervention of alcohol use, screening and follow-up plan for BMI, and evidence-based screening practices for suicide risk assessment are validated measures that reflect quality of care that may lead to improved patient outcomes as a result of adequate primary and preventive care. According to the National Committee on Quality Assurance, repeated follow-up outreach and in-person visits with patients can reduce the rate of subsequent suicide attempts (Luxton, 2013) or psychiatric readmissions (Barekatain, 2014).

6. Other General Comments

36. One stakeholder asked if efforts were made to decrease the gap between centers who provide services to high Medicaid populations versus those with low Medicaid. Another stallholder commented that the program will be primarily benefit those CMHCs with higher Medicaid utilization.

    HHSC Response: A DPP is exclusively a Medicaid program and can only be used to increase Medicaid reimbursements. The rates and dollar enhancements are uniform across all providers within a class.