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Community Behavioral Health 101

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Info Session Will Be Recorded

Please keep your microphone muted

Please use Q&A feature for questions

Survey will be sent out after Zoom meeting and in email

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Session Goals

1. Participants will increase their knowledge of the PA HealthChoices (Medicaid) program.

2. Participants will build their understanding of how to enroll as a provider with CBH.

3. Participants will gain tips on how to navigate CBH operations.

4. Participants will increase their awareness of how members can access CBH services and other behavioral health resources.

Agenda

- Introduction to HealthChoices
- Review of the Philadelphia Behavioral Health System
- What is Community Behavioral Health?
  - Who are our providers?
  - Who do we serve?
- How to Become a Provider
- Supports for Providers
- Resources and References
- Q&A

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Introduction to Health Choices-PA

What is HealthChoices ?

- HealthChoices is the name of the Pennsylvania (PA) managed care programs for Medicaid / Medical Assistance recipients.
- Medicaid, also known as Medical Assistance (or MA), pays for health care services for eligible individuals.

What are the Goals of HealthChoices?

To **improve access** to health care services for Medicaid recipients.

To **improve the quality** of health care available to Medicaid recipients.

To **stabilize** Pennsylvania's Medicaid **spending.**

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Key Facts on HealthChoices

- Centers for Medicare and Medicaid (CMS) is the federal Medicare and Medicaid authority responsible for oversight.
- Healthchoices is Pennsylvania's managed care program for Medicaid (aka Medical Assistance) recipients.
- Community HealthChoices is a specific program for folks who need long term services and supports.
- Physical Health and Behavioral Health are managed by separate managed care organizations (MCOs) in PA.
- Community Behavioral Health (CBH) is Philadelphia's behavioral health managed care organization (BH-MCO).

Historical Overview of HealthChoices & CBH

1990s **Closing of state hospitals around the country corresponded with push for managed behavioral health care delivered to individuals in their communities.**

1994 Pennsylvania announces plans to privatize the management of Medicaid.

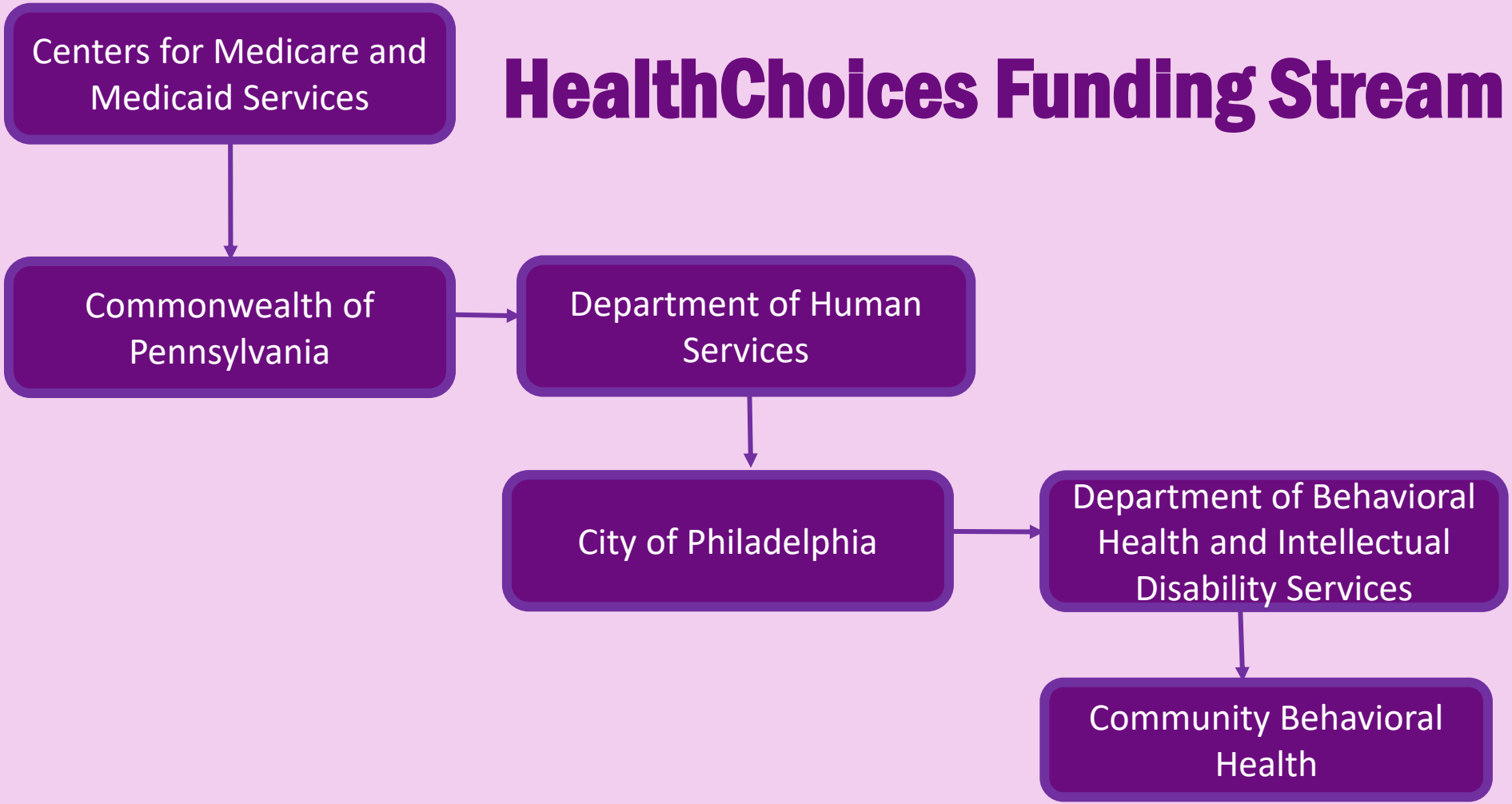
Activists fight for a "carve-out" on behavioral health.

1997 CBH established as a 501(c)3 non-profit and contracts with the City of Philadelphia to manage the Philadelphia Behavioral Health HealthChoices program.

CBH funded services for 48,000 members in the first year.

2024 **CBH serves over 100,000 members each year with a provider network of approximately 240 providers and approximately 750 locations.**

HealthChoices Funding Stream



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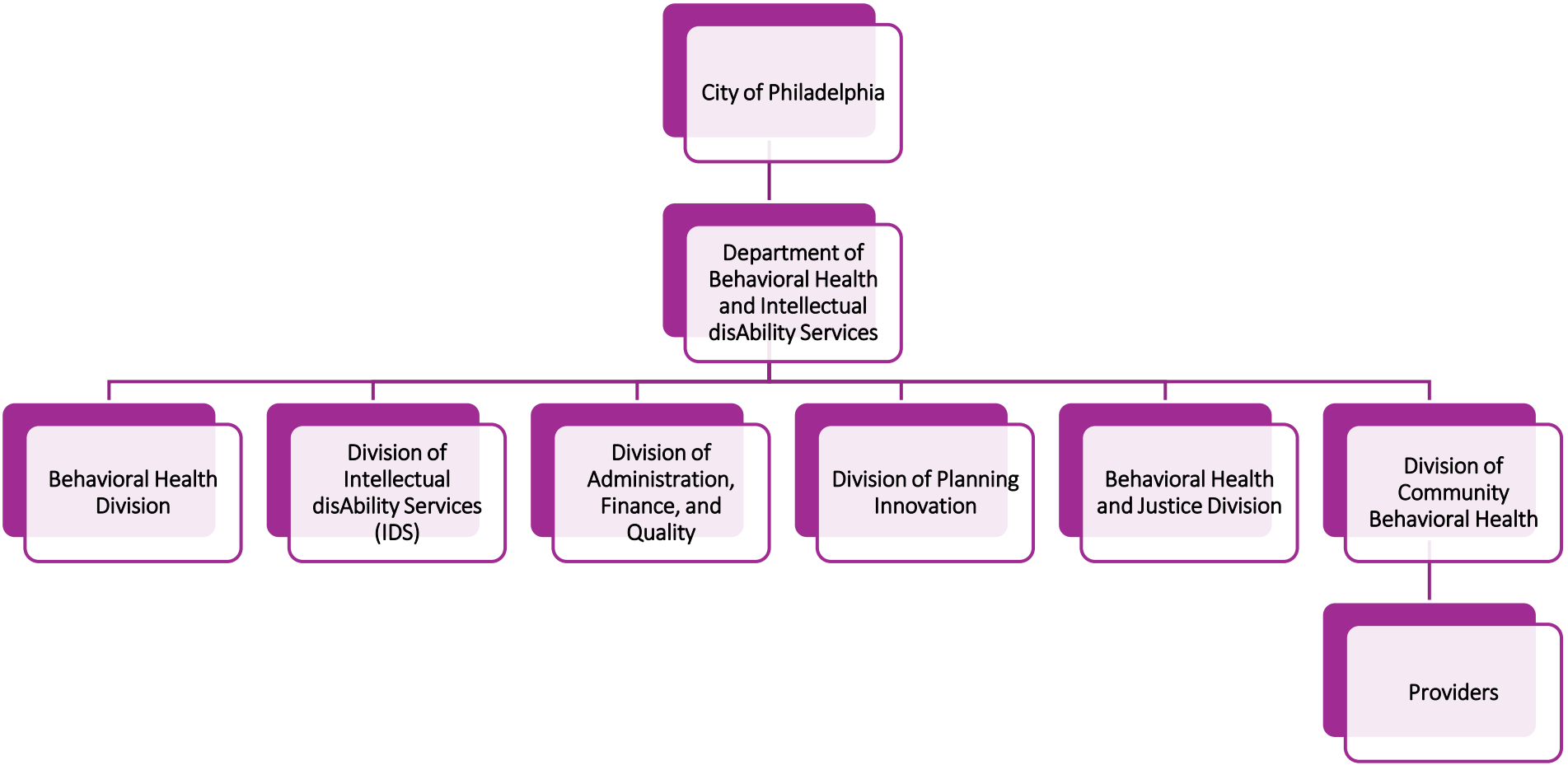
Philadelphia Behavioral Health System

Philadelphia Behavioral Health Structure



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What is Community Behavioral Health?

- Our Mission is to provide access to high-quality, accountable care to improve the health and mental wellness of its members.

- Our Vision is to lead innovation in whole person care for healthy, thriving communities.

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Services Available to CBH Members

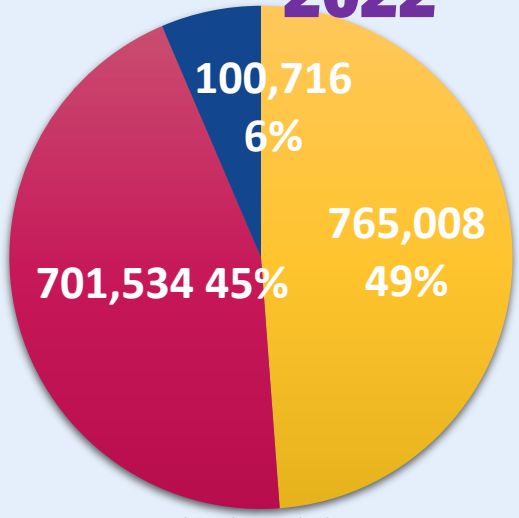
- Crisis Intervention
- Mental Health and Substance Use Disorder Outpatient
- Mental Health and Substance Use Disorder Inpatient
- Medication-Assisted Treatment
- Case Management and Peer Support Services
- School-Based Services
- Mobile Services
- Telehealth
- …and more!

Who are our Providers?

- Facilities, individual and group practitioners who contract with CBH to provide mental health and substance use services to CBH members.
- CBH providers range from individual clinicians in private practice to outpatient clinics to multi-service agencies to large hospitals.
- Since opening the network, the CBH provider network grew from 175 providers to approximately 240.

CBH Members At a Glance

Population of Philadelphia 2022



- Individuals must first enroll in Medicaid benefits.
- Recipients must apply for Medicaid benefits online via COMPASS, in person at a County Assistance Office, by phone, or via mail.
- Individuals must periodically renew their eligibility.

Eligibility for Members

- Based on income and/or disability. For instance, the following groups are eligible:
  - Adults aged 19-64 and families with children who meet low-income thresholds set by the federal government.
  - Individuals who are blind and/or disabled who meet certain income requirements.
  - Individuals 65+ who meet certain income requirements.

- Medicaid is available to Pennsylvania residents who meet eligibility requirements, regardless of how long you've been a Pennsylvania resident.
- Medicaid is available to United States citizens, refugees, and lawfully admitted non-citizens who meet eligibility requirements.

Providers can check individual's eligibility using the PA Medicaid PROMISe™ Eligibility Verification System (EVS).

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How to Become a Provider

Steps to Enroll as a Provider

1. Obtain appropriate state license (OMHSAS, DDAP, Licensing boards)

2. Enroll as a Medicaid Provider (PROMISe)

3. Enter the CBH Network
   a. Procurement /Application
   b. Open Network

4. Credentialing

5. Contracting

Begin Serving Members!

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Steps to Enroll as a Provider

1 . Obtain appropriate state license (OMHSAS, DDAP, Licensing boards)

- Application requirements include:
  - Service description
  - Letter of support from county/BH-MCO
  - Legal entity Articles of Incorporation

2. Enroll as a Medicaid Provider (PROMISe)

- Complete the PROMISe application process.

Steps to Enroll as a Provider

3. Enter the CBH Network

a. Procurement/Application Process

RFI (Request for Information):	RFA (Request for Application):	RFQ (Request for Qualifications):	RFP (Request for Proposals):
• A formal process for gathering input from providers which may inform future procurements.	• May include training offered at no cost to awardees to increase availability of high-quality, evidence-based treatments within the provider network.	• Issued in situations where any respondent that meets predetermined qualifications will be selected to provide the desired service or element of service.	• Seeks proposals to create new services within certain guidelines or modify existing services.

Steps to Enroll as a Provider

3. Enter the CBH Network

b. Open Network

- Allows the network to grow to meet member needs.
- Providers must be enrolled in Medicaid and licensed by the appropriate entity.
- Rolling application process
- Specific levels of care:

  Acute Inpatient Psychiatry, Intensive Behavioral Health Services-Applied Behavioral Analysis (IBHS-ABA), Mental Health Outpatient (MHOP), Psychiatric Residential Treatment Facility (PRTF), ASAM 4 and ASAM 4WM, and independent practitioners or group practices offering certain types of care

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Steps to Enroll as a Provider

4. Credentialing

- Providers are credentialed when entering the network and re-credentialed periodically afterwards.
- Involves review of a provider's credentials including licensure, employee education and work history, and exclusions from federally funded healthcare programs.
- Credentialing process varies by provider type.
    - Independent/individual practitioners, group practice, facility, and Federally Qualified Health Center (FQHC)

5. Contracting

- CBH contracts are also known as Provider Agreements.
- The provider's Schedule A is the billing fee schedule.

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Getting Started!

Provider Operations Outreach

CBH Orientation

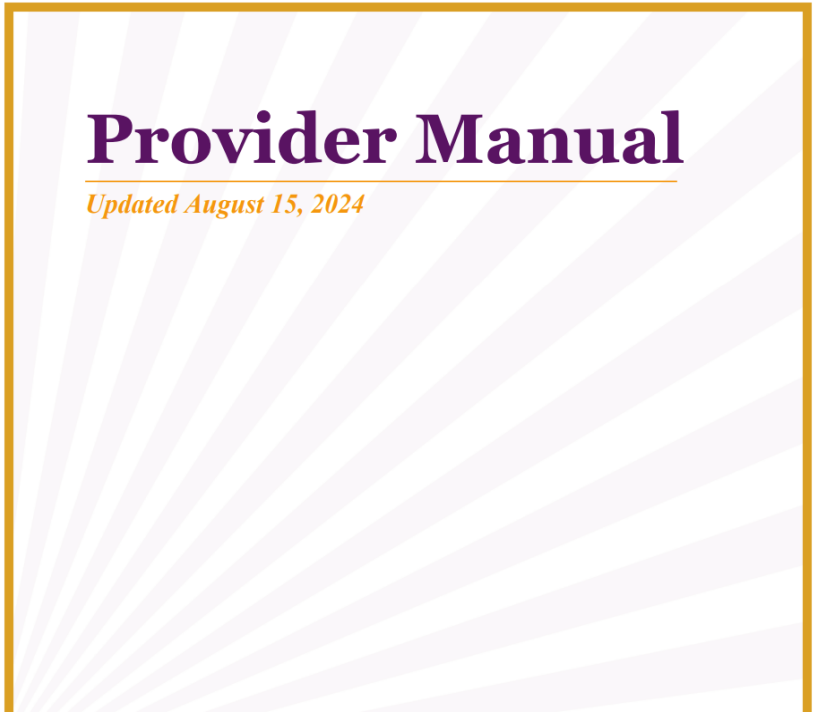
Learning Management System

Other Resources

Getting Started!

Other helpful resources for new providers:

- Provider Manual
- Member Handbook
- CBH News Blast Bulletins & Notices



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Some Factors to Consider…

Clients and Services	Staff	IT	Finance/Billing	Organizational Network

• What portion of your clients are Medicaid eligible?
• Are your services reimbursable by the MCO? (For services funded by CBH see the Provider Manual and Member Handbook).
	• Do your clinical staff meet qualification requirements? (see CBH MRPPF for more info and PA code)
	• Do you have staff and infrastructure needed to perform additional administrative functions needed for Medicaid like billing and compliance?
		• Do you have IT infrastructure that can help you to appropriately document services and bill Medicaid payers?	• What kind of billing methods will you use?
			  • Electronic
			  • Paper
			  • Converter
			• Other funding sources that are available to your organization to fill any gaps not covered by Medicaid.
				• Are there other organizations you can partner with to help you fill any gaps in your capacity?
				• Do you have or are you able to acquire appropriate licensure, enrollment, credentialing, etc. from appropriate entities? (e.g. state licensure entities, managed care organizations, etc.)

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Provider Support: CBH Provider Facing Departments

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Provider Facing Departments

Provider Operations

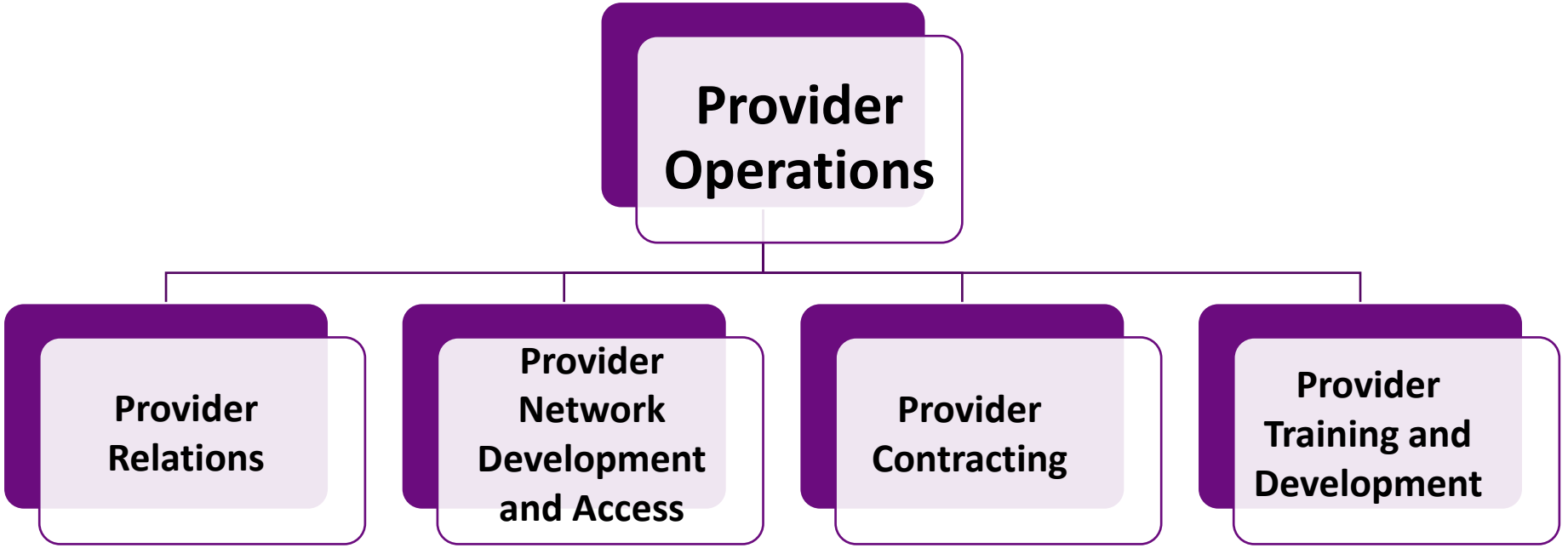
Claims

Clinical Management

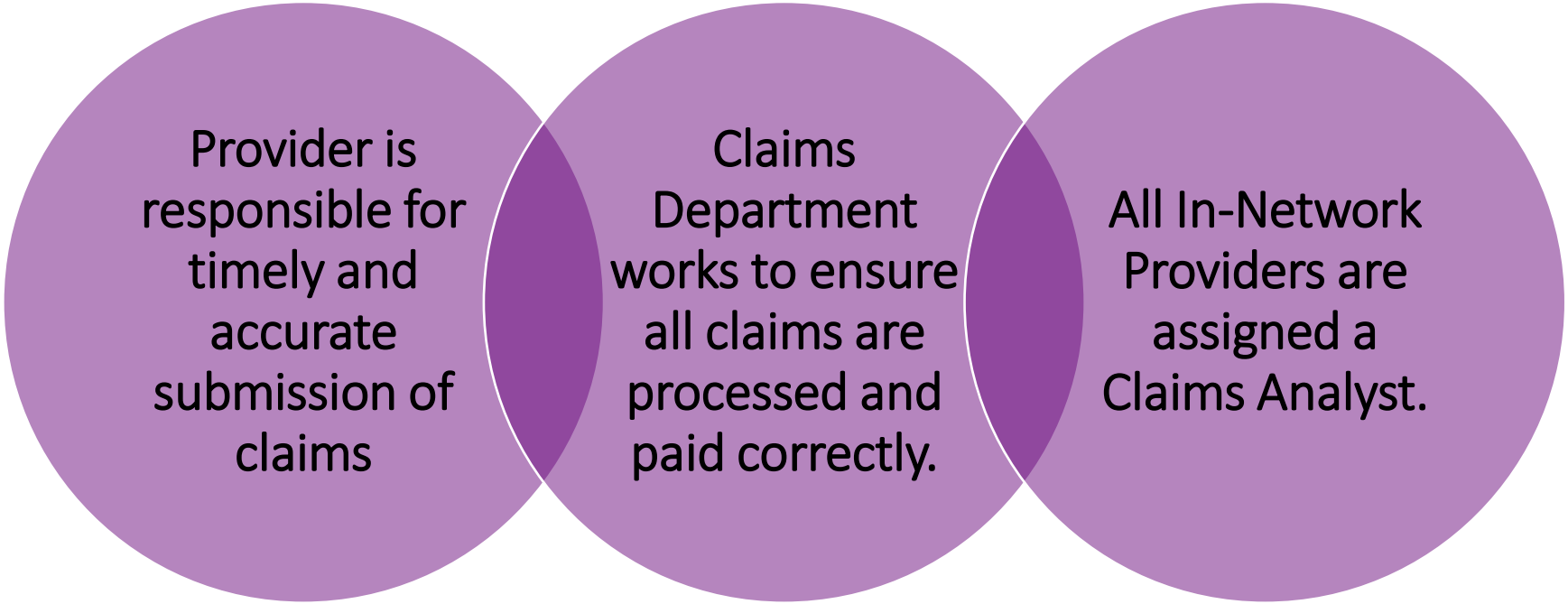
Program Integrity

Quality Management

Member Services


Provider Operations
Provider Relations
Provider Network Development and Access
Provider Contracting
Provider Training and Development

Claims


Provider is responsible for timely and accurate submission of claims
Claims Department works to ensure all claims are processed and paid correctly.
All In-Network Providers are assigned a Claims Analyst.

Clinical Management

The Clinical Department has staff specializing in:

- Psychiatric Emergency Services
- Adult Acute Services
- Adult Complex Care
- Adult Community-Based Services
- Intensive Behavioral Health Services
- Child Community-Based
- Child Acute Services
- Residential Treatment Facility Services
- Neurodevelopmental Services
- Child Complex Care
- School-based Services
- Cross-Systems Integration

Program Integrity

Prevent & Minimize:

Fraud

Intentional deception or misrepresentation with the knowledge the deception could result in some benefit to them or others.

Waste

Overuse of services or practices leading to unnecessary costs.

Misuse of resources.

Abuse

Inconsistent practices that fail to meet standards leading to unnecessary costs. Reimbursement for services that are not medically necessary.

(Definitions from the Code of Federal Regulations Title 42, Chapter IV, Subchapter C §455.2 and PS&R)

Quality Management

The Quality Management Department works to

- ensure that contracted providers are informed and follow all quality of care and service standards
- ensure members receive their right to a fair and impartial complaint and grievances process
- receive, review, and follow up on incident reports
- administer Quality Improvement and Performance Evaluation programs

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Member Services is available 24 hours, 7 days a week.

If you or someone you know has questions about behavioral health or drug and alcohol services, please contact Member Services at 1-888-545-2600

Toll Free Hotline

- Member support regarding treatment needs
- Serve as a connection between menbers and providers
- Complaints and Grievances

Care Coordination

- Aftercare Outreach
- Appointment Reminders
- Behavioral Health Screenings
- Clinical Outreach
- Treatment Availbility

Warm Line

- Operated by National Alliance on Mental Illness (NAMI)
- Call 855-PHL-HOPE (844-745-4673)

Language Access

- Coordinate non-language speaking and non-English speaking appointment requests
- Coordinate Interpretation Services for Behavioral Health Treatment

Education

- Community Events sponsored by DBHIDS
- Provide presentations to the community & internal stakeholders to enhance awareness of CBH services

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Additional Resources

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Behavioral Health Resources

These resources are available to all Philadelphia residents, regardless of Medicaid status.

If you are working with individuals with mental health or substance use challenges it may also be helpful to know about additional resources in Philadelphia:

- 988 Suicide and Crisis Lifeline
- Crisis Response Centers
- Mental Health Urgent Care
- Children's Urgent Care Center
- Mobile Crisis Response (CMCRT)
- Healthy Minds Philly

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Q&A

How do I determine if current rates paid by Medicaid for behavioral health services will be financially sustainable for my organization?

- CBH's rates come from the state and depend on level of care. Funding is subject to change based on state and federal budgets. Community-based rates are standard, bed-based rates are negotiated and bundled.
- It is recommended that providers develop business and operations plans that are reasonable to support the services and functions that the organization plans to provide.
- Some financial factors to consider include:
  - Your unit costs.
  - Your client mix and payer mix.
  - Other resources available to your organization such as grants and other payers. A diverse funding strategy is best practice.

What are options to get reimbursed for services that CBH does not fund?

- For any services that are not funded by CBH, other funding options may include grant funding, private donations, other health plans, or other payers.

I am interested in learning about how medical necessity is determined and used.

- Medical necessity criteria are determined by the state. More information on medical necessity criteria can be found on the CBH website here: https://cbhphilly.org/cbh-providers/oversight-and-monitoring/medical-necessity-criteria/
- CBH's Clinical Department uses medical necessity criteria when making decisions about services that require prior authorization. For more information on services requiring pre-authorization, please see the covered services section on the website or the member handbook.

What are the typical intake processes and wait times for members looking to receive services in the CBH network?

- Each provider has their own intake process.
- Wait times vary based on volume. There is no wait time dashboard available for public consumption. Each provider would need to verify their current wait time. Some providers also have open access walk-in hours for intake.
- CBH issues Provider Bulletins regarding standards for access to timely treatment. Providers should monitor these bulletins for updates.

What are the current rules regarding tele-health? Is there a requirement to have a physical office space?

- Guidelines for telehealth are in progress and will be released when completed.
  - In the meantime, for existing guidance, please see OMHSAS bulletins and CBH bulletins and notices. Links in Resource Guide.
- Currently it is required by the Centers for Medicare and Medicaid Services (CMS) that MHOP clinics have a licensed physical location and either the clinician or client must be physically located at this location for billed services (CMS “4 walls rule”).

What templates/resources/models exist regarding policies that are required by the State and/or CBH?

- Reviewing regulations, requirements, and announcements from the federal, state, and local level is a good place to start to develop your own policies for your organization:
  - PA code
  - OMHSAS
  - CBH provider manual
  - CBH bulletins & notices
  - Network Inclusion Criteria
  - Clinical Practice Guidelines and Performance Standards
  - CBH provider directory
  - CBH supports a Mental Health Outpatient Provider Learning Collaborative group where provider colleagues/peers can share best practices and resources.

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Thank you!