Behavioral Health Rate Increase Webinar

Welcome to the Presentation!

December 14, 2022

Oregon Health Authority

Agenda

1. Overview
2. CCO Behavioral Health Directed Payments (Jan 2023)
    - #1 – Tired Increase for BH Services
    - #2 – Increase for Co-occurring Disorders
    - #3 – Increase for Culturally and Linguistically Specific Services
    - #4 – Minimum Fee Schedule Increase
3. Fee-For-Service Increase Billing Update (July 2022)
4. Culturally and Linguistic Specific Services
5. Co-occurring Disorder
6. Questions & Answers

OHA Health Equity Definition

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not ***disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.***

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Sustainable, long-term investment that focuses on quality, accountability and advancing health equity in Behavioral Health

HB5202 Overview

$42.5m was appropriated to increase BH reimbursement rates (21-23)

- Legislature specified different effective dates for rate increases:
  1. FFS/Open Card providers – Effective July 1, 2022
  2. CCO network providers – Effective January 1, 2023

2021-2023	General Fund	Federal Funds	Total Funds
CCO	18,500,000	56,000,000	74,500,000
FFS/Open Card	24,000,000	56,000,000	80,000,000
	$42,500,000	**$112,000,000**	**$154,500,000**

- OHA received the appropriation in June 2022 from the Emergency Board to implement these increases

Goals

- **Sustainable**: Make a sustainable investment in BH
- **Access**: Tie payment to improved, equitable access
- **Workforce**: Improve wages, retention, and workforce diversity
- **Accountable:** Ensure the payment has accountability and measurable impact to provider stability and capacity
- **Health Equity**: Reduce behavioral health inequities and incentivize culturally responsive and linguistically appropriate services
- **Parity**: Improve parity of rates within Medicaid and compared with other payers
- **Quality**: Elevate quality and accountability
- **Feasible**: Implement successfully based on the timeline specified in the budget note
- **CMS/Federal Approval:** Achieve federal approval for this significant increase

Implementation Progress and Status

Open Card – Fee-For-Service (FFS)

- ✓ Distributed increased funds to FFS rates based on parity and access
- ✓ Proposed updated FFS rate schedule and gathered feedback
- ✓ Submitted and received **approval** from CMS (Nov 2022)
- ○ Retroactively adjust payments back to July 1, 2022

Coordinated Care Organizations

- ✓ Gathered feedback on increases needed in CCO provider network
- ✓ Developed and submitted Directed Payment application to CMS
- ✓ Submitted CCO capitation rates with increased funding to CMS
- ○ Waiting on Directed Payment application approval

CCO Behavioral Health Directed Payment

Chelsea Guest, Director of Office of Actuarial and Financial Analytics

Background
What are Directed Payments?

42 CFR §438.6(c)

A state Medicaid agency has the ability to tell its managed care (MC) plans how to pay **network** providers for specific services.

These are payments for services rendered to enrollees or payments for outcomes tied to the utilization of services.

Estimated Impact to 2023 CCO Capitation Rates

Initial funding was $149m

Directed Payment	CY 2023 CCO Rates
#1 Uniform Increase for BH services	$175,019,964
#2 Uniform Increase for Co-Occurring Disorders	$5,703,217
#3 Uniform Increase for Culturally and Linguistically Specific Services	$3,579,201
#4 Minimum Fee Schedule	$36,988,926
Total	**$221,291,308**

Note:
*Estimated rate increases subject to CMS review and approval.

Four Different BH Directed Payments

Subject to CMS approval

Tiered Payments for Majority of BH Services

Effective January 2023, CCOs will implement a tiered increase to negotiated rates (compared to Jan 2022) for network BH Providers for the following services:

- Assertive Community Treatment & Supportive Employment (ACT/SE)
- Mental Health (Non-inpatient)
- Substance Use Disorder (Non-inpatient)

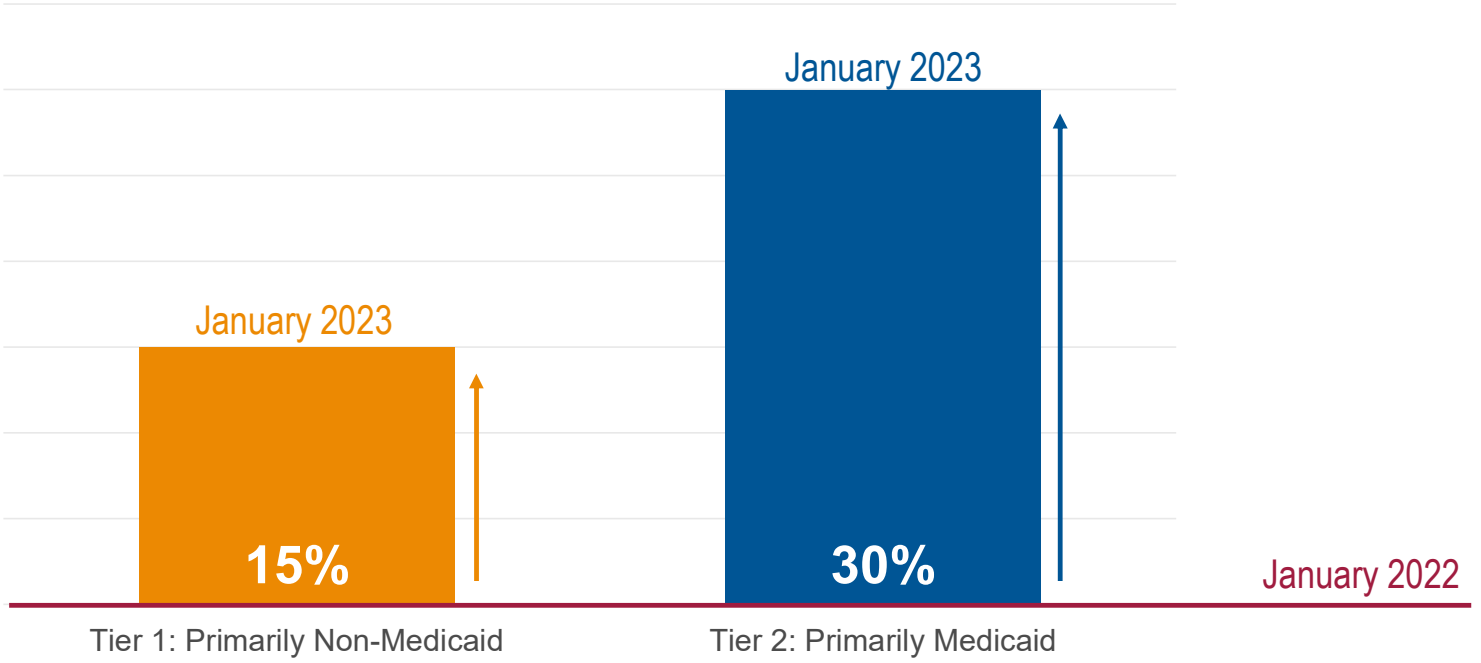
Increases vary depending on the provider's service revenue in Calendar Year 2022:

- **Primarily Medicaid (Tier 2)**: Providers who have more than 50% Medicaid Revenue* in CY22
- **Primarily Non-Medicaid (Tier 1)**: Providers who have 50% or less Medicaid Revenue* in CY22

**Note: Provider should include all BH patient service revenue for percent calculation.*

Tiered Payments

CCOs increases will be based on provider and their negotiated rates as of January 2022



CCO & Provider Responsibilities

Tiered payments for Majority of BH Services

Coordinated Care Organizations

- **Increased Payment for Tier 2**: Upon receipt of documentation supporting Tier 2, CCOs must pay the higher increase effective the quarter in which documentation is received – Timeline examples:
  - Tier 2 provider documentation received March 30, 2023, increase effective January 1, 2023
  - Tier 2 provider documentation received April 15, 2023, increase effective April 1, 2023
- **Increased Payment for Tier 1:** Provider documentation is not required for the 15% increase
- **Website**: CCOs must create a publicly accessible website for providers to understand how to access these increases
- **Attestation**: CCOs must attest to compliance to all BH Directed Payments by March 31, 2023
- **Deliverables**: CCOs must submit network and financial information with BH Directed Payment split outs and provider designations (as required by contract)

Behavioral Health Providers

- **Finances**: Providers should gather financial information for 2022 to show the distribution of patient service BH revenue between Medicaid and non-Medicaid payors
- **Submit Information if Tier 2**: If provider is Primarily Medicaid (>50% Medicaid), they must notify CCOs and submit information
  - OHA is working on a consistent financial template for providers to submit to CCOs
  - Tier 1 providers do not have to submit information to get the 15% increase

Integrated Co-occurring Disorder Directed Payment

Effective January 2023, CCOs will increase payment for network BH Providers approved by OHA for integrated treatment of Co-Occurring Disorders (COD) for the following services:

- Substance Use Disorder Residential and Non-inpatient
- Mental Health Non-Inpatient
- Mental Health Children's Wraparound

CCO will increase rates with an add-on payment depending on the provider and services provided for integrated COD:

- **Master's Level Providers:** 20% increase based on Medicaid FFS
- **SUD Residential Service Providers:** 15% increase based on Medicaid FFS
- **Non-Master's Level & Peers**: 10% increase based on Medicaid FFS

CCO & Provider Responsibilities

Integrated COD

Coordinated Care Organizations	Integrated COD Providers
• **Increased Payment for COD**: CCOs must pay the higher increase effective upon the provider's integrated COD approval from OHA once they receive documentation and/or view the approved list on the OHA website • **Website**: CCOs must create a publicly accessible website for providers to understand how to access these increases • **Attestation**: CCOs must attest to compliance to all BH Directed Payments by March 31, 2023 • **Deliverables**: CCOs must submit network and financial information with BH Directed Payment split outs and provider designations (as required by contract)	• **Apply**: Providers who qualify for the integrated COD qualifications should apply with OHA to gain approval • **Billing**: Once approved, providers should use appropriate billing practices to gain this increase from CCOs (e.g., diagnostic, modifiers, etc.)

Culturally and Linguistically Specific Services (CLSS) Directed Payment

Effective January 2023, CCOs will increase payment for network BH Providers approved by OHA for qualifying for Culturally and Linguistically Specific Services delivery for the following services:

- Substance Use Disorder Non-inpatient
- Mental Health Non-Inpatient
- Mental Health Children's Wraparound
- Assertive Community Treatment and Supportive Employment (ACT/SE)
- Applied Behavioral Analysis (ABA)

CCO will increase rates with an add-on payment depending on the provider and services provided for CLSS:

- **Rural CLSS providers:** 27% increase based on Medicaid FFS
- **Non-Rural CLSS providers:** 22% increase based on Medicaid FFS

CCO & Provider Responsibilities

CLSS

Coordinated Care Organizations	Integrated COD Providers
• **Increased Payment for CLSS**: CCOs must pay the higher increase effective upon the provider's CLSS approval from OHA once they receive documentation and/or view the approved list on the OHA website • **Website**: CCOs must create a publicly accessible website for providers to understand how to access these increases • **Attestation**: CCOs must attest to compliance to all BH Directed Payments by March 31, 2023 • **Deliverables**: CCOs must submit network and financial information with BH Directed Payment split outs and provider designations (as required by contract)	• **Apply**: Providers who qualify for the CLSS qualifications should apply with OHA to gain approval for this designation • **Billing**: Once approved, providers should use appropriate billing practices to gain this increase from CCOs (e.g., diagnostic, modifiers, etc.)

BH Minimum Fee Schedule Directed Payment

Effective January 2023, CCOs will pay all BH Providers no less than the applicable State Medicaid FFS payment rate effect on the date of services for the following services:

- Substance Use Disorder Residential
- Applied Behavioral Analysis
- Children's Wraparound

Please note: No provider actions needed

How do BHDPs interact?

Providers may be eligible for more than one BHDP depending on the service

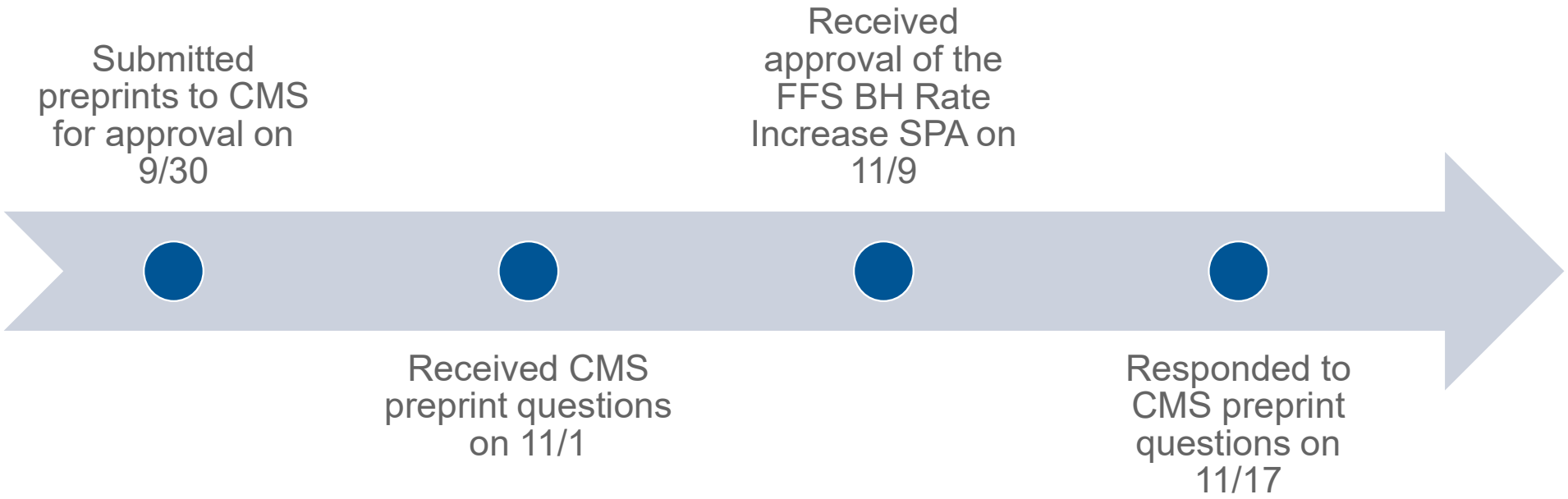
**Note: Axis does not start at zero*

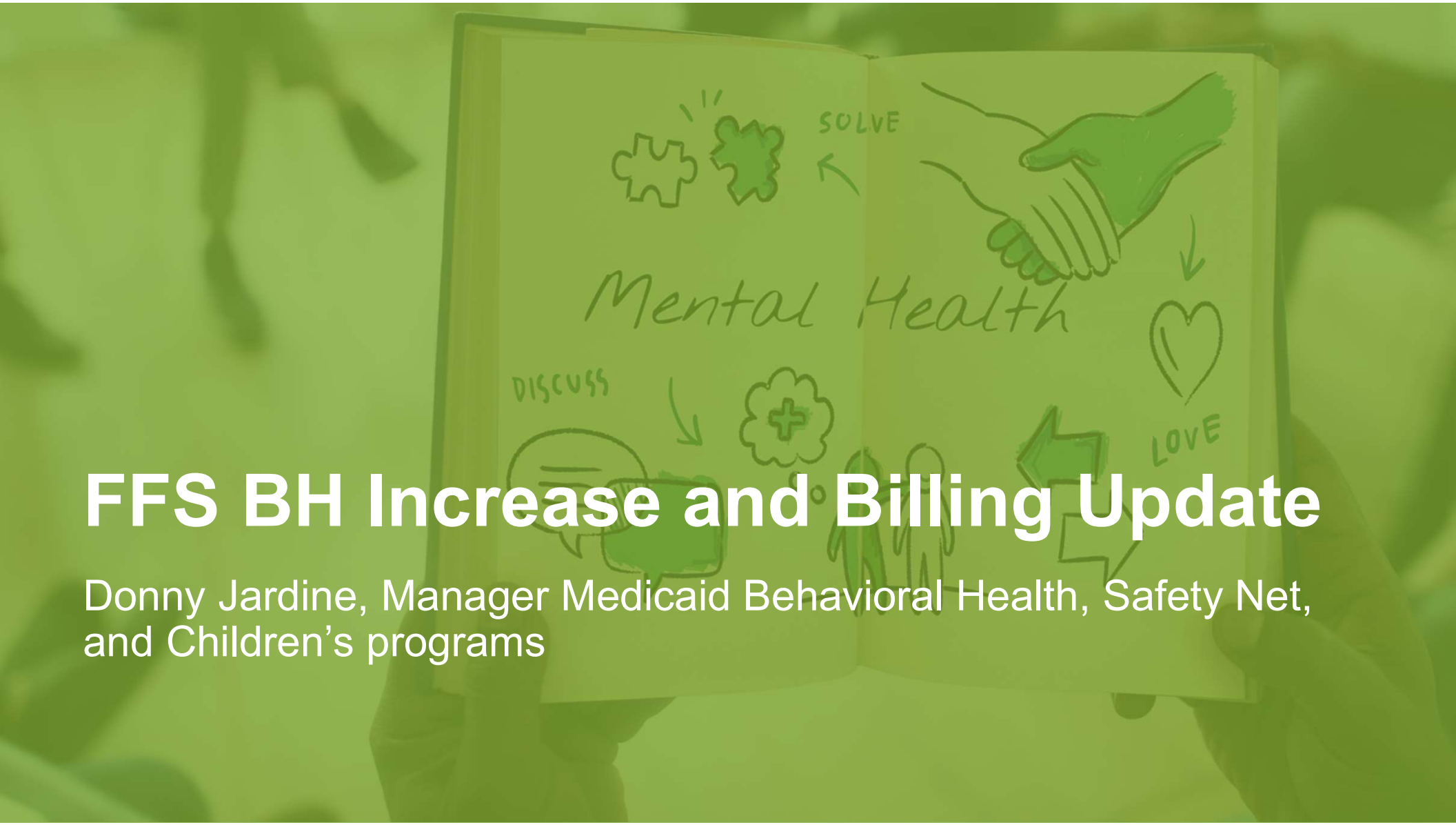
Alternative Payment Methodologies

- CCOs may utilize alternative payment methodologies (APMs) in paying providers, but must demonstrate to OHA how they incorporated the directed payment increase
- CCOs may choose to utilize APMs for some directed payments and not all
    - Note: If CCOs chooses an APM for CLSS or COD, OHA encourages CCOs to include a settlement or risk-sharing arrangement as these are new services and have limited history – meaning utilization may be **higher** or **lower** than APM

CMS Application Timing

OHA is hoping to secure CMS approval before Dec 31, 2022





FFS BH Increase and Billing Update

Donny Jardine, Manager Medicaid Behavioral Health, Safety Net, and Children’s programs

Billing FFS Claims

On August 4, 2022, OHA provided three options to bill for rate increases:

Option 1: Wait to Bill for services rendered

Option 2: Bill at the Proposed Rate increase

Option 3: Bill at the Current Rate… and then Adjust to the New Rate

OHA will communicate with providers via memo and through our webpage when the MMIS is updated and configured.

OHA will update and post the behavioral health fee schedule which will include the updated, approved rates, when MMIS is appropriately configured.

Option 1: Wait to Bill for Services Rendered

Providers who elected this option should bill for services rendered at the amount identified on the BH fee schedule

This option will result in the timeliest reimbursement for service

Claims may be billed as soon as the BH fee schedule is updated and posted, and OHA communicates MMIS is updated

Option 2: Bill at the Proposed Rate Increase

Providers who elected to bill at the increased, proposed rate may choose one of two actions.

1. Take no action, OHA complete the System Mass Adjustment Process (SMAP) two weeks after the MMIS is configured; or
2. For more immediate reimbursement, providers may adjust their claims to the same, approved amount, which will prompt payment for the difference between the new high amount and the previous, paid amount

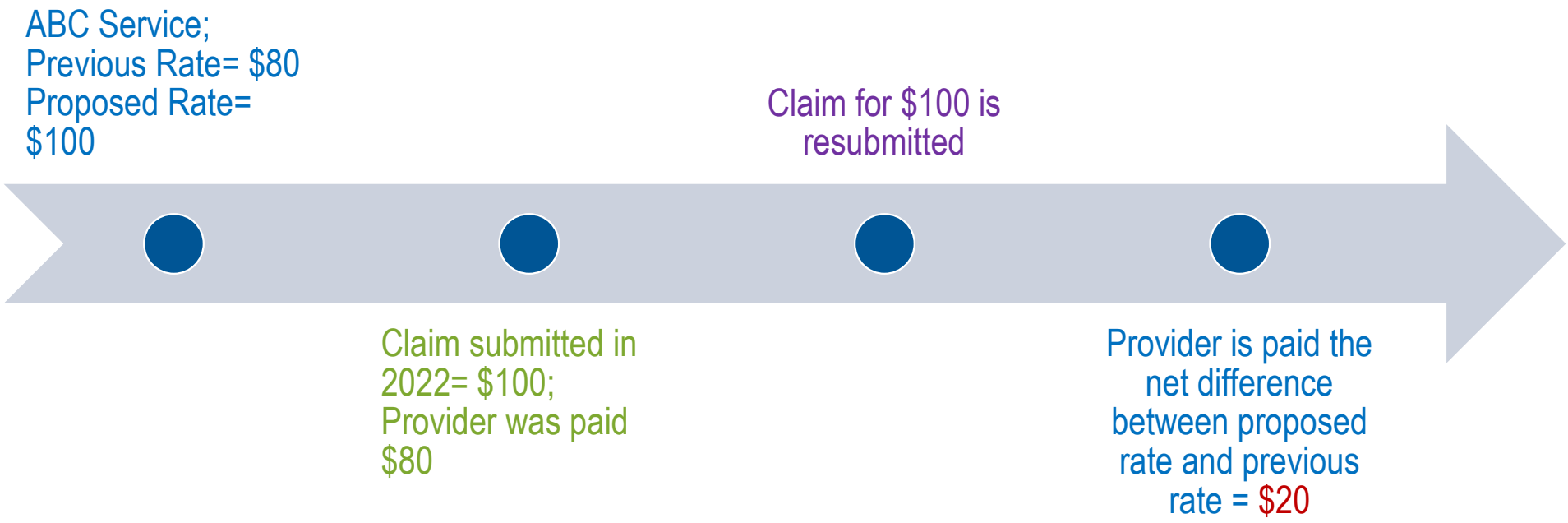
Example: For service ABC- previous rate = $80, proposed rate = $100

Provider submitted claim for $100 in Sep 2022; they were paid $80

If the provider resubmits claim for $100; they will be paid the net difference between proposed rate and previous rate = $20

- Adjusted claims will follow the steps outlined in the following slide

Option 2: Example



Option 3: Bill at the Current Rate, then Adjust to the New Rate

Once OHA posts the updated fee schedule and disseminated communication providers may adjust their billing to receive the updated rates

Providers may adjust rates using either the web portal or the 1036 form.

- Web Portal: May adjust billed amounts for up to 18 months after the date of service
- 1036 Form: Requires OHA claims to enter manual adjustments (which takes additional time to reconcile)

Billing FFS for Adult Residential Services

OHA will direct Comagine Health to enter the higher approved tier rates into MMIS immediately.

- All newly assessed members will be entered at the higher tier rate

Providers who have been holding their billing for adult residential services should now submit their claims for reimbursement

OHA will work on a manual process to update rates retroactive to July 2022

- Due to the manual processing, this will take significant time and resources to complete, as identified in the August 4th webinar
- OHA anticipates this work completed by June 2023.
- OHA will ensure all claims for Adult BH services will be reimbursed retroactive to July 2022

Tips - FFS Billing for CLSS

FFS providers must bill for the **FFS base rate** and then use a modifier for the **enhanced rate**.

- Future billing guidance for CLSS will be made available soon on the OHA website.

Note: CCO's have the option to use a modifier for CLSS services or another billing mechanism and the CCO will be responsible for communicating to their provider network.

Culturally and Linguistically Specific Services

Alfonso Ramirez, Director of Behavioral Health Equity and Community Partnership

What are Culturally and Linguistically Specific Services?

CLSS are services that are grounded in the cultural values of minoritized communities (communities that have experienced historical and contemporary racism, trauma, and social, political, and economic injustices) to elevate their voices and experiences.

CLSS aims are to enhance emotional safety, belonging, and a shared collective cultural experience for healing and recovery of the community served.

They are provided by a culturally and/or linguistically specific organization, program or individual provider.

Covered Services

Covered services in Assertive Community Treatment (ACT)/Supported Employment (SE), Applied Behavior Analysis (ABA), Mental Health Non-Inpatient, Mental Health Children's Wraparound services and Substance Use Disorder Non-Inpatient listed on the Medicaid Fee-For-Service Behavioral Health Rate Increase Fee Schedule

- Non- rural settings: 22% enhanced payment at FFS Rate
- Rural Settings: 27% enhanced payment at FFS Rate
  - *Rural is defined as any geographic areas in Oregon ten or more miles from the centroid of a population center of 40,000 people or more.*

How to access the enhanced payment

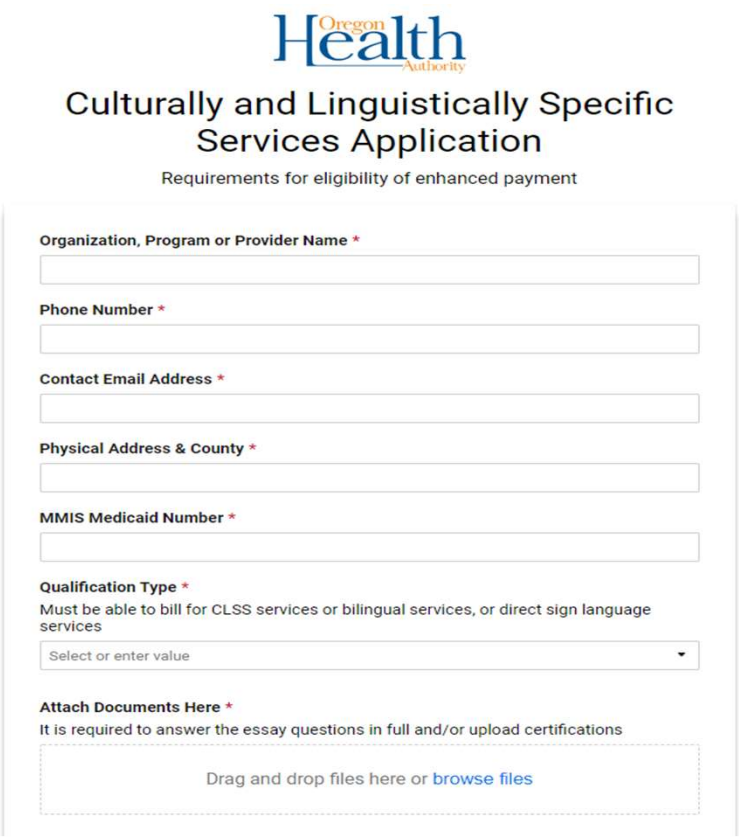
Providers must meet OHA eligibility requirements as outlined in Oregon Administrative Rule 309-065-000 to receive enhanced payments for CLSS and may access the application process on OHA's website.

- Culturally and Linguistically Specific Service (CLSS) Organization, Program or Individual Provider
- Bilingual Service or Sign Language Providers

For FFS, providers will be instructed on how to access billing guidance on the OHA Website. Billing is retroactive to July 1, 2022.

For CCOs, they will determine their own process for reimbursing providers at enhanced rates. They may only reimburse providers deemed eligible by OHA after January 1, 2023, beginning on the date of application/approval.

Eligibility Determination Application Process



Oregon Health Authority

Culturally and Linguistically Specific Services Application

Requirements for eligibility of enhanced payment

Organization, Program or Provider Name *

Phone Number *

Contact Email Address *

Physical Address & County *

MMIS Medicaid Number *

Qualification Type *

Must be able to bill for CLSS services or bilingual services, or direct sign language services

Select or enter value

Attach Documents Here *

It is required to answer the essay questions in full and/or upload certifications

Drag and drop files here or browse files

- Application will be available by January 15.
- It may take up to 30 days to review the application.
- Notice of approval will be the providers documentation that they are an eligible CLSS provider.
- Providers should wait for notification of approval prior to billing.

Integrated Co-occurring Disorders

David Corse, Treatment Program Development Analyst

Integrated Co-Occurring Disorders (COD)

10% rate enhancement for all COD approved services in approved programs (modifier HH).

Providers with QMHP/master's level or above are eligible for 20% rate enhancement (modifier HO).

15%-day rate increase for residential services (modifier HH).

- Step 1: Organization application (application available by January 1)
- Step 2: OHA approval of organization application
- Step 3: Practitioner commits to engage in Integrated COD training and all staff qualifications as outlined in rule
- Modifiers are used to bill for enhanced rate

Integrated Co-Occurring Disorders (COD)

Oregon Administrative Rule OAR 309-019-0145 which will be finalized mid-January 2023 and will be retroactively effective January 1st.

Oregon Health Authority will create an approval process that will be accessible on the Integrated Co-Occurring Disorders website.

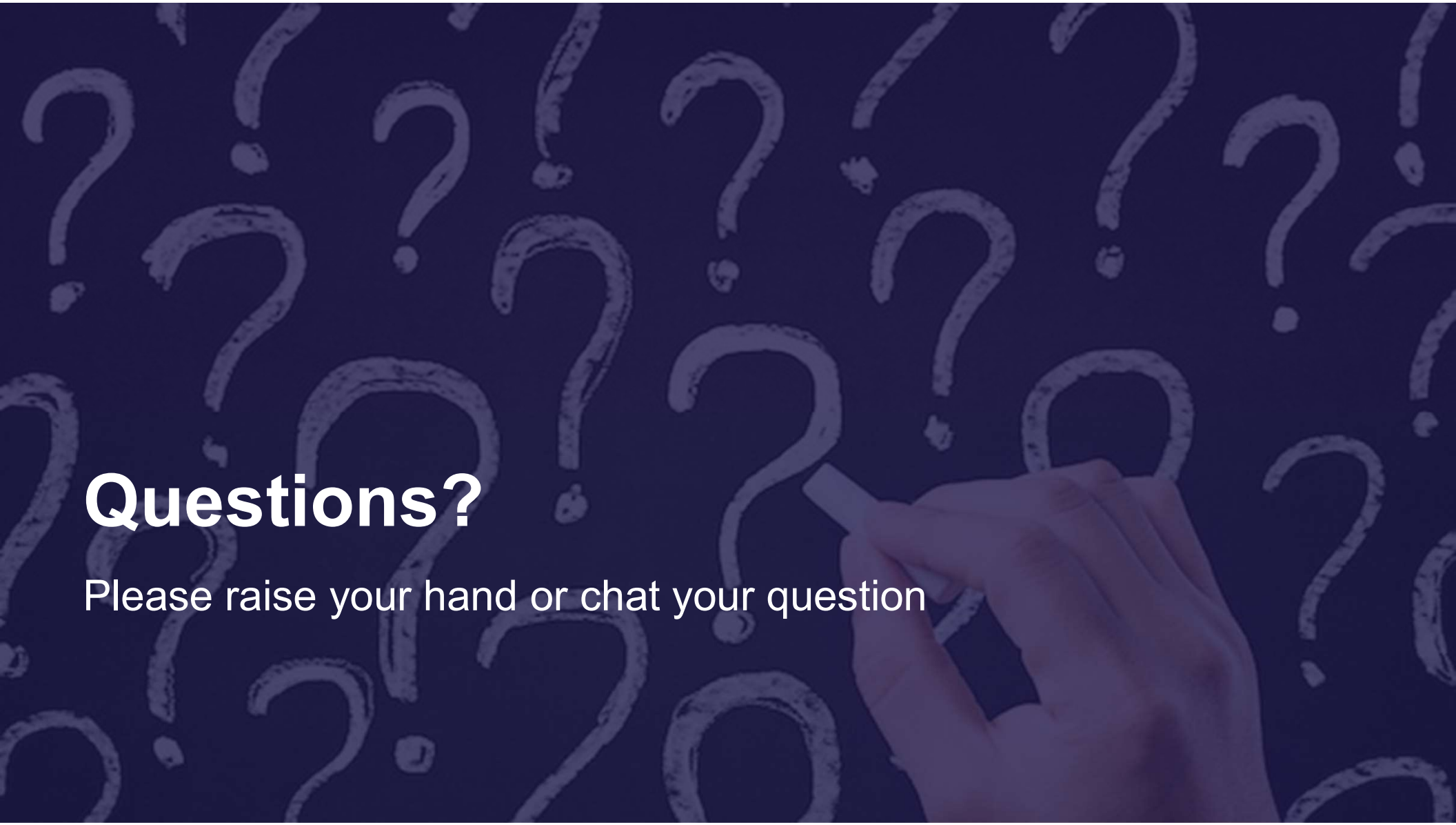
A supplemental implementation guide will be provided by OHA and will include:

- Further details about using the modifiers
- Authorized diagnostic combinations (MH/SUD/problem gambling)
- How OHA will notify CCO's when programs in their service area are approved
- How provider's will notify OHA and CCO's of their staff progression toward training completion on a quarterly basis

Resources

If you have issues or questions after this webinar, please use the contact information below:

- Billing issues, providers may contact Provider Services at 800-336-6016
  or dmap.providerservices@odhsoha.oregon.gov
- CCO rate increases, contact Actuarial Services at: Actuarial.Services@dhsoha.state.or.us
- CLSS enhanced rates, contact the Behavioral Health Equity team at: BHEquity@dhsoha.state.or.us
- Integrated Co-Occurring Disorders (COD) enhanced rates: icod.support@odhsoha.oregon.gov


Questions?
Please raise your hand or chat your question