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) has implemented four behavioral health directed payments (BHDPs) within the CCO contracts that will further the goals and priorities of the Medicaid program, as follows:

This document outlines frequently asked questions related to the new behavioral health directed payments going into effect January 1, 2024. 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

- 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.

- How is a provider's Tier status calculated if the provider has been contracted for less than a year?

  Response: Providers should calculate their percentage of Medicaid service revenue by calculating that revenue for the previous billing year or, if the provider has not been operating for a full year, this should be calculated using the service revenue from the time the provider began billing for services. The percentage increase will be calculated by increasing the existing rate paid to the provider by the CCO by the applicable percentage (15% for tier 1 and 30% for tier 2).

- 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. Preprints have been submitted to CMS.

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

  Response: Yes, 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 2024 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.

- Do we have to break down percentages for each clinician or just the company as a whole for the 30%? I have a group practice of 16 clinicians. The attestation form does not clarify this and seems to ask two different things on both forms.

  Response: Percentages of Medicaid revenue should be reported for the company as a whole and separated out by payer types.

- Do CCO rate increases stack upon each other. For example: What would the CCO rate increase be if a provider is deemed to be a primary Medicaid provider and is eligible for the Culturally and Linguistically Specific Services (CLSS) certification?

  Response: The tier rate increases (30% for primarily Medicaid) are for all BH rates. So, additional rate increases/enhanced payments that a provider is eligible for would be in addition to that rate increase. This would include the enhanced rate for approved CLSS providers.

APM Example 1

CCO contracts with subcontractor to provide MH Non-Inpatient services. Rate effective January 1, 2023 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, 2024, 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, 2024, 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, 2023 was $5 PMPM. CCO rebases the rate effective January 1, 2024 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.

- 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, 2023 = $180.00
- State plan FFS fee schedule rate as of January 1, 2024 = $172.72

CY 2024 CCO PAYMENT

- Tier 2 base payment: = Contracted rate as of January 1, 2023 * Tier 2 uniform increase = $180.00 * 1.30 = $234.00
- COD Increase: State plan FFS fee schedule rate as of January 1, 2024 * Master's COD increase = $172.72 * 20% = $34.54
- CLSS Increase: State plan FFS fee schedule rate as of January 1, 2024 * 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, 2023 = $700.00
- State plan FFS fee schedule rate as of January 1, 2024 = $910.00

CY 2024 CCO Payment

- Minimum fee schedule base payment: = State plan FFS fee schedule rate as of January 1, 2023 $910.00
- COD Increase: State plan FFS fee schedule rate as of January 1, 2024 * 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, 2024, if contracting with a new provider or renegotiating current provider contracts after the initial attestation due March 31, 2024.

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

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

TIERED UNIFORM RATE INCREASE DIRECTED PAYMENT

- 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 has created 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.

- Are tiers re-assessed yearly, based on Medicaid patient percentages?

  Response: Attesting to Tier 2 (30% increase) is an annual process. Tier 1 (15% increase) does not require any attestation.

- 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.

- If a provider is not contracted with a CCO and then becomes contracted: How far back, if at all, are payments retroactively adjusted to include their CLSS increase?

  Response: There would not be retro in that situation. The CLSS increase would begin once credentialing is complete, and the contract is executed.

- 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.

- 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.

- How does the tiered directed payment covering mobile crisis services interact with the new

requirement that mobile crisis services be paid using the FFS rate as a minimum?

Response: Directed payments for mobile crisis services are addressed in a separate MCIS Guidance document for CCOs posted to OHA's contracts forms website.

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 provides a list of certified providers on the rate increase webpage HERE.

- If a group or facility is set up with OHA and CCOs for the ICOD payment, do each of the individual providers within the group/facility need to enroll as well?

  Response: No, not all providers in the group need to be registered as ICOD practitioners. However, to be approved, programs must have listed or recruiting all OAR 309-019-0145 and OAR 309-019-0160 required scopes of practice: MH provider, SUD provider, problem gambling specialist, peer services provider and LMP that can provide psychiatric medical services.

CULTURALLY AND LINGUISTICALLY SPECIFIC SERVICES DIRECTED PAYMENT

- We understand that OHA approves culturally and linguistically specific service providers who meet OHA standards. Can OHA share the list of these statewide 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.

- Where can CCOs find a list of approved Culturally and Linguistically Specific providers?

  Response: OHA will maintain a list of providers eligible for the CLSS enhanced payments and billing guidance on its website HERE.

- How will providers continue to stay on the OHA CLSS & ICOD lists?

  Response: The approval may be revoked during review process if eligibility requirements per OAR 309-019-0145 or OAR 309-018-0160 (Outpatient/Residential) are not being met.