POLICY AND PROCEDURE FOR PROVIDER RATE SETTING

There are two different kinds of rates, depending on the type of service offered:

- Standard Rates
- Non-Standard Rates

Standard Rates

This includes the following Levels of Care:

- Intensive Behavioral Health Services (IBHS)
- Outpatient and Intensive Outpatient D&A
- Outpatient Mental Health
- Inpatient D&A Services (ASAM 4.0, 4WM)
- Non-Hospital D&A (ASAM 3.1, 3.7, 3.7WM)

And the following is taken into consideration:

- Timing of last increase
- Funding availability
- Market conditions
- Laboratory Services

To note: New and out-of-network providers receive the current standard rate.

Non-Standard Rates

This includes the following Levels of Care:

- Inpatient Psychiatry
- Non-Hospital D&A (ASAM 3.5)
- All residential programs with per diem rates (including RTF)
- Intensive Case Management (ICM)
- Resource Coordination (RC)

And the following is taken into consideration*:

- Timing of last increase
- Funding availability
- Current PA MA Rates
- Budget and/or actual financial data
- Quality of Care Clinical Assessment
- Defined Performance Measures

**Requirements vary depending on level of care*

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

Standard Rates

Requests for rate increases should only be submitted in extenuating circumstances. Requests may only be submitted biannually, on March 15th and September 15th. Only one request per calendar year is reviewed for a specific program and level of care.

The provider must submit a letter justifying the rate increase. Additional information must be submitted which may include audited statements, balance sheet, income statement, cashflow statements, the most recent 990, and anticipated clinical outcomes.

Once all corresponding information is received, it will be reviewed by CBH's Rate Request Committee, as well as CBH's Provider Strategy and Financial Stability team or the DBHIDS Finance Committee.