BEHAVIORAL HEALTH DIRECTED PAYMENT FREQUENTLY ASKED QUESTIONS

The Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 C.F.R. §438 govern how states may direct plan expenditures in connection with implementing delivery system and provider payment initiatives under Medicaid managed care contracts. Effective January 1, 2023, the Oregon Health Authority (OHA) will implement four behavioral health directed payments (BHDPs) within the CCO contracts that will further the goals and priorities of the Medicaid program, as follows:

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This document outlines frequently asked questions related to the new behavioral health directed payments going into effect January 1, 2023. Please note, in the CCO contract these payments are referred to under the section called Qualified Directed Payments (QDPs) within CCO Payment Rates (Exhibit C Section 1).

GENERAL QUESTIONS

- Is the expectation that the CCOs begin paying the increased rate beginning January 1, 2023?

  Response: The BHDPs are effective January 1, 2023, and CCO payments to eligible providers for services for the rating period beginning on January 1, 2023, must comply with the payment levels described in the BHDP preprints. However, federal regulations require CMS approval of the BHDP methodologies before the actual funding described in the BHDP can be paid under the contract. If CMS approves the BHDPs after the start of the rating period, CCOs must make providers whole for the amounts in the BHDP for services delivered on January 1, 2023, and after. OHA encourages CCOs to set expectations with providers that retroactive increases back to January 1, 2023, may be needed depending on when OHA receives CMS approval and as appropriate documentation is gathered.

- Do CCOs need to implement either the Item 1 increase (15/30%) **or** the Item 4 increase (FFS schedule change), or is the Item 1 in addition to the Item 4 increase?

  Response: Yes, the CCOs need to implement either the tiered increase or the minimum fee schedule **depending on the service provided**. Refer to Appendix A of the guidance document for a crosswalk of OHG financial criteria to the impacted Categories of Service for each directed payment. The impacted services for each of those directed payments do not overlap.

- Are CCOs required to retroactively pay FFS back to 7/1/2022, or does this only apply to only to 'Open Card' billing to OHA?

  Response: With the directed payment implementation, OHA is not requiring CCOs to pay providers at the new FFS fee schedule retroactively back to 7/1/22. Effective 1/1/23, under the Minimum Fee Schedule for Providers of Substance Use Disorders (SUD) residential services, Applied Behavior Analysis (ABA), and Wraparound directed payment, CCOs are required to pay providers no less than the applicable State Plan BH payment rate in effect on the date of service for eligible services.

- Please describe how the BHDPs are at-risk and different from the current hospital directed payments.

  Response: The BHDPs are included as a prospective rating adjustment in the capitation rates. The CCOs are at-risk for differences in actual utilization versus assumed utilization in the capitation rates similar to other components of the capitation rate. The current hospital and GEMT directed payments are not included as prospective rating adjustments and are instead paid as a separate payment term based on actual utilization as it occurs.

- Due to the increased costs of implementing the BHDPs, will an additional administration component be considered in the capitation rates?

  Response: An administrative and underwriting gain load was assumed on the BHDP component of the capitation rates. The revised load in the capitation rate development is a weighted blend of the prior load percentage on the base capitation claims and a 1% administrative load plus the underwriting gain applied to the BHDP.

- Are the BHDPs restricted to the Categories of Service (COS) in the preprints? How are the impacted COS defined?

  Response: The BHDPs are limited to services on the Behavioral Health FFS fee schedule and in the impacted COS as identified in the preprints submitted to CMS. The impacted COS services are defined using OHG financial criteria that was sent to CCOs on 3/9/2022.

- Can you please clarify if the CCOs will receive additional BH funding in the capitation rates for the July – December 2022 time period?

  Response: There will be no additional funding increase for the CCOs in the capitation rates for the July – December 2022 time period.

- Will the BHDPs apply to services rendered in Federally Qualified Health Center (FQHC) and Rural Health Clinics (RHC)?

  Response: The BHDPs will apply to services rendered in FQHCs and RHCs.

- Please provide more details around the Alternative Payment Methods (APM) discussion during the meeting. For example, in 2023, if we utilized capitation agreements, would we compare the capitation paid versus an underlying FFS value (now including the new directed payments)?

  Response: CCOs are encouraged to continue to utilize APMs that are more advanced in the provider risk continuum than paying on an FFS basis. Overall pricing levels for these arrangements must be

consistent with the BHDP reimbursement levels described in the preprints. The CCO must notify OHA of these arrangements, provide supporting evidence of equivalence with the notification and in the notification and identify the directed payment component of the APM reimbursement. Below are examples of how supporting evidence of equivalence could be demonstrated. These examples are not intended to be exhaustive or prescriptive.

APM Example 1

CCO contracts with subcontractor to provide MH Non-Inpatient services. Rate effective January 1, 2022 was $5 PMPM which is based on 150,000 projected member months. CCO determines 20% of utilization is associated with Primarily Medicaid providers and 80% is associated with Primarily Non-Medicaid providers.

- For the rate effective January 1, 2023, CCO determines the Tiered Uniform Rate Increase component of the directed payment ($5 * 20% * 30% + $5 * 80% * 15%) = $0.90 PMPM increase.
    - Additionally, the CCO projects there will be 500 units of 90837 provided in CY 2023 that would be eligible for the CLSS non-rural increase and no services that would be eligible for the COD increase.
- For the rate effective January 1, 2023, CCO determines the CLSS Increase component of the directed payment = Number of units * State plan FFS fee schedule rate as of January 1, 2023 * Non-Rural CLSS increase = 500 * $172.72 * 22% = $18,999.20. Converting this to a PMPM equates to $18,999.20 / 150,000 = $0.13 PMPM increase.
    - The total subcontracted PMPM = $6.03 PMPM including $0.90 Tiered Uniform Rate Increase and $0.13 CLSS increase.

OHA encourages CCOs to include a settlement or risk sharing arrangement related to COD and CLSS as these are new services.

APM Example 2

CCO contracts with subcontractor to provide MH Non-Inpatient services. Rate effective January 1, 2022 was $5 PMPM. CCO rebases the rate effective January 1, 2023 prior to consideration of the directed payment and determines the rate would be $4 PMPM due to decreased utilization from the prior year. The CCO then determines 20% of utilization is associated with Primarily Medicaid providers and 80% is associated with Primarily Non-Medicaid providers.

- For the rate effective January 1, 2023, CCO determines the Tiered Uniform Rate Increase component of the directed payment ($4 * 20% * 30% + $4 * 80% * 15%) = $0.72 PMPM increase.
    - Additionally, the CCO modifies the contracted rate to pay out the enhanced COD and CLSS payments to providers on an FFS or non-risk basis outside of the at-risk subcapitation arrangement.

The total subcontracted PMPM = $4.72 PMPM excluding separate payments for the COD and CLSS directed payments.

- Can OHA/Mercer provider greater details on the methodology in which CCO specific BH Directed Payments will be developed, inclusive of which current adjustments will or will not be applied (e.g., risk adjustment, hospital factors, regional factors)?

  Response: The behavioral health uniform increases and minimum fee schedule directed payments were calculated based on actual CY 2021 utilization by procedure code, COA, and CCO projected to CY 2023 utilizing assumptions and adjustments consistent with the CY 2023 capitation rate development. Additionally, below is detail on directed payment specific assumptions:

  - The Tiered Uniform Rate Increase Directed Payment assumptions were developed based on 1) a review of provider type/provider specialty descriptions 2) annual managed care spend per provider and 3) discussion with OHA on anticipated Primarily Medicaid providers. Specifically, 50% of Mental Health Non-Inpatient, 50% of Substance Use Disorder and 100% of the ACT/SE utilization was assumed to be for Primarily Medicaid providers. These assumptions did not vary by CCO.
  - The COD assumptions were developed based on review of eligible procedures meeting the COD diagnosis criteria provided by OHA. A utilization ramp up assumption was also used recognizing that not all current COD utilization will be performed by certified providers in the future and all eligible providers may not be certified as of January 1, 2023. These assumptions did not vary by CCO.
  - The CLSS assumptions were developed utilizing a list of anticipated CLSS-eligible providers by OHA with an assumption for potential new qualifying providers. Additionally, assumptions were varied by CCO with those serving urban locations projected to have a higher percentage of providers that are CLSS-eligible and would receive the non-rural increase.

  CCO-specific adjustments were developed and therefore the risk adjustment, hospital factors and regional factor adjustments were not applied to avoid double counting.

- Please provide examples showing how CCOs should increase contracted rates if providers meet multiple directed payment criteria.

  Response: Please see the following examples.

  Calculation Example 1

  Consider the following example for a provider who qualifies for the Tier 2 (30% of negotiated rate) increase, COD Master's increase (20% of State Plan fee schedule) and CLSS Non-Rural increase (22% of State Plan fee schedule):

  PROVIDER AND SERVICE CHARACTERISTICS

  - COS/CPT Code: Mental Health Non-Inpatient, 90837
  - Primarily Medicaid / Primarily Non-Medicaid: Primarily Medicaid
  - CLSS Eligible: Yes, non-rural
  - COD Eligible: Yes, non-residential, master's level
  - CCO-contracted rate as of January 1, 2022 = $180.00

- State plan FFS fee schedule rate as of January 1, 2023 = $172.72

CY 2023 CCO PAYMENT

- Tier 2 base payment: = Contracted rate as of January 1, 2022 * Tier 2 uniform increase = $180.00 * 1.30 = $234.00
- COD Increase: State plan FFS fee schedule rate as of January 1, 2023 * Master's COD increase = $172.72 * 20% = $34.54
- CLSS Increase: State plan FFS fee schedule rate as of January 1, 2023 * Non-Rural CLSS increase = $172.72 * 22% = $38.00
- Total CCO payment = Tier 2 payment + COD Increase + CLSS increase = $234.00 + $34.54 + $38.00 = $306.54

Calculation Example 2

Consider the following example for a provider who qualifies for the minimum fee schedule directed payment and COD residential increase (15% increase):

Provider and Service Characteristics

- COS/CPT Code: SUD Residential, H0019
- Primarily Medicaid / Primarily Non-Medicaid: N/A
- CLSS Eligible: N/A
- COD Eligible: Yes, residential
- CCO-contracted rate as of January 1, 2022 = $700.00
- State plan FFS fee schedule rate as of January 1, 2023 = $910.00

CY 2023 CCO Payment

- Minimum fee schedule base payment: = State plan FFS fee schedule rate as of January 1, 2022 $910.00
- COD Increase: State plan FFS fee schedule rate as of January 1, 2023 * Residential COD increase = $910.00 * 15% = $136.50
- Total CCO payment = Minimum fee schedule base payment + COD Increase = $910.00 + $136.50 = $1,046.50

- How will single case agreements be handled in the directed payment?

Response: CCO are expected to pay new providers, whether participating or non-participating, at rates comparable to existing providers after the tiered payment increase. CCO shall submit an updated written attestation of compliance no later than September 30, 2023, if contracting with a new provider or renegotiating current provider contracts after the initial attestation due March 31, 2023.

- Will CCOs be required to pass along these reimbursement increases?

  Response: Yes, once approved by CMS, the CCOs must comply with the BHDP reimbursement requirements as part of their contract.

- Does CMS need to approve both the FFS schedule and the BHDP for these to be effective in the managed care contract?

  Response: Yes, the FFS proposed fee schedule submitted to CMS in August was approved in November 2022 and thus the minimum fee schedule requirements are approved for CCOs. OHA hopes to receive the approvals for the tiered, CLSS and COD directed payments prior to the end of 2022.

TIERED UNIFORM RATE INCREASE DIRECTED PAYMENT

- Some CCOs increased their reimbursement rates to providers in 2022. Those increases would not count towards meeting the directed payment requirement as there must be further increases off negotiated rates from the rates as of June 30, 2022. We request the directed payment be based on negotiated rates as of January 2022.

  Response: The tiered uniform increase directed payment was revised to be in addition to the rates in place for CCOs for qualified BH providers effective January 2022.

- How will providers who meet the Primarily Medicaid/ Primarily Non-Medicaid criteria be identified? Can we receive a list of these providers?

  Response: The Tier 1 increase is for providers with less than 50% of BH revenue derived from providing Medicaid services in the prior CY and Tier 2 is for providers with 50% or greater of BH revenue derived from providing Medicaid services in the prior CY. OHA will not be providing a list of these providers. The CCOs must collect data from providers documenting the Medicaid portion of payment revenue in the prior year and identify whether they would meet the Primarily Medicaid or Primarily Non-Medicaid criteria. This supporting documentation must be provided to OHA upon request. OHA is in the process of creating a provider template that can be used by CCOs to validate the revenue. BH providers that have not submitted documentation supporting qualification for the higher payment tier should automatically be paid at the lower tier. CCOs cannot delay payment at the lower tier while waiting for these providers to submit documentation that they qualify for the higher tier.

- Do CCOs need to retroactively increase payment once attestation is received?

  Response: OHA recognizes it will take time for providers to gather the necessary documentation to demonstrate whether they are a Primarily Medicaid provider. To ensure Primarily Medicaid providers receive the enhanced payment rates timely, OHA is requiring the tiered increase be retroactively implemented based on date of service effective as of the first day of the calendar quarter in which the provider provides the documentation to the CCO. Additional administrative funding was included to implement these payment increases.

- There is no standardized template for providers to use to report to the CCO. The CCO will need to develop a template and instructions and communicate that with a multitude of providers. Providers contracted with more than one CCO will receive multiple requests.

  Response: OHA is in the process of creating a uniform attestation template for providers to fill out and provide to CCOs.

- Is provider "Revenue" defined as billed charges or net cash collected? Are non-claim APM's included in the calculation as Medicaid revenue?

  Response: Provider revenue would include net cash collected as it should represent net income to the provider. Non-claim APMs should be included in the calculation as Medicaid revenue if received from a CCO on behalf of Medicaid-covered individual for a Medicaid-covered service.

- What is the process to document compliance with this directed payment to OHA? How frequently will providers need to be re-certified?

  Response: The CCO must provide OHA with a written attestation of compliance with the tiered uniform rate increase requirement on an annual basis. The attestation should include a list of all contracted providers eligible for the tiered uniform rate increase payment and confirmation that negotiated rates comply with the parameters of the directed payment. The CCO shall submit a revised written attestation of compliance on an annual basis if contracting with a new provider or renegotiating current provider contracts. Additional supporting documentation of each provider's prior CY Medicaid percentage of total revenue must be provided to OHA upon request. Please see guidance document and CCO contract for specific timelines.

- Providers may not wish to disclose their financial information to the CCO. Additionally, the CCO may be required to forward that information to OHA, increasing the unease of the provider and the CCO unable to clearly define where that information may ultimately be stored or published.

  Response: It is in the providers' interest to disclose this information to receive the higher Primarily Medicaid rate. If a provider does not disclose this information, then it would receive the Primarily Non-Medicaid rate.

- Clarity is needed regarding the maintenance of the tier levels. For example, what if a provider has greater than 50% Medicaid Revenue in the measurement year but falls below that level in the following year. Are payments to be retroactively adjusted downward to adjust for the tier reclassification after year end?

  Response: Providers are attributed to only one tier for the current contract year based on revenue in the prior contract year. If the provider qualified as Primarily Medicaid in the current contract year based on revenue in the prior contract year, it would not be reclassified as Primarily Non-Medicaid for the current contract year if revenue falls below 50% Medicaid in the current contract year.

- We are already getting started and committed to getting the funding to our providers as soon as possible, but we are concerned about the timing expectations. The scope of the project is simply too large to execute an attestation by January 30th. We strongly suggest that any attestation date is moved further into the year, or an extension request process be utilized.

Response: OHA is revising the contract to require the attestation of compliance no later than March 31, 2023, for participating providers and updated attestation September 30, 2023, for providers whose contracts are new or have been modified for any reason relating payment rates since the initial attestation.

CO-OCCURRING DISORDER DIRECTED PAYMENT

- We understand that OHA will be certifying co-occurring disorder (COD) providers. Once all approved statewide BH COD providers are certified, can OHA share the statewide list with CCOs to assist with implementing the rate increases to certified outpatient COD and residential providers?

  Response: The billing entity must be certified under the forthcoming COD rules to be eligible for this directed payment. OHA will provide a list of certified providers once available.

CULTURALLY AND LINGUISTICALLY SPECIFIC SERVICES DIRECTED PAYMENT

- We understand that OHA will be certifying culturally and linguistically appropriate service providers who meet OHA standards. Can OHA share the list of these statewide certified providers along with those that qualify as rural and non-rural?

  Response: The billing entity will no longer be required to be certified by OHA but they must meet eligibility requirements as outlined in OAR 309-065-0010 - Culturally and Linguistically Specific Services Organization and Program Qualifications for this directed payment. OHA will provide a list of eligible providers once available and CCO's may request documentation directly form the provider. Both the list of eligible providers and billing guidance defining rural and non-rural will be made available on OHA's website.

- When can CCOs expect the list of eligible BHDP providers referenced on page 11 of the FAQ? This list is important for the CCOs to make sure we can have timely operational processes in place to report and contract with the appropriate providers. We also want to make sure that both CCOs and providers have enough time to implement the modifier and other coding changes. These changes are a large lift operationally for the CCOS and the provider partners, especially the smaller clinics with resource limitations.

  Response: OHA will maintain a list of providers eligible for the CLSS enhanced payments and billing guidance on its website. it is anticipated that the first list of providers will be available on January 30, 2023.