House Bill 23-1269
Directed Payment Legislative Report

In compliance with 25.5-4-430 (2), C.R.S.

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COLORADO
Department of Health Care Policy & Financing

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I. Executive Summary

The Department of Health Care Policy & Financing (HCPF) created this report in accordance with House Bill 23-1269 (C.R.S. § 25.5-4-430 (2)), which called for an analysis of "how directed payment authority can be used as part of a comprehensive plan to facilitate an adequate network of services for children and youth." This report outlines ways in which federal authorities may be used in Medicaid's capitated behavioral health benefit to improve access to care and behavioral health provider networks for children and youth. With federal approval and using federal authorities, the Department of Health Care Policy & Financing (HCPF) may direct managed care entities (MCEs, i.e., Regional Accountable Entities and Managed Care Organizations) in how they pay for care or what amount to pay for care, which are exceptions to standard managed care regulations and must be approved by the federal Centers for Medicare and Medicaid Services (CMS).

Following an analysis of directed payment authorities, HCPF is implementing a two-pronged strategic approach to using directed payments. As of July 2023, HCPF set a minimum reimbursement rate for certain targeted, child high intensity outpatient services and will expand use of directed payments through value-based payment model expansion in July 2024. This approach is targeted, and avoids an oversimplified approach to payment, which is needed to expand access to quality behavioral health services for children of varying need and acuity.

Requiring a fixed payment for a targeted set of services is also referred to as minimum fee schedule directed payments. HCPF identified the following factors to inform when minimum fee-schedule directed payments are considered:

- A service is new or is being underutilized across the state.
- Access issues related to a specific service are identified.
- Minimum fee-schedule directed payments should be limited in scope, time-limited, and reviewed on a regular basis.

This criterion was applied when considering minimum fee schedule directed payments for clinical stabilization services, including psychotherapy services and residential treatment services for children and youth. To improve access to

care and behavioral health provider networks for children and youth, HCPF has identified a set of priority underutilized services and implemented directed payments for four high-intensity outpatient services: Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Comprehensive Community Support Services, and Community-Based Wrap-Around Services.

HCPF estimated that using directed payments to set minimum reimbursement rates using the July 2022 Physician Fee-for-service Fee Schedule for outpatient psychotherapy services for members under 21 years of age at current utilization would cost just over $8 million annually, with approximately $4 million dollars coming from general fund.

For residential treatment services, HCPF is still analyzing how directed payments could be best utilized. Due to the significant changes and reforms that have happened in the child-serving residential continuum over the last two years, and the upcoming year, HCPF will need at least another year to determine if it is appropriate to establish minimum fee schedule directed payments for these services.

The second prong of HCPF's directed payment approach involves directing *how* MCEs pay. Effective July 1, 2023, HCPF required MCEs to offer value-based payment (VBP) strategies to community mental health centers (CMHCs) within their region. Additionally, effective July 1, 2024, HCPF will implement a VBP reimbursement strategy for all safety net providers, including smaller essential providers. For the past three years, HCPF has worked with stakeholders to develop an alternative payment methodology that will improve access to outpatient behavioral health services by sustainably funding comprehensive safety net providers using a prospective payment system. In order to qualify for this funding, the comprehensive safety net providers must agree to offer a full array of services to all individuals seeking behavioral health services and have the demonstrated ability to serve Colorado's priority populations, as defined in in C.R.S. 27-50-101 (17).

Minimum fee schedule directed payments is one approach to support the behavioral health network and improve access to services. Implementing VBPs is another, more broadly applicable approach that CMS allows states to direct MCEs to use. By utilizing both approaches, the state can ensure preservations

of managed care flexibilities to ensure they have strong and complete networks, can cover specialty or high-demand services at a higher rate, and overall must operate within certain budgetary parameters.

II. Background and Legislative Directive

The Department of Health Care Policy & Financing (HCPF) created this report in accordance with House Bill 23-1269 (C.R.S. § 25.5-4-430 (2)), which called for an analysis of "how directed payment authority can be used as part of a comprehensive plan to facilitate an adequate network of services for children and youth … by requiring each managed care entity to pay no less than state department-established fee schedule rates … applied to clinical stabilization services, including, but not limited to residential treatment services, Multi-Systemic Therapy, Functional Family Therapy, and psychotherapy services.... In analyzing directed payment authority and establishing fee schedule rates, the state department shall consider whether the rates should increase based on the acuity of the child or youth."

The Medicaid Capitated Behavioral Health Benefit is operated under the authority of a 1915(b)(3) Waiver. This allows Colorado to provide behavioral health services through a flexible managed care system which is governed by federal managed care regulations. HCPF contracts with eight Managed Care Entities (MCEs): seven Regional Accountable Entities (RAEs) and Denver Health Medicaid Choice [Rocky Mountain Health Plans (RAE 1) operates an MCO called Prime, which offers only physical health services.]. These MCEs administer, manage and operate the Medicaid Capitated Behavioral Health Benefit by providing medically necessary covered behavioral health services. Federal managed care regulations include rate methodology standards that govern how states pay MCEs. These are called “capitation rates.” Using these capitation payments, MCEs then have sole responsibility and discretion to contract with service providers, as well as to set provider rates. According to 42 CFR 438.6(c)(1), “Special contract provisions related to payment”, as a general rule, “...the State may not direct the [MCEs] expenditures under the contract.” However, there are some exceptions for directing MCE payments listed in regulation.

III. Federal Guidance for Directed Payments

A. Managed Care Regulations on Provider Reimbursement

Federal regulations generally prohibit states from directing payments of MCEs unless the arrangement meets the requirements of an exception (42 CFR 438.6(c)(1)). These exceptions include requiring value-based purchasing models, participation in performance improvement initiatives, adopting a minimum or maximum fee schedule, or providing a uniform dollar or percentage increase for network providers.

B. Federal Approval for Directed Payments

Some directed payment arrangements, such as the value-based payment model, require states to submit a standard form that details the state's directed payment plans, in accordance with 42 CFR § 438.6(c) in order to receive prior approval for the arrangement. The submission of this form, called a "preprint", allows CMS to expedite the approval process and provide technical assistance prior to the rating period in which the directed payment is effective. The preprint allows states to demonstrate the following conditions are met: (1) the arrangement is based on the utilization and delivery of services; (2) the arrangement directs expenditures equally, and using the same terms of performance, for a class of providers providing services under the MCE contract; (3) the arrangement advances at least one of the goals and objectives from the quality strategy (see 42 CFR § 438.340); (4) the state has an evaluation plan that measures the degree to which the arrangement advances that goal and objective; (5) the arrangement does not condition provider participation in the arrangement on entering into or adhering to intergovernmental transfers; and (6) the arrangement is not automatically renewed.

C. Minimum Fee Schedule Directed Payments

Minimum fee schedule directed payments allow states to require MCEs adopt a minimum pricing list for network providers that provide a particular service under the contract using State Plan approved rates (42 CFR 438.6(c)(1)(iii)(A)). State Plan approved rates are defined as "amounts calculated for specific services identifiable as having been provided to an individual beneficiary described under CMS approved rate methodologies in the Medicaid State plan" (42 CFR 438.6(a)). Per the 2020 Medicaid and CHIP final rule at 42 CFR §

438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State Plan approved rates as defined in 42 CFR § 438.6(a).

CMS affirmed they will treat a fee schedule for behavioral health services covered under Colorado's 1915(b)(3) waiver the same way they treat a State Plan approved fee schedule; therefore, preprint approval is not required for minimum fee schedule type directed payments tied to a 1915(b)(3) waiver.

D. Upcoming Changes to Federal Regulatory Policy on Reimbursement

CMS has recently proposed new managed care regulations including potential policy changes related to 42 CFR § 438.6(c) "state directed payment" (SDP) arrangements. CMS is considering whether to set a payment ceiling for SDP at the average commercial rate (ACR) or whether to align with Medicare rates for certain inpatient settings. In the proposed rule packet CMS explicitly said it is not proposing to require states to use a specific data source in its ACR demonstration. CMS described multiple acceptable data sources, including all payer claims data, proprietary commercial payment databases, and hospital cost reports.

For standard psychotherapy services, if the new managed care rules take the ACR approach, HCPF would potentially have to reduce rates under a SDP arrangement to meet the average commercial rates reflected in Colorado's All Payer Claims Data (APCD) database [see "Average Commercial for CY 2021" below].

Procedure code	Procedure description	Medicaid 2023 rate	Medicare 2023 rate	Average Commercial for CY 2021
90791	PSYCH DIAGNOSTIC EVALUATION	$ 156.54	$ 176.89	$118.00
90792	PSYCH DIAG EVAL W/MED SRVCS	$ 174.90	$ 198.49	N/A
90832	PSYTX W PT 30 MINUTES	$ 67.41	$ 76.41	$57.00
90833	PSYTX W PT W E/M 30 MIN	$ 61.70	$ 70.14	$70.00
90834	PSYTX W PT 45 MINUTES	$ 89.30	$ 101.04	$76.00
90836	PSYTX W PT W E/M 45 MIN	$ 78.07	$ 88.93	$98.00
90837	PSYTX W PT 60 MINUTES	$ 137.02	$ 148.69	$103.00
90838	PSYTX W PT W E/M 60 MIN	$ 103.34	$ 117.65	N/A
90839	PSYTX CRISIS INITIAL 60 MIN	$ 125.50	$ 142.74	$113.00

90840	PSYTX CRISIS EA ADDL 30 MIN	$ 59.50	$ 70.68	$50.00
90846	FAMILY PSYTX W/O PT 50 MIN	$ 85.30	$ 96.08	$81.00
90847	FAMILY PSYTX W/PT 50 MIN	$ 88.32	$ 100.20	$84.00
90849	MULTIPLE FAMILY GROUP PSYTX	$ 30.82	$ 38.07	$55.00
90853	GROUP PSYCHOTHERAPY	$ 23.88	$ 27.04	$41.00

To address concerns about the potential increase related to state directed payment (SDP) expenditures, CMS is also considering an alternative policy that would place an "additional fiscal guardrail" and would limit the use of an ACR ceiling to VBP initiatives only. Under this alternative policy, for other "directed fee schedule" SDPs (such as minimum fee schedules, maximum fee schedules, and uniform increases) the payment ceiling would be the "Medicare rate." CMS is considering applying this Medicare ceiling to all provider types. This policy would require states to transition a significant portion of directed fee schedules to VBP in order to preserve existing funding levels.

IV. Current Directed Payment Policy

HCPF is currently developing a value-based payment model for behavioral health services that will require federal approval. To align with the transformation of Colorado's safety net provider network, HCPF is developing a single prospective payment system (PPS) rate with carve outs for select services and utilization management strategies outside of the encounter rate structure (quality incentives, program integrity oversight, and other regulatory mechanisms) for comprehensive safety net providers who will offer a full continuum of outpatient behavioral health services. This approach moves away from a fee-for-service reimbursement structure based on relative-value units (RVUs), and instead emphasizes value over volume of services that rewards providers for long-term care coordination and quality outcomes.

Additionally, HCPF understands that there are unique situations where targeted action is necessary to support network access and growth for specific services. In such circumstances, in accordance with federal policies, HCPF has the discretion and authority to establish a directed payment as a minimum reimbursement rate for specific services that MCEs must pay.

HCPF published a Directed Payment Fee Schedule in the July 1, 2023, edition of the State Behavioral Health Services (SBHS) Billing Manual, Appendix D, that

includes services for members under 21 years old such as Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Comprehensive Community Support Services, and Community-Based Wrap-Around Services. The fee schedule does not include residential treatment services (2 distinct service codes), or psychotherapy services (7 distinct service codes). HCPF estimated that setting a minimum reimbursement rate using the July 2022 Physician Fee-for-service Fee Schedule for outpatient psychotherapy services for members under 21 years of age at current utilization would cost a minimum of $8.2 million annually, with $3.9 million in General Fund. If directed payments were considered for just adult members for these same psychotherapy services, the estimated impact would be $2.7 million General Fund annually (total of $17.2 million annually). Thus, to do minimum fee schedule directed payments for seven psychotherapy codes for adults and children would cost a total of $25.4 million, with approximately $6.6 million in General Fund.

When attempting to estimate a budget impact of a directed payment for residential treatment services, HCPF was unable to calculate this confidently due to the significant changes and reforms that have happened in the child-serving residential continuum over the last two years. The creation of a new residential provider type (Qualified Residential Treatment Provider - QRTP) with a new per diem reimbursement rate, the ramp up of transitioning providers to QRTPs and shift in utilization patterns, the addition of three new Psychiatric Residential Treatment Facilities (PRTFs) and a substantial increase in the per diem reimbursement rate, and the change in guidance for how PRTFs bill for their services all created challenges with any reasonable analysis. HCPF anticipates being able to estimate a fiscal impact of directed payments for child-serving residential services as the system stabilizes.[1]

Under the current policy, directed payments are time-limited investments that will be reviewed on a regular basis and are not used exclusively for the purpose

[1] As transformation in the child-serving residential system stabilizes and we can assess residential utilization, HCPF will review these services for directed payment consideration. HCPF is working closely with the Colorado Department of Human Services and the Behavioral Health Administration to identify a comprehensive approach to supporting child-serving residential treatment providers, as well as expanding access to other services in order to strengthen and expand the behavioral health continuum for children and adolescents.

of a rate review/increase. HCPF identified the following factors to inform when a Directed Payment would be considered:

- A service is new or is being underutilized across the state.
- Access issues related to a specific service are identified.

V. Using Directed Payments for Tiered Payments

One challenge HCPF hears from both members and providers is that Medicaid payments are not always reflective of individuals with complex needs, especially for children and youth. HCPF's requirements to standardize payments and set managed care budgets don't always fully consider how much time, effort, and wraparound care might be needed for those who are experiencing acute or ongoing care needs (i.e. mental health disorders, physical or developmental disabilities, substance use, lack of stable housing, trauma, etc).

One of the conditions of a directed payment, as mentioned above, requires that the arrangement directs expenditures equally, and using the same terms of performance, for a class of providers providing services under the MCE contract. This means that rates are based on a provider class (i.e. residential) or service (i.e. MST or FFT) and not on an individual member being served the same service as other members or by the same provider.

In an outpatient context, the acuity or severity of a member's needs is generally addressed by frequency of contact, intensity (length of contact or team-based services), and accessibility (in the home or community, on-call outside of office hours, etc.). MST and FFT are considered high intensity outpatient services when compared to standard psychotherapy services and are appropriate for youth and families with higher acuity needs. While Medicaid rates are developed to account for services that require specialization, enhanced provider credentials, and team-based models, some individuals still require more intense supports even within residential settings.

To address this ongoing challenge, HCPF contracted a vendor, Optumas, in 2022 to develop tiered rate methodologies for residential settings certified as Alternative Care Facilities (ACFs), Qualified Residential Treatment Programs

(QRTPs), and Psychiatric Residential Treatment Facilities (PRTFs). This work included four deliverables:

1. *Summary of Findings National Landscape* which describes best practices related to the development and application of tiered rates, assessment tools used by other states for application of tiered rates- including limitations of assessments used, analysis of other states' use of tiered rates, and analysis of how other states assess individuals for appropriate service tiers-including length of stay for children and youth;
2. *Draft Tier Recommendations for ACF, QRTP, and PRTF.* A critical component for an effective acuity-based tiered rate structure is the use of clear guidelines for level of care (LOC) coordination or tier criteria. An objective method to ensure clarity in tier criteria is to utilize an assessment tool for tier placement. This report included recommendations outlining specific level of care and need. Tier recommendations included factoring for acuity of need and geography;
3. *Assessment Tool Recommendations* for residential facility placement and tiering, including appropriateness of using the state developed Colorado Single Assessment (CSA); and
4. *Final New Rate Methodology Report* that recommended a Direct Wage Model (DWM) approach that can be customized to provide a basis for different payment rates for different tiers. The components of the DWM include direct worker wages, availability, employee-related expenses, program support, administration, and staffing ratios. A primary source of informing the true costs of these components is provider cost reports.

HCPF recognizes cost reporting can create an administrative burden on providers. HCPF identified ARPA dollars to fund a grant opportunity for QRTP providers to collect and share data with HCPF that may help inform future payment strategies to support placement of high acuity Medicaid children and youth.

However, as HCPF engaged stakeholders regarding this work, as well as reviewing the components of the rate methodology, the Medicaid-covered clinical services were not identified as the primary driver of increased costs for higher acuity youth. Components such as staffing ratios (for appropriate

supervision and safety related to aggressive youth or youth who elope), and indirect costs for non-billable services and resources are key factors to serving youth at higher levels of care. With this understanding further collaboration with Colorado Department of Human Services, Division of Child Welfare, as well as the Behavioral Health Administration is critical to identifying a reimbursement approach that includes these non-clinical resources.

VI. Conclusion and Action Plan

HCPF is working to implement value-based payments for behavioral health safety net providers as one approach to improving quality services and strengthening the behavioral health provider network. This is a directed payment allowed as an exception to general managed care regulations.

Directed payments that require MCEs to pay a minimum rate to network providers is a second allowed exception to the general federal regulation that States may not direct the MCEs expenditures under their contract.

A limited approach to minimum fee schedule directed payments is important to managing the total continuum of behavioral health services since HCPF, as well as MCEs, must operate within certain budgetary parameters. Implementing directed payments too broadly would mean limiting funding for other behavioral health services. HCPF has laid out policy guidelines for directed payments that target access issues for members. This demonstrates focus and drives investment in key services that aligns with broader policy goals, such as strengthening community-based services that stabilize families and maintain children in their homes.

HCPF has implemented a Directed Payment Fee Schedule for a targeted scope of outpatient behavioral health services for members under 21 years of age, through updated managed care contracts. Given the current reforms to payments for residential services, as well as the estimated significant fiscal impact of adding additional outpatient services to the minimum fee schedule, these have not been added to the directed payment fee schedule at this time. HCPF will continue to monitor the impact of these directed payments, how they increase access and utilization, as well as the impact on service providers.

While directed payments are a strategic resource in a comprehensive plan to facilitate an adequate network of services for children and youth with behavioral health needs, there are several other needed changes. HCPF has also prioritized American Rescue Plan Act (ARPA) funding to address the challenges outlined in HB 23-1269. In addition to ARPA project 4.04 Tiered Residential Rates and Benefits, which is referenced above, APRA project 3.06 funded four projects:

- Conduct a gap analysis for high intensity outpatient services to assess the extent to which its current delivery system provides adequate high intensity outpatient services and to identify any needed improvements.
- Develop training and technical assistance to build capacity with providers and health plans to improve their capacity to deliver high intensity outpatient services.
- Develop a value-based payment framework for high intensity services and whole person care. HCPF will create a new value-based reimbursement model to support the implementation of high intensity outpatient services and to improve capacity of the service networks.
- Assess and review regulatory foundations for high intensity outpatient services. HCPF will work with the Behavioral Health Administration to review and align their credentialing and contracting policies with the safety net framework. HCPF will assess and revise critical regulations concerning high intensity outpatient services.

Additionally, HCPF has provided MCEs with a total of $14 Million in the Spring of 2023 to invest in expanding High Intensity Outpatient Services across the state. These funds are targeted for intensive community-based, member and family-centered services designed to engage adults and youth with severe mental health and/or substance use conditions who are at risk for or experiencing complicating problems such as physical health problems, developmental challenges, involvement in criminal and juvenile justice systems, and/or institutionalization.

Finally, HCPF is working closely with the Colorado Department of Human Services and the Behavioral Health Administration on a comprehensive implementation plan. This implementing the recommendations from the Behavioral health Task Force, Children's Subcommittee, supporting children and

families with higher acuity needs, as well as expanding access to residential, in home, and outpatient services in order to strengthen and expand the behavioral health continuum for children and adolescents.