# 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 and $7.5 million in the fourth year, totaling $97.5 million for the demonstration period ending December 31, 2013. Since the demonstration was extended to December 31, 2014, additional FFP was requested and approved by CMS. The FFP increased to $111.6 million for the entire demonstration period. 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 (ended 12/31/2013)
- Encounter rates
    - Primary care
    - Behavioral health care
        - Basic
        - Serious mental illness (SMI)
        - Inter-Pregnancy Care Coordination (IPC)
- Targeted payments (ended 12/31/2013)
    - 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

## 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.

**Inter-Pregnancy Care Coordination Encounter Rate**

CMS approved inter-pregnancy care coordination or IPC in June 2012. IPC covers care coordination and case management. It is separate and distinct from care coordination services provided by the primary care provider, which is reimbursed under the primary care encounter rate.

IPC enrollment efforts are provided by Healthy Start New Orleans. Healthy Start outreaches women who have had a low or very low birth weight baby, a preterm birth, fetal death, or infant death on or after January 1, 2011 and meet the eligibility criteria for GNOCHC and the Take Charge program. The goal is to improve their reproductive health, achieve optimally spaced, planned pregnancies, and avert another adverse birth outcome. Enrollment is voluntary. Enrollees are usually followed for 18 months.

Providers must possess a masters level degree in social work, or bachelor's degree in social work and supervised by a licensed case manager, or a bachelor's degree with case management experience and supervised by a licensed case manager, or have 5 years case management experience in a community setting and supervised by a licensed case manager and be a salaried employee of the New Orleans Health Department and Healthy Start New Orleans. IPC does not include any direct clinical health care service. Billable services include in-home, face-to-face, telephonic and/or electronic interaction with a participant, her family and/or her medical and behavioral providers. Billable activities do not include travel time, general employer time, training time, and/or supervisory time. Missed appointments are not billable.

IPC is paid on a per unit (15 minute) basis. Utilization per enrollee is limited to 28 units per month. Healthcare Common Procedure Coding System (HCPCS) code T1016 with one modifier (HD) is used when claiming IPC services. T1016 HD should be the only CPT code listed. The IPC unit rate is based on the independent rate model in use by Louisiana Medicaid for case management, support coordination, and targeted case management services. The rate is based on the 2009 Bureau of Labor Statistics 25th percentile for the category children, family and school social workers. Assumptions regarding employee related expenses were based on provider

survey data and FUTA, FICA and SUTA percentages. Expenditures for IPC are limited to 5 percent of the total computable expenditures under the demonstration.

## 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.

## 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.