COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

CMHC Cost Report Explanation

Fact Sheet July 2023

Introduction

The below report includes an overview of each of the sections listed in HB 22-1268. Section A is an excerpt of HB 22-1268. Section B provides background on CMHC Cost Reports and known changes going forward. Section C covers the purpose of the Cost Report. Section D further details the contents of the schedules, or sub-lists, of the Cost Report. Section E explains the determination of reimbursement rates. Section F addresses reasonable and unallowable costs. Section G pertains to value-based payments and their effect on reimbursement rates.

A. HB 22-1268 Excerpt

25.5-4-403.1. Providers - community mental health centers - cost reporting. (1) FOR THE PURPOSES OF INCREASED PAYMENT METHODOLOGY TRANSPARENCY, NO LATER THAN MARCH 15, 2023, AND EACH MARCH 15 THEREAFTER, THE STATE DEPARTMENT SHALL:
(a) PUBLISH COST REPORTS FOR COMMUNITY MENTAL HEALTH CENTERS;
(b) ESTABLISH A COST-REPORTING TEMPLATE AND COST-REPORTING SCHEDULE TO ASSIST PROVIDERS IN PROVIDING COST REPORTS;
(c) REDACT INFORMATION TO MAINTAIN COMPLIANCE WITH STATE AND FEDERAL LAW INCLUDING, BUT NOT LIMITED TO, PERSONALLY IDENTIFYING INFORMATION AND PROTECTED HEALTH INFORMATION AS NECESSARY TO PROTECT THE PRIVACY OF PATIENTS;
(d) CREATE A PUBLICLY AVAILABLE WEBSITE THAT PROVIDES INSIGHT TO MEDICAID MEMBERS, MEDICAID PROVIDERS, AND MEMBERS OF THE PUBLIC REGARDING BEHAVIORAL HEALTH REIMBURSEMENT RATES. THE WEBSITE MUST INCLUDE THE FOLLOWING:
(I) ALL COMPLETED COST REPORTS FOR EACH BEHAVIORAL HEALTH SAFETY NET PROVIDER, AS DEFINED IN 27-50-101 (7);
(II) AN OVERVIEW OF THE PURPOSE OF THE COST REPORT DESCRIBED IN THIS SUBSECTION (1);
(III) INFORMATION ON HOW TO INTERPRET THE COST REPORTS AND WHERE TO FIND INFORMATION IN THE COST REPORTS;
(IV) AN OVERVIEW OF:
(A) How REIMBURSEMENT RATES ARE DETERMINED;
(B) WHAT CONSTITUTES A REASONABLE AND ALLOWABLE COST; AND
(C) HOW VALUE-BASED PAYMENTS IMPACT REIMBURSEMENT RATES; AND

(V) THE STATE DEPARTMENT'S PLAN TO IMPROVE BEHAVIORAL HEALTH REIMBURSEMENT RATES AND ANNUAL UPDATES TO THE PLAN.

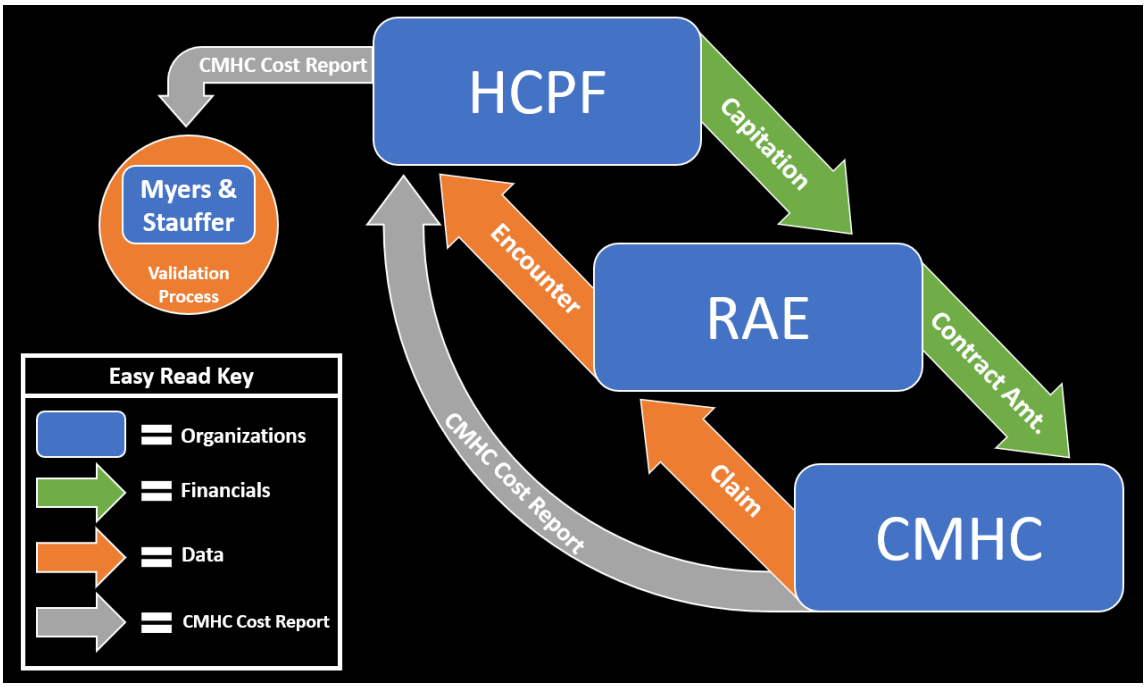
B. HB 22-1268 Revisions Addressed

Community Mental Health Centers (CMHCs) are paid through Medicaid either by a Regional Accountable Entity (RAE) or directly by the Department of Health Care Policy and Financing (HCPF). The costs incurred by the CMHCs for the provision and availability of BH services are captured each year via the Colorado Unit Cost Report (CMHC Cost Report). The CMHC Cost Report is a standard reporting tool developed by HCPF, the Behavioral Health Administration (BHA), and representatives from the CMHCs; it is completed on an annual basis for each CMHC by individuals employed or contracted by the centers, and it captures all costs incurred during the state fiscal year. Principles governing the completion of the CMHC Cost Report and the reporting of costs therein are dictated within the ***Behavioral Health Accounting and Auditing Guidelines*** (A&A Guidelines). The A&A Guidelines were originally drafted in 2013 by HCPF, the Office of Behavioral Health, and an independent consultant; they are now reviewed and updated annually by a committee composed of representatives from HCPF, the BHA, and the CMHCs. The CMHC Cost Report contains the cost and encounter (units) data for the state fiscal year and is submitted by the CMHCs on November 30 of each year. They are subject to an annual cost report review process, wherein costs are evaluated by an independent certified professional accounting firm contracted by HCPF for allowability and proper reporting in accordance with the A&A Guidelines. Within HB 22-1278, there are statutory changes to remove the definition of CMHCs on a go forward basis. The CMHCs will be replaced with new safety net provider types starting in July, 2024. There is also a mandate to redesign and rebuild the A&A guidelines committee to be more inclusive.

The reviewed cost report is used by the Department, the BHA, and the RAEs for rate setting purposes. Rate setting utilizes Base Units Costs (BUC) and the Relative Value Unit (RVU) methodology. For additional information, see the descriptions and graphic beginning on page 5 of this document and the Appendix of the Behavioral Health Provider Rate Comparison Report.

C. 25.5-4-403.1(D)(II) An Overview of the Purpose of the Cost Report Described in this Subsection (1)

a. Graphic: Relationship Between HCPF, RAEs, and CMHCs



The above graphic displays the relationship between HCPF, RAEs, and CMHCs. The purpose of the Cost Report is to allow HCPF set a rate schedule that is based on actual costs, in order to meet the statutory requirements in 25.5-403.

HCPF pays RAEs a capitation on a per member per month basis, the RAEs then contract with CMHCs for services. CMHCs provide the RAEs with claims, RAEs provide HCPF with their total encounter data. CMHCs also provide HCPF with an annual cost report to ensure they are reimbursed at a reasonable rate. HCPF validates Cost Reports directly through its contracted auditor, Myers & Stauffer.

D. Information on How to Interpret the Cost Reports and Where to Find Information in the Cost Reports - CRS 25.5-4-403.1(D)(III)

CMHCs must also complete a Colorado Unit Cost Report that requires detailed reporting of expenses and utilization. These schedules capture the data necessary to calculate the base unit cost and per diem costs for each CMHC, which are used in the service pricing methodologies of HCPF and BHA (Behavioral Health Accounting and Auditing Guidelines).

The Colorado Unit Cost Report is composed of the following:

Schedule 1: Expenses

Schedule 1A: Non-Clinical Direct Salary Limit

This schedule identifies the five largest non-clinical direct salaries paid during the cost reporting period. Direct salary includes wages and bonus amounts.

Schedule 1B: Indirect Cost Allocation Methodology

This schedule details the methods used to allocate indirect costs amongst all functional cost centers on Schedule 1.

Schedule 1C: Less-Than-Arm's-Length (Related Party) Transactions

This schedule identifies all transactions with related party entities.

Schedule 2: Service Groups

This schedule accumulates amounts from the subsequent series of schedules, in order to summarize costs by applicable service group. Service groups are a statutory category and are subject to change.

Schedule 2A: Emergency Services

This schedule identifies costs associated with emergency services provided. These services are those that are necessary to stabilize individuals experiencing a behavioral health emergency.

Schedule 2B: Consultative and Educational Services

This schedule identifies costs associated with consultative and educational services provided. These services include all non-clinical services that enhance care coordination and the health and well-being of individuals.

Schedule 2C: Outpatient Services

This schedule identifies costs associated with outpatient services provided. These types of services focus on maintaining and improving functional abilities for a patient at risk of, or with a history of, psychiatric hospitalization.

Schedule 2D: Partial Hospitalization

This schedule identifies costs associated with partial hospitalization services.

Schedule 3: Inpatient and Residential Services

This identifies costs associated with residential and inpatient facilities reported in Schedule 1 Column 4, All Inpatient Hospital Services and Residential Services without RVU Weights.

Schedule 4: Base Unit Cost Calculation

This schedule calculates the provider-specific base unit cost.

E. 25.5-4-403.1(D)(IV)(A) How Reimbursement Rates are Determined

The Accountable Care Collaborative (ACC) is the managed care system that provides the structure by which health care is provided and paid for in Health First Colorado. This structure focuses on integrating both behavioral and physical health care to improve member choice and engagement; strengthen coordination of services; pay providers for increased value they deliver; and ensure greater accountability and transparency (Behavioral Health Provider Rate Comparison Report, pp. 11-12).

Reimbursement rates for CMHCs are determined by utilizing Department policy, legislation, and federal policy. State statute at section 25.5-4-403, C.R.S. obligates the Department to reimburse CMHCs for allowable costs, as CMHCs are required to maintain an infrastructure to provide an array of services that independent providers are not required to offer (Behavioral Health Provider Rate Comparison Report, p. 19). The following variables are used for calculating each CMHCs rate of reimbursement: Relative Value Units (RVU), Base Unit Cost (BUC), and units.

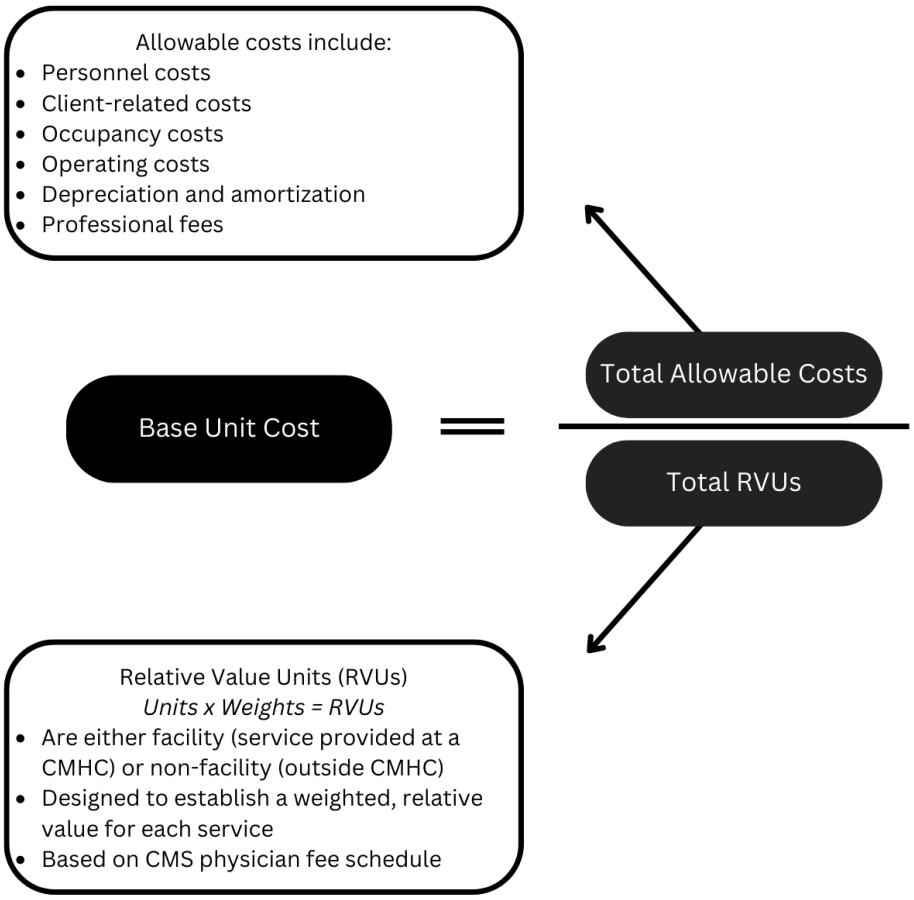
Base Unit Cost × *Units* × *Relative Value Units* = *Repriced Paid Amount*

Base Unit Cost (BUC)
The Base Unit Cost (BUC) is calculated on an annual basis using the CMHC Cost Report and is utilized by HCPF, the BHA, and the RAEs to set reimbursement rates for the CMHCs. The BUC captures total allowable costs (as defined within the **A&A Guidelines**) associated with providing BH services, and the total number of BH services provided; the services provided are weighted through the relative value unit (RVU) methodology. Under this methodology, the varying values (or weights) are assigned to each BH service.

Relative Value Unit (RVU)
The RVU method is designed to establish relative values for each service, which reflect the resources necessary to provide each individual service in relation to all other BH services. This methodology was implemented by Colorado in 2009 and was founded on the resource-based relative value scale utilized by the Centers for Medicare & Medicaid Services (CMS) in the national physician fee schedule. The weights associated with each BH service in the RVU method (distinguished by procedure code) come from the CMS physician fee schedule. Weights are specific to the location of the service, either classified as "facility," meaning at the CMHC, or "non-facility," meaning outside the CMHC.

a. Graphic: How Base Unit Costs (BUCs) are Determined

How Base Unit Costs (BUCs) are Determined



F. 25.5-4-403.1(D)(IV)(B) What Constitutes a Reasonable and Allowable Cost

Allowable CMHC costs include direct and indirect expenses associated with programs and teams providing behavioral health services, such as personnel costs, client-related costs, occupancy costs, operating costs, depreciation and amortization, and professional fees. Certain costs are unallowable for reimbursement by BHA and HCPF or are only allowable in certain situations. An accounting system needs to be established for these costs to be readily identified so they can be segregated from the allowable cost categories. Definitions of these costs, both those that are wholly non-allowable and those that are unallowable in certain situations, are detailed below (Behavioral Health Accounting and Auditing Guidelines). Additional detail, such as executive salaries over 150% of the federal limit being disallowed, is available in the CMHC Cost Report Walkthrough Fact Sheet.

Allowable costs include items such as:

Personnel costs

Salaries, payroll taxes, and employee benefits of direct program staff and indirect administrative staff.

Client-related costs

External doctors, clinics, and hospitals; food provided to clients; medical supplies; payments to other service providers; supplies used by clients; and transportation for clients.

Occupancy costs

Janitorial, maintenance and supplies, property insurance, rent, real estate taxes, and utilities.

Operating costs

Dues, fees, licenses, subscriptions, equipment rentals and maintenance, insurance, office supplies, postage, printing, copying, telephone, travel of staff for business purposes, and vehicle expenses for owned or leased vehicles.

Depreciation and amortization

Depreciation and amortization for all owned assets.

Professional fees

Non-clinical professionals and consultants who are not employees of the CMHC (Behavioral Health Provider Rate Comparison Report, Appendix D).

UNALLOWABLE COSTS: Certain costs are unallowable for reimbursement by BHA and HCPF or are only allowable in certain situations. The accounting system needs to be established for these costs to be readily identified so they can be segregated from the allowable cost categories. Definitions of these costs, both those that are wholly non-allowable and those that are unallowable in certain situations, are detailed below.

Advertising and Public Relations Costs, Alcoholic Beverages, Bad Debts, Contingency Reserve, Donations and Contributions, Defense and Prosecution of Claims Plus Civil and Criminal Proceedings, Depreciation, Direct Salary in Excess of Limit, Entertainment Costs, Fines and Penalties, Fundraising, Goods or Services for Personal Use, Housing and Personal Living, Expenses, Idle Facilities, Interest, Investment Costs, Less-than-arm's-length Transactions, Lobbying, Maintenance and Repair Costs, Memberships, Outreach, Personal Gifts, Prior Period, Subsequent

Period, Rental Costs of Real Property and Equipment, Retainer Fees, Severance Pay, & Travel Expenses (Behavioral Health Accounting and Auditing Guidelines).

G. 25.5-4-403.1(D)(IV)(C) How Value-Based Payments Impact Reimbursement Rates

The Behavioral Health Administration bill, HB 22-1278, created the Behavioral Health Administration (BHA), which has been tasked with collaborating to create new standards for providers and new standards for how providers are paid that consider not just the actual cost of services, but also critical factors such as service quality, access to care, access for priority populations, health equity and expanded use of value-based payments. Value-based payments connect publicly funded providers to flexible payments that reward evidence-based innovations, whole person care, and comprehensive access to care when it is needed (Behavioral Health Provider Rate Comparison Report, p. 9).

The Department has engaged outside consultants to help design and implement a pilot value-based payment (VBP) model to ensure the creation of "equitable payment and payment models that minimize inappropriate payment variation". The model will be designed to reduce possible disparities in payment structures for a BH provider between differing MCEs. The model takes into account quality metrics to improve outcomes and equity in payments. After initial stakeholder engagement was completed, the Department has engaged actuaries to build out the financial model. The Department worked through a pricing exercise with a select group of providers.

The Department will launch a value-based payment (VBP) program for BH services within Health First Colorado. The Department is opening this VBP program in SFY24 to a larger network of providers to ensure equitable and flexible payments to safety net providers that incentivize whole-person quality care as well as improve quality, access and equity. This will require monitoring and reporting protocols to ensure improvements in quality, network engagement, and member outcomes. The expansion of the VBP models to the larger statewide network will require federal authority to change the payment methodologies of the MCEs. The Department is currently seeking federal authority for directed payments or other federal mechanisms to implement the VBP models within the Health First Colorado managed care BH program. These additional federal authorities, such as directed payment models, will allow for greater transparency, consistency and understanding of BH rates across services and providers. The universal contracting innovations funded through HB 22-1302 and required by HB 22-1278, will be an essential tool to execute on the previous recommendations, increase CMHC accountability, and ensure contractual alignment for value-based payment models (Behavioral Health Provider Rate Comparison Report, p. 41).

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