

01/12/10

**Community Behavioral Health
HealthChoices Behavioral Health Program
Policy and Procedure for Provider Rate Setting**

This policy has been reviewed and approved by the Pennsylvania Department of Public Welfare (Department/DPW) Office of Mental Health and Substance Abuse Services (OMHSAS). This policy is available on the City of Philadelphia Department of Behavioral Health and Mental Retardation Services (City) website:
<http://www.dbhmrs.org/community-behavioral-health/>.

OMHSAS will be notified at least forty-five (45) days in advance of any network wide proposals to increase or decrease provider rates. In accordance with the Provider Agreement, providers will be notified 30 days in advance of any rate changes. OMHSAS will review to ensure standards for access and choice remain in compliance with HealthChoices requirements.

The City or Community Behavioral Health (CBH) will not institute an across the board rate decrease for all Providers or a specific Provider type or group of Providers unless the City or CBH has: i) notified the Department of its intention to impose such an across the board rate decrease at least forty-five (45) days prior to the imposition of such a rate decrease; (ii) provided the Department with the justifications for instituting such an across the board rate decrease; (iii) discussed the proposed action with all affected Providers; (iv) provided justification that such action will not adversely affect compliance with HealthChoices access and choice requirements, and (v) in accordance with the Provider Agreement, providers will be notified 30 days in advance of any rate changes.

CBH has standard and non-standard rates, depending on the type of service.

Standard Rates

Outpatient Psychiatric, Outpatient and Intensive Outpatient D&A, and Behavioral Health Rehabilitation Services for Children have standard rates for all providers. 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
- ❑ Market conditions

New and out-of-network providers receive the current standard rate. Providers with significant out-of-network activity who refuse to join the network have the standard rate reduced by 20%.

Currently, performance factors are not considered with services at standard rates.

An exception to the standard rates may occur for specialized services for special populations. These rates are negotiated based on budgeted financial data submitted by the provider and current market conditions.

Non-Standard Rates

Inpatient Psychiatric and Inpatient D&A Services

There are provider specific per diem rates for Inpatient Psychiatric and Inpatient D&A Services. Rate increases are typically given at the same time to all providers. 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 follows the most recent MA rate increase, with the per diem capped at the MA rate

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

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 one year 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.

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

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.

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.

Provider Requests for a Rate Increase

Providers have the opportunity to request rate increases. The provider must submit a letter addressed to the Chief Executive Officer of CBH. This letter must justify the rate increase, include financial data that details line item expenses (actual and budgeted), and discuss expected clinical outcomes. For new programs and services, this information will be forwarded to the Clinical Review Committee for review. If approved, the information will be forwarded to the Finance Committee. For existing programs and services, this information will be directly forwarded to the Finance Committee. The Finance Committee will review and either approve or deny the request. The provider will receive a written notification as to whether the request has been approved or denied.