REIMBURSEMENT

Reimbursement for services covered under the Greater New Orleans Community Health Connection (GNOCHC) Waiver is limited to only those recipients who meet the program criteria.

Federal financial participation (FFP) for this waiver program is limited to the federal share of $30 million annually in demonstration expenditures in each of the first three years of the demonstration. In the fourth year, FFP is limited to the federal share of $7.5 million. Federal funding will not be available for expenditures in excess of these annual limits even when the expenditure limit was not reached in prior years.

Reimbursement Methodologies

This demonstration waiver uses the following four reimbursement methodologies:

- Interim payments
- Encounter rates
    - Primary care
    - Behavioral health care
        - Basic
        - Serious mental illness (SMI) – not to exceed 10 percent of total computable expenditures
- Targeted payments
    - Infrastructure investments – not to exceed 10 percent
    - Community care coordination – not to exceed 10 percent
- Incentive payments

  National Committee on Quality Assurance Patient Centered Medical Home recognition – not to exceed 10 percent

Interim Payments

Interim payments may be made to GNOCHC providers as described below:

- For the period October 1, 2010 through December 31, 2010, a GNOCHC provider's interim payment will be a quarterly urgent sustainability payment equal to 25 percent of the provider's average annual historical grant award received under the Primary Care Access and Stabilization Grant (PCASG) as described in Special Terms and Conditions (STC) approved by the Centers for Medicare and Medicaid Services (CMS) for the demonstration, specifically STC 23.

- For the period January 1, 2011 through September 30, 2011, a GNOCHC provider's interim payment will be monthly up to one third of the quarterly urgent sustainability payment.

Interim payments may be reduced by the Department of Health and Hospitals (DHH) at the request of the provider and after consideration of limitations to ensure budget neutrality and promote sustainability.

The amount of interim payments, including urgent sustainability payments, made to providers in the period of October 1, 2010 through September 30, 2011 will be reconciled against the actual payments that would have been made to the providers to reimburse waiver related costs through targeted payments, incentive payments, and encounter rate payments for dates of service during the period.

The reconciliation shall occur simultaneously with the adjustment described in the section entitled "Demonstration Year End" for demonstration year one. After supplemental payments are calculated, any overpayments may be offset against a provider's payment in the quarter following the reconciliation. Any underpayments may be made in the quarter following the reconciliation, subject to any limitations necessary to maintain budget neutrality and promote sustainability. This reconciliation will be completed and a document detailing the reconciliations and any over or under payments identified will be submitted to CMS by December 31, 2011.

Encounter Rates

Primary Care Encounter Rate

Payments to GNOCHC providers for covered services defined as primary care services in Section 47.1 will be made on a per visit/encounter basis. This primary care encounter rate will be a fixed amount for all providers and all sites. It will not be provider specific or vary by patient acuity or service intensity.

The primary care encounter rate covers primary care services, including primary care, care coordination/case management, preventive care, specialty care, immunizations and influenza vaccines not covered by the vaccines for children program, and laboratory and radiology (including the professional and technical components) services that are routinely available in a primary care setting or through contracted services (e.g., physician office or Federally Qualified Health Center) (See Section 47.1). A separate fee-for-service payment will be made for vaccine administration up to the charge limit specified for Louisiana.

The primary care encounter rate does not include behavioral health care services as defined in Section 47.1, but may include screenings for mental health disorders as a component of the primary care visit.

A primary care encounter is defined as a visit to a GNOCHC provider during which the recipient receives primary care services as defined by the procedure codes or successor codes from a licensed practitioner or a person working under the supervision of a licensed practitioner including but not limited to physicians, clinical nurse specialists, nurse practitioners and physician assistants. (See Appendix E for information on covered codes).

The primary care encounter rate is all inclusive; Medicaid will not pay for any primary care medical services separate from the primary care encounter rate for recipients. Only one primary care visit may be billed per day. The sum total of payments for specialty care shall not exceed 15 percent of the total computable expenditures under the demonstration.

Behavioral Health Care Encounter Rate

Payments to GNOCHC providers for covered services defined as behavioral health care services in Section 47.1 will be made on a per visit/encounter basis. Two encounter rates, distinguished by patient acuity, are for behavioral health:

- A basic behavioral health encounter rate for services provided to recipients who meet the American Society of Addictive Medicine (ASAM) criteria for substance abuse and/or have a major mental health disorder as defined by Medicaid but do not meet the federal definition of SMI. All GNOCHC providers are eligible for the basic behavioral health encounter rate.

- An SMI behavioral health encounter rate for services provided to recipients who meet the federal definition of SMI, including those who also have a co-occurring addictive disorder (Only two providers are eligible for the SMI behavioral health care encounter rate: Jefferson Parish Human Services Authority (JPHSA) and Metropolitan Human Services District (MHSD).

Healthcare Common Procedure Coding System (HCPCS) code T1015 with one modifier (TF) that points to the basic behavioral health care encounter rate and a second modifier (TG) that points to the SMI behavioral health care encounter rate are used to distinguish the basic SMI behavioral health encounter rates. Jefferson Parish Human Services Authority (JPHSA) and Metropolitan Human Services District (MHSD) will identify individuals meeting the federal SMI definition and apply the appropriate modifier subject to audit.

If a GNOCHC provider other than JPHSA and MHSD identifies a recipient suspected to meet the SMI definition, the provider will refer the recipient to JPHSA or MHSD for SMI behavioral health care services.

If both a primary care encounter and a separate behavioral health care encounter occur on the same day, both the primary care encounter and the basic behavioral health care or the SMI behavioral health care encounter rate may be billed.

Basic Behavioral Health Care Encounter Rate

Payments to GNOCHC providers for covered services defined in Section 47.1 as basic behavioral health care are made on a per visit/encounter basis.

The basic behavioral health care encounter rate is a fixed amount for all providers. It is not provider specific or varies by patient acuity or service intensity.

A basic behavioral health care encounter is defined as a visit to a GNOCHC provider during which the recipient receives covered mental health and/or substance abuse services from a licensed practitioner and or other practitioner authorized under Medicaid Mental Health Clinic policies to provide services directly or under supervision to the extent permitted by the practitioner's scope of state licensure (See Section 47.4). Only one behavioral health care visit may be billed per day.

Rates are designed to cover behavioral health care services provided to recipients who do not meet the federal definition of SMI but do meet the American Society of Addiction Medicine (ASAM) criteria and/or have a major mental health disorder as defined by Medicaid or previously had a major mental health disorder and are in need of maintenance services. Behavioral health care services include mental health and/or substance abuse screening, assessment, counseling, medication management, laboratory and follow-up services for conditions treatable or manageable in primary care settings, but do not include primary care services. Services in residential, inpatient hospital and outpatient hospital settings are not covered.

The basic behavioral health encounter rate is distinct from the primary care encounter rate and compensates providers for a different package of services. The basic behavioral health encounter rate and the primary care encounter rate may be billed on the same day if the recipient receives both types of services.

The basic behavioral health care encounter rate is all-inclusive; Medicaid will not pay for any behavioral health care services separate from the encounter rate for recipients.

Serious Mental Illness Behavioral Health Care Encounter Rate

Payments to JPHSA and MHSD for covered services defined in Section 47.1 as SMI behavioral health care services are made on a per visit/encounter basis distinct from the basic behavioral health care encounter rate. The SMI behavioral health care encounter rate is a fixed amount for both JPHSA and MHSD.

An SMI behavioral health care encounter is defined as a visit to JPHSA or MHSD during which the recipient who meets the federal SMI definition, including those who also have a co-occurring addictive disorder, receives covered mental health and/or substance abuse services from a licensed practitioner and or other practitioner authorized under Medicaid Mental Health Clinic policies to provide services directly or under supervision to the extent permitted by the practitioner's scope of state licensure (See Section 47.4).

Rates are designed to cover behavioral health care services provided to recipients who meet the federal definition of SMI, including those who also have a co-occurring addictive disorder and those who were previously identified as SMI and are in need of maintenance services. SMI behavioral health care services include mental health and/or substance abuse screening, assessment, counseling, medication management, laboratory, follow-up and community support services. Services in residential, inpatient hospital and outpatient hospital settings are not covered. Only one SMI behavioral health care visit may be billed per day.

The SMI behavioral health encounter rate is distinct from the primary care and basic behavioral health care encounter rates and compensates providers for a different pattern of services typically provided to those with SMI. JPHSA and MHSD are required to coordinate with other GNOCHC providers for the provision of primary care services to the recipient if they are unable to provide primary care services. The SMI behavioral health care encounter rate and the primary care encounter rate may be billed on the same day if the recipient receives both types of services.

The SMI behavioral health care encounter rate is all inclusive; Medicaid will not pay for any behavioral health care services separate from the encounter rate.

The sum total of payments for behavioral health care services for SMI shall not exceed 10 percent of the total computable expenditures under the demonstration.

Targeted Payments

Infrastructure Investments

Payments to GNOCHC providers for infrastructure costs related to the provision of heath care services, as defined in STC 21 as approved by CMS for the demonstration, and the expenditure authority approved by CMS for the demonstration, will be made based on proposals from GNOCHC providers and the state's assessment of the extent to which a provider's proposal meets designated criteria for targeted infrastructure investment listed below. Payments will vary by provider.

The five targets for funding under the Infrastructure Investment Initiative will be in priority order:

- To acquire, install and train staff to operate practice management, billing, financial and data collection systems required for payment, encounter reporting and accountability

- To enhance care management capacity through the acquisition of care/case management systems, development of comprehensive care management protocols and in depth staff training

- To acquire technical assistance to gain National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) recognition and to cover the costs of the NCQA PCMH application process

- To develop, acquire and install data collection/reporting systems required to participate in quality/performance improvement incentive programs

- To acquire and install equipment required for telemedicine consults and/or mobile service capacity

Payments for infrastructure investments cover expenditures to support the providers' delivery of services, billing for services, financial accountability, and encounter/quality reporting. Infrastructure payments do not cover any costs for the acquisition, construction or renovation of bricks and mortar.

Consistent with the expenditure authority approved by CMS for the demonstration, the sum total of payments for infrastructure investments shall not exceed 10 percent of the total computable expenditures under the demonstration.

GNOCHC providers will be required to report quarterly on the use of infrastructure investment payments as defined in Section 47.5. Effective October 1, 2011, a provider may not receive infrastructure investment payments until the required reports have been submitted.

Community Care Coordination

Payments to GNOCHC providers for community care coordination, as defined below, are based on limited allocations.

STCs approved by CMS for the demonstration, specifically STC 17, defines care coordination as follows:

"Care coordination includes services delivered by health provider teams to empower patients in their health and health care and improve the efficiency and effectiveness of the health sector. These services may include health education and coaching, navigation of the medical home services and the health care system at large, coordination of care with other providers including diagnostics and hospital services, support with the social determinants of health such as access to healthy food and exercise. Care coordination also requires health care team activities focused on the patient and communities' health including outreach, quality improvement and panel management."

Based on this definition, DHH has identified two different types of care coordination:

- Enrollee Care Coordination, and
- Community Care Coordination

Reimbursement for enrollee care coordination is included in the primary care encounter rate until PCMH choice and assignment processes are established. Once PCMH choice and assignment processes are established, a care coordination fee will be paid separately based on a per member per encounter rate to the recipient's designated PCMH.

Reimbursement for community care coordination is through targeted payments and covers provider initiatives to improve the health of the communities they serve, including but not limited to:

- Community health promotion

- Events to increase health awareness by providing health screenings, activities, materials, demonstrations, and information
- Education to increase awareness of local, state, and national health services and resources and assist with navigation of the health care system at large
- Health and wellness education
- Disease prevention education
- Teaching "self-care" practices that lead to improved health status
- Education on chronic disease self-management
- Efforts to improve access to no-cost or low-cost healthy food and exercise
- Events to motivate recipients to make positive health behavior changes
- Peer education and peer support/counseling to enhance culturally competent care
- Programs that identify and respond to high-prevalence health problems in the community

Payments for community care coordination will be made to providers in demonstration year one only. Any community care coordination funds not expended by September 30, 2011 shall be reallocated as described under "Demonstration Year End".

GNOCHC providers will be required to report quarterly on the use of community care coordination payments as defined in Section 47.5.

The sum total of payments for community care coordination shall not exceed 10 percent of the total computable expenditures under the demonstration during demonstration year one.

Incentive Payments

National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) Recognition

Incentive payments to GNOCHC providers for NCQA PCMH recognition are made on a quarterly basis.

Payment methods differ for the pre- and post-June 30, 2011 periods.

- For the period October 1, 2010 through June 30, 2011, the amount of a provider's payment was the product of the fixed rate assigned to the level of NCQA PCMH recognition documented for the provider on the first day of the preceding quarter and the provider's quarterly number of uninsured adult encounters for the preceding quarter.

- Rates for NCQA PCMH recognition levels 1, 2, and 3 will be fixed amounts for all providers and will be determined on an encounter basis. Payments will be made quarterly.

Effective July 1, 2011, the amount of a provider's payment is the product of the fixed rate assigned to the level of NCQA PCMH recognition documented for the provider on the first day of the preceding quarter and the provider's quarterly number of recipient encounters for the preceding quarter.

Rates for NCQA PCMH recognition levels 1, 2, and 3 will be fixed amounts for all providers and will be determined on an encounter basis. Payments will be made quarterly.

The sum total of payments for NCQA incentive payments shall not exceed 10 percent of the total computable expenditures under the demonstration.

Adjustments

Demonstration Year End

For each demonstration year, the state will subtract the sum of all payments made under the demonstration for the year, including payments for state administrative costs and targeted payments, incentive payments and primary care, basic behavioral health and SMI behavioral health care encounter rate payments for dates of service during the year to providers, from the limit of total computable expenditures allowed under the demonstration as per STCs approved by CMS for the demonstration, specifically STC 22. If the sum of all payments made under the demonstration for the year is less than the limit of total computable expenditures allowed under the demonstration for the year, the state will divide the remainder of total computable expenditures allowed under the demonstration for the year by the total number of primary care and behavioral health care (basic and SMI) encounters for recipients with dates of service during the year as reported by all GNOCHC providers; and, the quotient will be considered a supplement to the primary care and behavioral health care encounter rates.

A supplemental payment will be made to each GNOCHC provider, and the payment amount will be the product of the supplemental rate and the number of primary care and behavioral health care encounters for recipients with dates of service during the year as reported by the provider. Supplemental payments, if any, will be made to providers during the quarter following the end of the demonstration year.

Reporting Deadline for Encounters

Providers must submit encounter reports for dates for service applicable to the demonstration year no later than 45 days following the end of the demonstration year, regardless if the encounter is reported in Excel format or on the CMS 1500, in order to be considered within the adjustment described above. (See Section 47.5 for deadline dates)

Other Adjustments

Rates and payments may be adjusted as necessary to continue providing access to services while maintaining expenditures within budget neutrality limitations, or in conjunction with the various other payment mechanisms within the waiver. Such adjustments may be necessary if enrollment volume warrants a prioritization and/or limitation of services. If annual expenditures, based on actual or projected enrollment and payments, are projected to exceed the annual limit as authorized in the waiver, DHH will impose enrollment caps, encounter rate reductions and/or modifications to other payments to manage expenditures within budget neutrality limitations.

Recipient Cost Sharing

A provider may require recipients to share in the cost of their care within the limits of federal statutes, regulations and policies. Recipient cost sharing may not exceed $3.50 per encounter as defined in this section.