Request for Rate Increase

Policy and Procedure

Effective 10/3/19

POLICY

Community Behavioral Health (CBH) is committed to assuring quality and value in all of the services provided by CBH Providers. In effort to do so, we are requesting Providers who wish to submit a request for a rate adjustment to adhere to the components outlined in this updated policy and corresponding appendices. This includes the submission of standard financial documentation as well as a clear and concise outline of the anticipated value within programs that will be added as a result of a rate increase. It is expected that financial support will result in additional value added at the programmatic level.

This policy has been written to be consistent with the policies of the Pennsylvania Department of Public Welfare (Department/DPW) Office of Mental Health and Substance Abuse Services (OMHSAS) in relation to the Pennsylvania Behavioral HealthChoices Program. This policy is available by request from CBH.

In accordance with the Provider Agreement, Providers will be notified 30 days in advance of any rate changes. CBH's goal is to regularly provide both Standard and Non-Standard Rate increases. CBH will annually review current rates and will consider rate increases based on the following factors:

- Funding availability based on State Capitation Rates
  - Funding increase may result in rate increases across the board
  - Funding decreases may result in limited or no rate increase
- City of Philadelphia's living wage increases
  - CBH will consider rate increases for in network Providers
    - Provider must request a rate increase and adhere to the request for a rate increase procedure
- Timing of last increase
  - A minimum timeframe of one year since the previous rate increase

Standard Rates

CBH has rates that are considered standard for Providers. New and out-of-network Providers receive the current Standard Rate. The following Levels of Care and Financial Categories are included in Standard Rates:

- Outpatient Psychiatric, Outpatient D&A, Behavioral Health Rehabilitation Services for Children and Laboratory

An exception to Standard Rates may occur for specialized services for specialized populations. The specialized services rates are negotiated based on budgeted financial data submitted by

the Provider, current market conditions, or other factors and will be considered Non-Standard for that service and Provider combination only. Other Providers and/or Standard Rates will be impacted.

Laboratory Services

Rates for laboratory services were determined based on the State MA rates at the inception of the HealthChoices Program. No rate increases have been given since inception. Any future rate increase will follow the State MA rates.

Non-Standard Rates

The following Levels of Care are generally Non-Standard with various exceptions by Level of Care. CBH will identify, by Provider request, which Levels of Care are considered Standard and which are Non-Standard.

Inpatient Psychiatric and Inpatient D&A Services

There are Provider-specific per diem rates for Inpatient Psychiatric and Inpatient D&A Services. The following factors are considered in providing rate increases:

- Timing of last increase, normally a minimum timeframe of one year since the previous rate increase
- Funding availability
- Pennsylvania Medical Assistance (MA) rate increase given to Providers – CBH rate increase *may* follow the most recent MA rate increase, with the per diem capped at the MA rate unless otherwise adjusted to account for other rate issues.

New Provider rates are negotiated based on budgeted financial data submitted by the Provider, market conditions, financial considerations or other factors.

Out of network Providers receive the MA rate, if available. Otherwise, Providers receive the CBH weighted average rate based on current rates applied to units paid for services during the most recent calendar year-end. The rates are determined separately for teaching and non-teaching facilities.

The goal is to move toward performance measurements as outlined in Provider Profile Reports in developing rates in the future.

Non-Hospital D&A, RTFs, Host Homes and Other Residential Per Diem Rates

There are Provider specific per diem rates for Non-Hospital D&A, RTFs, and Other Residential Services.

The following factors are considered in providing rate increases:

- Timing of last increase, normally a minimum timeframe of three years since the previous rate increase
- Funding availability
- Provider submitted budgeted and/or actual financial data
- Quality of Care Clinical Assessment
- Defined performance measurements specifically given to Providers

New Provider rates are negotiated based on budgeted financial data submitted by the provider.

Out-of-network Provider rates are negotiated with the Providers, with consideration given to our current in-network rates for similar services.

Intensive Case Management and Resource Coordination Services

Services for Intensive Case Management (ICM) and Resource Coordination (RC) are developed by the Philadelphia Office of Mental Health. Rates are determined based on budgeted and actual financial data submitted by the Providers.

PROCEDURE

Providers will have the opportunity to request rate increases for Non-Standard Rates if they have not had an increase within the past three years or can demonstrate extenuating circumstance. For a period of less than three years, Providers will be required to present economic evidence as to why an increase is necessary, such as changes in the marketplace, staff hiring issues, and the inability to operate as a going concern. The Provider must also demonstrate what aspects of their program provides a justification of a higher rate than peer Providers if that is, in fact, the case. Providers will be given minimal consideration for an increase if primary need is due to low census and/or inability to submit clean claims.

Requests for rate increases should only be submitted in extenuating circumstances. Requests may only be submitted at the end of each quarter; January, April, July and October. All requests must be submitted by the last business day of the identified month and will not be reviewed until all materials have been submitted and the submission period has closed.

The Provider must complete and submit the Request for Rate Increase Coversheet and a complete rate request financial package. This must include all items listed on the coversheet.

The Provider must use these designated forms and must submit the requested expenditure documents in an editable Excel worksheet, all information can be sent to CBH.RateRequest@phila.gov. Providers will receive a confirmation of receipt within 10 business days following submission. At this time, additional items may be requested.

All Provider rate increases may be reviewed by various CBH Clinical and Finance committees as appropriate with the DBHIDS Finance Committee making the final decision. The Provider will receive a written notification drafted by Provider Operations as to whether the request has been approved or denied. The following factors will drive the decision to increase a rate:

- Funding availability based on DHS Capitation Rates
- Rate equity with similar services
- Provider financial data
- Timing of last rate increase
- Other factors supplied by the provider

CBH Goals for Provider Rates

CBH is committed to paying competitive Provider reimbursement rates and our goal is to ensure that our Providers are able to pay their staff a quality wage that appropriately matches their job duties and supports the current cost of living.

In 2019, an increase for all rates with no increase in five years to more was implemented. The goal, financial conditions allowing, is to move sequentially to annual rate adjustments by 2025 with interim adjustments annually until all rates have been adjusted during the prior year. In summary, CBH is committed to streamlining the across-the-board rate increase process as well as individual rate requests to ensure that our providers are financially stable and fully supported.