COLORADO
Department of Health Care
Policy & Financing

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Behavioral Health Prospective Payment System

Fact Sheet August 2024

Introduction to Prospective Payment Reimbursement

Beginning July 1, 2024, Community Mental Health Centers and Comprehensive Safety Net Providers are being paid under a new Prospective Payment System (PPS) reimbursement methodology.[1] The transition to a PPS reimbursement model is part of broader delivery system reform efforts in Colorado which includes an expansion of providers participating in the safety net, changes to provider licensure, and broader efforts to promote quality, accountability, and value through payment while ensuring provider sustainability. These efforts are guided by legislative requirements in Senate Bill 19-222: "Individuals at Risk of Institutionalization" and House Bill 22-1278: "Behavioral Health Administration", which direct the Department of Health Care Policy and Financing (HCPF) to introduce alternative payment models, such as the PPS, specifically for Comprehensive Safety Net Providers.[2]

Prospective Payment System (PPS) Methodology

The PPS methodology is a flexible, advanced reimbursement model that ties payment to daily encounters instead of to individual services. This means that a provider will receive an encounter payment for each patient they see in a day, and the payment is the same regardless of which services are provided so long as the services are covered by the PPS rate.[3]

The PPS is provider-specific and based on each providers' unique cost structure, designed to cover a safety net provider's actual cost of services. The PPS methodology is calculated based on a provider's submitted cost reports, which are independently audited. The daily encounter rate is intended to reflect the average cost of an encounter, not the actual cost of any individual encounter, and encourage Comprehensive Providers to offer a full continuum of outpatient mental health and substance use treatment and recovery services and serve priority populations.

[1]CMHCs must transition to comprehensive provider status by 12/31/2024 in order to continue to participate in PPS-based reimbursement.
[2]SB 19-222, Individuals At Risk Of Institutionalization | Colorado General Assembly, HB 22-1278, Behavioral Health Administration | Colorado General Assembly
[3]State Behavioral Health Services Billing Manual | Colorado Department of Health Care Policy & Financing Appendix D, July 1, 2024 Billing Manual.

The PPS differs from historical reimbursement policy in several ways. Managed care entities, called Regional Accountable Entities (RAEs) in Colorado, have historically had the flexibility to negotiate rates with providers. Previously, negotiated rates paid by managed care plans leveraged cost information from providers and a Relative-Value Unit (RVU) strategy for pricing individual services based on the providers' reported costs. Managed care plans had no mandate for a minimum level of payment other than to pay sufficiently to ensure an adequate provider network based on patient needs.

Key differences between historical reimbursement models and the PPS are summarized in the table below.

Table 1: Comparison of Model Characteristics Before and After 7/1/2024

Model Characteristics	Historical	PPS Effective July 1, 2024
Provider-specific, Cost-based Reimbursement for Eligible Providers	✓	✓
Guaranteed Minimum Payment	✗	✓
Flexibility to Adjust Care Model to Meet Patients' Needs without Revenue Loss	✗	✓
Open to providers other than CMHCs (or former CMHCs)	✗	✓

Benefits of PPS for Behavioral Health Providers and Patients

There are several benefits to leveraging a PPS reimbursement methodology. Some of the key benefits include:

- Standardized payment rates for qualifying encounters with patients allowing for a focus on what the patient needs, and not what generates revenue
- Increased predictability in payment
- Calculations allow for built in cost-trends to address cost of living, inflation

- Encourages comprehensive providers to provide wrap around services and supports to individuals with complex and co-occurring needs
- Movement away from the RVU model that incentivized providing services with high RVU values over the most appropriate and efficient services to support a patient
- Potential for improved access to care for patients by allowing for changes in the delivery model without reducing revenue
- Prepare the state for participation in the federal Certified Community Behavioral Health Clinic model, which also uses a PPS reimbursement model

Development and Direction of PPS in the State

Implementation of the PPS reimbursement methodology is the culmination of several years of effort on the part of the state and various stakeholder groups. Development included a stakeholder engagement process, a modeling phase, and now implementation. Future behavioral health payment reform efforts will include any potential revisions to the PPS design, but also an emphasis on value-based purchasing, which is the explicit attachment of payment to outcomes and performance.

Frequently Asked Questions with Answers

Question: Who is eligible to receive the PPS?
Answer: Only licensed and BHA-approved Comprehensive Safety Net Providers are eligible to receive the PPS.

Question: Are Regional Accountable Entities (RAE) required to pay the PPS to Comprehensive Providers? Can the provider or RAE opt out?
Answer: RAEs are required to pay at least the PPS rate when contracted with a Comprehensive Safety Net Provider. It is a minimum level of payment, not the required level of payment. RAEs and providers can negotiate different payment arrangements or higher rates than the PPS, but they must demonstrate they have satisfied the minimum payment level required. Neither the RAE nor the provider can opt out of receiving the minimum payment level.

Question: If I am both a Comprehensive provider and an Essential provider, do I bill all services under the PPS?
Answer: If a provider is both a Comprehensive and an Essential provider, only services included in the PPS (defined in the State Behavioral Health Services Billing Manual | Colorado Department of Health Care Policy & Financing – Appendix D in the July 1, 2024 Billing Manual) should be billed under the PPS. All other services should be billed on a fee-for-service basis. If a service is both on the essential provider fee schedule and is included in the PPS rate, it should be billed under a PPS encounter.

Question: My system has multiple locations. Does each location have a unique PPS rate?
Answer: Systems with multiple locations will have a single PPS rate set at the system level. Additionally, this means the system will submit a single cost report for all locations. Please note that each location needs to adhere to applicable provider enrollment policies including having unique National Provider Identifiers (NPIs) for each location and licensure type. Information on licensure can be found on the state website in the Safety Net Approval Paths fact sheet.

Question: I am a comprehensive provider that has not previously done cost reporting. Will I be eligible for the PPS rate prior to submitting a cost report?
Answer: Yes, comprehensive providers that do not have a cost reporting history will receive the statewide PPS rate, which is not based on the provider's own costs.

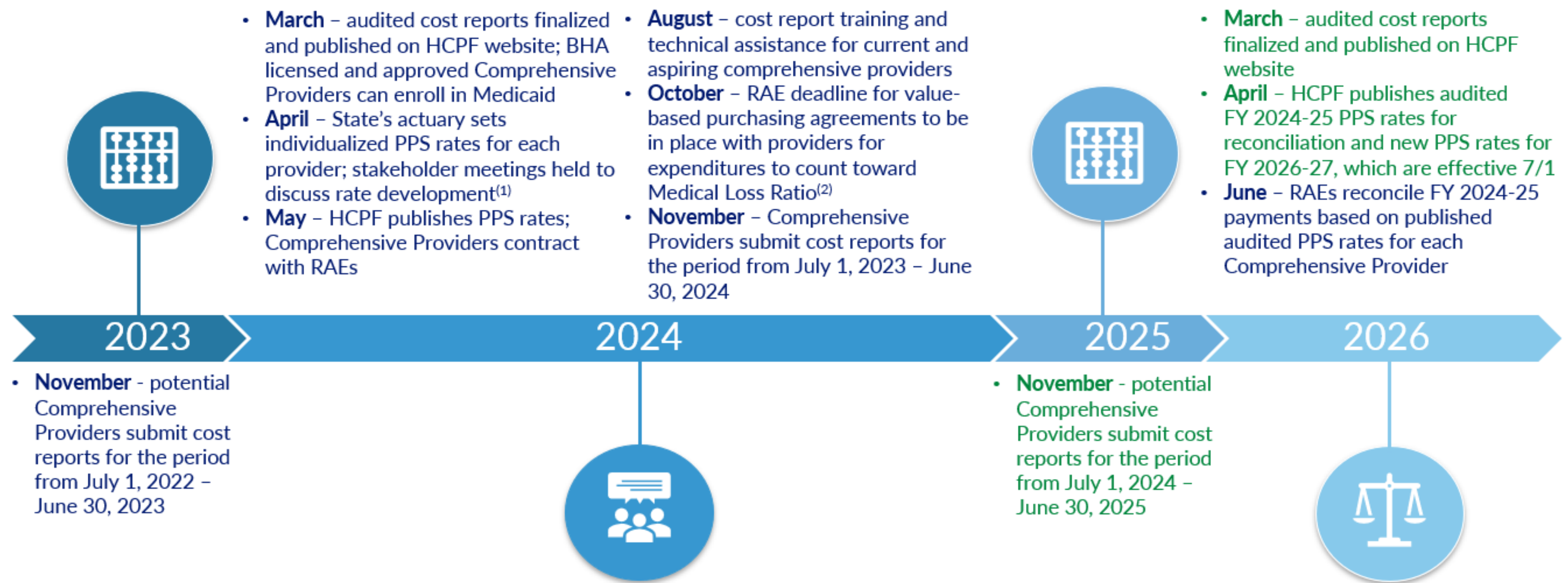
Question: What if the statewide rate is not well aligned with my actual costs?
Answer: In this circumstance, there may be a payment reconciliation to bring payments closer in alignment with actual costs. This would be done after receiving audited cost reports for the period in question.

Questions: How will I bill encounters?
Answer: Please refer to the July 1, 2024 billing manual found in the State Behavioral Health Services Billing Manual | Colorado Department of Health Care Policy & Financing.

Question: I haven't done cost reporting. Where can I find more information about it?
Answer: A variety of resources regarding cost reporting, including examples of completed cost reports can be found on the state website, Behavioral Health Rate Reform | Colorado Department of Health Care Policy & Financing

Question: Where can I get information about timelines and process deadlines related to the PPS?
Answer: The figure on the next page shows the Life Cycle for the PPS from cost reporting to reconciliation. This includes major deadlines and a description of relevant processes and when they occur.

The Life Cycle of the Comprehensive Provider Prospective Payment System: Cost Reporting Through Reconciliation



Notes:

(1) Rates are set based on individual providers' cost reports, adjusted for trend when possible; for providers that do not have cost reports, they will receive the statewide PPS rate until future cost reports are available.

(2) RAEs can negotiate rates higher than the PPS rate or pay under different methodologies that result in compensation above the PPS rate. In these cases, for the additional payment to count towards the services component of the RAE's Medical Loss Ratio, the additional funding must be tied to quality through an agreement that is in place by the deadline noted on the timeline.

Color Key:
Impacts FY 2024-25 Rate Cycle
Impacts Both FY 2024-25 and FY 2025-26 Rate Cycles