JOINT STATE GOVERNMENT COMMISSION

General Assembly of the Commonwealth of Pennsylvania

MEDICAL ASSISTANCE CAPITATION FUNDING FOR DRUG AND ALCOHOL TREATMENT PROVIDERS WITHIN THE COMMONWEALTH

Staff Study

June 2023

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REPORT

Medical Assistance Capitation Funding for
Drug and Alcohol Treatment Providers within the Commonwealth

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The report is also available at http://jsg.legis.state.pa.us

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The Joint State Government Commission was created in 1937 as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.[1]

A fourteen-member Executive Committee comprised of the leadership of both the House of Representatives and the Senate oversees the Commission. The seven Executive Committee members from the House of Representatives are the Speaker, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. The seven Executive Committee members from the Senate are the President Pro Tempore, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. By statute, the Executive Committee selects a chairman of the Commission from among the members of the General Assembly. Historically, the Executive Committee has also selected a Vice-Chair or Treasurer, or both, for the Commission.

The studies conducted by the Commission are authorized by statute or by a simple or joint resolution. In general, the Commission has the power to conduct investigations, study issues, and gather information as directed by the General Assembly. The Commission provides in-depth research on a variety of topics, crafts recommendations to improve public policy and statutory law, and works closely with legislators and their staff.

A Commission study may involve the appointment of a legislative task force, composed of a specified number of legislators from the House of Representatives or the Senate, or both, as set forth in the enabling statute or resolution. In addition to following the progress of a particular study, the principal role of a task force is to determine whether to authorize the publication of any report resulting from the study and the introduction of any proposed legislation contained in the report. However, task force authorization does not necessarily reflect endorsement of all the findings and recommendations contained in a report.

Some studies involve an appointed advisory committee of professionals or interested parties from across the Commonwealth with expertise in a particular topic; others are managed exclusively by Commission staff with the informal involvement of representatives of those entities that can provide insight and information regarding the particular topic. When a study involves an advisory committee, the Commission seeks consensus among the members.[2] Although an advisory committee member may represent a particular department, agency, association, or group, such representation does not necessarily reflect the endorsement of the department, agency, association, or group of all the findings and recommendations contained in a study report.

[1] Act of July 1, 1937 (P.L.2460, No.459); 46 P.S. §§ 65–69.

[2] Consensus does not necessarily reflect unanimity among the advisory committee members on each individual policy or legislative recommendation. At a minimum, it reflects the views of a substantial majority of the advisory committee, gained after lengthy review and discussion.

Over the years, nearly one thousand individuals from across the Commonwealth have served as members of the Commission's numerous advisory committees or have assisted the Commission with its studies. Members of advisory committees bring a wide range of knowledge and experience to deliberations involving a particular study. Individuals from countless backgrounds have contributed to the work of the Commission, such as attorneys, judges, professors and other educators, state and local officials, physicians and other health care professionals, business and community leaders, service providers, administrators and other professionals, law enforcement personnel, and concerned citizens. In addition, members of advisory committees donate their time to serve the public good; they are not compensated for their service as members. Consequently, the Commonwealth receives the financial benefit of such volunteerism, along with their shared expertise in developing statutory language and public policy recommendations to improve the law in Pennsylvania.

The Commission periodically reports its findings and recommendations, along with any proposed legislation, to the General Assembly. Certain studies have specific timelines for the publication of a report, as in the case of a discrete or timely topic; other studies, given their complex or considerable nature, are ongoing and involve the publication of periodic reports. Completion of a study, or a particular aspect of an ongoing study, generally results in the publication of a report setting forth background material, policy recommendations, and proposed legislation. However, the release of a report by the Commission does not necessarily reflect the endorsement by the members of the Executive Committee, or the Chair or Vice-Chair of the Commission, of all the findings, recommendations, or conclusions contained in the report. A report containing proposed legislation may also contain official comments, which may be used to construe or apply its provisions.[3]

Since its inception, the Commission has published almost 450 reports on a sweeping range of topics, including administrative law and procedure; agriculture; athletics and sports; banks and banking; commerce and trade; the commercial code; crimes and offenses; decedents, estates, and fiduciaries; detectives and private police; domestic relations; education; elections; eminent domain; environmental resources; escheats; fish; forests, waters, and state parks; game; health and safety; historical sites and museums; insolvency and assignments; insurance; the judiciary and judicial procedure; labor; law and justice; the legislature; liquor; mechanics' liens; mental health; military affairs; mines and mining; municipalities; prisons and parole; procurement; state-licensed professions and occupations; public utilities; public welfare; real and personal property; state government; taxation and fiscal affairs; transportation; vehicles; and workers' compensation.

Following the completion of a report, subsequent action on the part of the Commission may be required, and, as necessary, the Commission will draft legislation and statutory amendments, update research, track legislation through the legislative process, attend hearings, and answer questions from legislators, legislative staff, interest groups, and constituents.

[3] 1 Pa.C.S. § 1939.

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To the Members of the General Assembly:

We are pleased to release *Medical Assistance Capitation Funding for Drug and Alcohol Treatment Providers within the Commonwealth*, as directed by Senate Resolution 352 of 2022. SR352 directed the Commission to collect information on data and mechanisms that determine capitation funding paid to Pennsylvania's drug and alcohol treatment providers. Specifically, the resolution asked for an explanation of the process used to distribute funding from the Department of Human Services (DHS) to counties and from counties to Behavioral HealthChoices Managed Care Organizations (BH-MCOs). Additionally, the resolution asked for information on DHS' cost-reporting system for capitation rates and factors included in calculations. Similar information was requested from Single County Authorities (SCAs). The resolution also asked for information about expenses, policies, and mechanisms related to BH-MCOs rate negotiations.

Commission staff conducted dozens of interviews with over 20 different stakeholders at varying levels of the funding process, including representatives from DHS and the Department of Drug and Alcohol Programs (DDAP), those involved with administering SCAs, county officials, primary contractors in the Behavioral HealthChoices program, all five BH-MCOs in Pennsylvania, and several provider representatives.

On behalf of the Joint State Government Commission, we extend our thanks to DHS, DDAP, BH-MCOs, county staff, and care providers for their cooperation.

The full report is available at http://jsg.legis.state.pa.us.

Respectfully submitted,

Glenn J. Pasewicz
Executive Director

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INTRODUCTION

Senate Resolution 352, Printer's No. 1964 of 2022 (SR 352) was adopted on October 25, 2022 and directed the Joint State Government Commission (the Commission) staff to collect information on the specific data and mechanisms used to determine the amount of capitation funding paid to drug and alcohol treatment providers in Pennsylvania. Specifically, the resolution asked for an explanation of the process used to distribute funding from the Department of Human Services (DHS) to counties, and from counties to Behavioral HealthChoices Managed Care Organizations (BH-MCOs). Additionally, the resolution asked for information on the cost-reporting system utilized by DHS to create capitation rates and asked whether the following factors were included in the calculations:

- increases in the general cost of living,
- inflation, capital depreciation and amortization costs,
- workforce and salary demands,
- regional differences; and
- other information that the Commission finds relevant in the calculation that informs the Medicaid capitation allocation.

The resolution also requested the information and data informing the allocation of county funding to Single County Authorities (SCAs). Lastly, the resolution asked for specific data regarding the portion of capitation funding ultimately used for drug and alcohol treatment, the percentage increase in reimbursement rates from 2018-2019, and the policies and mechanisms provided by BH-MCOs for rate negotiation.

To obtain this information, Commission staff conducted interviews with over 20 different stakeholders at varying levels of the funding process, including representatives from DHS and the Department of Drug and Alcohol Programs (DDAP), those involved with administering SCAs, county officials, primary contractors in the Behavioral HealthChoices program, all five BH-MCOs in Pennsylvania, and several provider representatives. The following report is a collection of the available documentation for the Behavioral HealthChoices program and the information shared by stakeholders in interviews and other communications that was not previously publicly available.

This report will address the aforementioned directives after providing a brief overview of both federal and state legal authority governing funding systems for drug and alcohol treatment programs as well as an overview of Pennsylvania's managed care and SCA system.

Summary of Pennsylvania's Drug and Alcohol Treatment Funding

Pennsylvania's system of public funding for drug and alcohol treatment is administered through two separate sources: DHS funding based on a managed care model for those on Medical Assistance through Behavioral HealthChoices and DDAP funding for treatment for those who are uninsured or underinsured. The focus of this report is the managed care model, specifically the BH-MCOs. In this model of funding, DHS receives federal Medicaid funding and enters contracts with primary contractors in which primary contractors are reimbursed at a per member/per month rate. This rate, also called a capitation rate, is calculated by the state's actuary using actuarily sound practices. Primary contractors then enter contracts with BH-MCOs, which provide administrative support and potentially share risk for the contract with DHS. Primary contractors and BH-MCOs collaborate to meet HealthChoices contract requirements and on setting reimbursement rates for individual services offered by providers at treatment facilities. Providers are able to request rate increases if they feel the rates offered do not cover the cost of care. Due to the large range of combinations of counties, primary contractors, BH-MCOs and providers, the rates for services can vary significantly in different regions. Funding for uninsured and underinsured clients flows from DDAP to SCAs and is distributed to providers through a cost-based package called the XYZ Package.

Through many interviews with stakeholders at all levels of the funding mechanisms, Commission staff found that there is a lack of publicly available information on how these programs are administered, leading to confusion or even disillusion with the system from some providers. Additionally, the HealthChoices contracts include many eligibility requirements for providers to participate in the programs, but do not place accountability on BH-MCOs to ensure that providers receive a fair rate. BH-MCOs must have a rate increase request policy but are not required to reveal the specific information they consider in a rate review or explain a denial for an increase to a provider.

The report details the mechanisms used at each level of the funding process and includes stakeholder feedback on these mechanisms.

SUMMARY OF RECOMMENDATIONS

Based on the research conducted and stakeholder feedback collected throughout the following report, the Joint State Government Commission makes the following recommendations:

RECOMMENDATION 1: *The Process for Developing Reimbursement Rates Should Be Made More Transparent.*

The Behavioral HealthChoices Program Standards and Requirements for Primary contractors and Behavioral Health Managed Care Organizations (BH-MCOs) should include a requirement to more fully document and standardize the reimbursement rate review process.

RECOMMENDATION 2: *Providers Should Be Properly Trained to Submit Financial Information.*

Primary contractors should be required to train small providers to accurately collect and report the financial information pertinent to a rate increase request. Small providers were overwhelmed with the amount and specificity of information requested by both Single County Authorities (SCAs) and BH-MCOs.

RECOMMENDATION 3: *BH-MCOs Should Give Providers Explanations for Rate Increase Denials or Counteroffers.*

BH-MCOs must have a policy for responding to a rate increase request, but they are given broad discretion over what this policy looks like. They are not expressly required to respond to a rate increase request with an explanation if their internal review process does not grant a rate increase, causing frustration and suspicion among providers. The Program Standards and Requirements should include clear language requiring BH-MCOs to offer a written justification for a rate request, denial, or counteroffer.

RECOMMENDATION 4: *SCAs Should Give Providers Explanations for Rate Increase Denials or Counteroffers.*

Similarly, SCAs are not expressly required to justify the denial of a rate increase after a cost-based packet and formula called the XYZ Package is submitted until a formal appeal is filed. If BH-MCOs are using the same rates as the XYZ packages, which some have stated they are, provider frustration with the XYZ rates would translate to the BH-MCO rates as well. SCAs

providing explanations for refusing or countering a rate increase could foster dialogue between the provider and SCA and make the provider more prepared for conversations with BH-MCOs about rates as well.

RECOMMENDATION 5: *Funding Opportunities Should Focus on Sustainable Rate Increases instead of Inconsistent Lump Sums.*

Providers were thankful for lump sum payment incentives, as additional funding is always valued; however, they indicated that a value-based purchasing incentive or other incentives granting a rate increase would be more effective. Providers cannot budget throughout the year on a lump sum payment they may or may not receive based on whether they meet a certain quality threshold. Incentives that would lead to a sustained rate increase in the following years would be preferred.

Initially enacted in 1965 in an amendment to the Social Security Act of 1935[4], Medicaid serves as a medical assistance program contained within 42 U.S.C. § 1396 *et seq.* The Medicaid program pays for medical assistance for certain individuals and families with low income and resources. Medicaid covers services such as in-patient hospital services, out-patient hospital services, laboratory and x-ray services, skilled nursing home services, physicians' services, physical therapy, hospice care, and rehabilitative services.

Before its enactment, health care services for indigent or impoverished individuals were "provided primarily through a patchwork of programs sponsored by State and local governments, charities, and community hospitals."[5] Today, federal and state governments jointly fund and administer the Medicaid program. The U.S. Centers for Medicare and Medicaid Services (CMS) administers the program at the federal level, while DHS administers the program at the state level in Pennsylvania.

Many states began receiving waivers from the federal government to create what are known as "Medicaid managed care" programs in the 1980s. Under managed care programs, eligible Medicaid recipients are enrolled in a private health plan that receives a fixed monthly premium from the state. The health plan provides for all or most of the recipient's healthcare needs. The term "managed care" can refer to several different arrangements for delivering and financing health care services operated by a state as authorized under the Federal statute.[6]

Medicaid managed care arrangements differ from those in the private sector and in Medicare largely due to the difference in the populations served by each. In addition, Medicaid is a joint federal and state program, while Medicare is purely a federal program. Enrollment of low-income populations with limited resources and often complex health needs affects Medicaid managed care program design. Managed care organizations (MCOs) cover a specific range of benefits for a fixed payment rather than charging for individual services. The fixed payments are commonly referred to as "capitation payments", and the rate for these payments is determined annually.

In 2014, provisions within the Affordable Care Act (ACA)[7] sought to expand Medicaid eligibility to cover additional low-income individuals. Health care coverage rates increased, as well as enrollment in managed care plans in many states that adopted and implemented the Medicaid expansion. The ACA's expansion guidelines extended Medicaid eligibility to adults

[4] The Social Security Act of 1935, Pub. L. 74-271, 49 Stat. 620.
[5] Christie Provost, M.P.P. and Paul Hughes, M.P.P., "Medicaid: 35 Years of Service," *Health Care Financing Review* (Fall 2000): 22:1, p. 141.
[6] Medicaid and CHIP Payment and Access Commission, *Report to Congress: The Evolution of Managed Care in Medicaid*, (June 2011), p. 2.
[7] The Patient Protection and Affordable Care Act of 2010, Pub L. 111-148, 124 Stat. 119 – 124 Stat. 1025.

under the age of 65 with incomes up to 138 percent of the federal poverty level (133 percent plus a 5 percent income disregard). This was viewed as a significant change to the Medicaid system because prior to the ACA, Medicaid was generally not available to adults without disabilities under the age of 65, unless they had minor children and low income. However, in 2012, the U.S. Supreme Court held in a landmark decision that states could not be compelled to expand their Medicaid programs. The court opined that an attempt to do so was an unconstitutional act by Congress to coerce states to adopt the expansion or risk losing existing federal Medicaid funding.[8] The result was that states would each determine whether to participate in the expansion or not. When the expansion first took effect in 2013, only 26 states and the District of Columbia adopted it. As of 2023, 38 states and the District of Columbia have adopted it.[9] Pennsylvania adopted and implemented the expansion in 2015.[10]

Today, managed care is the primary way states deliver health services to Medicaid enrollees. Of the 83.5 million total Medicaid enrollees throughout the U.S. in fiscal year 2020, 70.4 percent were enrolled in comprehensive managed care plans.[11] Nearly three quarters of the 50 states now utilize a managed care model for Medicaid delivery.[12] Like Pennsylvania, many states have shifted to risk-based contracting with MCOs in hopes of increasing their budget predictability, constraining their Medicaid spending, and improving access to high quality care for their Medicaid enrolled residents.[13]Almost every state has some form of managed care in place – comprehensive risk-based managed care and/or primary care case management programs[14]. As of July 2021, there were 41 states (including DC) that contract with comprehensive, risk-based managed care plans to provide care to some of their Medicaid beneficiaries.[15]

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[8] *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

[9] Healthinsurance.org, "Medicaid Expansion," https://www.healthinsurance.org/glossary/medicaid-expansion/, last accessed March 27, 2023.

[10] "Status of State Medicaid Expansion Decisions: Interactive Map," Kaiser Family Foundation, (Feb. 16, 2023), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/#:~:text=Coverage%20under%20the%20Medicaid%20expansion,%2C%20Virginia%20(1%2F1%2F, last accessed March 27, 2023.

[11] Medicaid and CHIP Payment and Access Commission, "MACStates: Medicaid and CHIP Data Book 2022), Exhibit 30, https://www.macpac.gov/wp-content/uploads/2022/12/EXHIBIT-30.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-and-Eligibility-Group-FY-2020.pdf, last accessed January 18, 2023.

[12] *Medicaid Managed Care Capitation Rate Setting* (Washington, D.C., MACPAC, March 2022), 1.

[13] Elizabeth Hinton and Lina Stolyor, "10 Things to Know about Medicaid Managed Care," Kaiser Family Foundation, (Feb. 23, 2022), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/, last accessed on January 6, 2023.

[14] In Primary Care Case Management Programs, enrollees are assigned to a designated primary care provider that is paid a monthly case management fee to manage and coordinate care. MACPAC, "Types of Managed Care Arrangements," https://www.macpac.gov/subtopic/types-of-managed-care-arrangements/#:~:text=In%20a%20PCCM%20program%2C%20each,FFS%20basis%20for%20covered%20services, last accessed May 24, 2023.

[15] *Supra.*, n. 13.

Federal Statutory Authority

States have the authority to determine how they deliver and pay for care for Medicaid beneficiaries. However, while states are responsible for designing and administering their own Medicaid programs, these programs must comply with federal regulations.

All federal regulations must have statutory authorization to be promulgated. Federal law under 42 U.S.C. § 1302 expressly permits for the establishment of rules and regulations and the impact analyses of Medicare and Medicaid rules and regulations on small rural hospitals. Section 1302(a) further provides:

> [t]he Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, respectively shall make and publish such rules and regulations … as may be necessary to the efficient administration of the functions with which each is charged…[16]

The Secretary of Health and Human Services is responsible for ensuring the agency protects the health of Americans and provides essential human services.[17] Therefore, the Secretary is authorized by law to establish rules and regulations necessary to its functions, which include the provision of managed care services to eligible American citizens, reimbursed through federal funds.

Federal Regulations

Federal regulations authorized under 42 U.S.C. § 1302 and governing the framework of this complex system of managed care programs in the states can be found within Title 42 of the Code of Federal Regulations (CFR), Part 438.[18] The CFR is the codification of the general and permanent rules published within the Federal Register by different federal departments and agencies.

Specifically, 42 CFR 438 provides requirements, prohibitions, and procedures for the provision of Medicaid services through MCOs, prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case management (PCCMs) programs, and PCCM entities. Requirements vary depending on the type of entity and on the authority under which the state contracts with the entity. Part 438 rules include provisional regulations regarding the following:

- General provisions.
- State responsibilities.
- Enrollee rights and protections.

[16] 42 U.S.C. § 1302.
[17] 42 U.S.C. § 202; USgov, "U.S. Department of Health and Human Services," https://www.usa.gov/federal-agencies/u-s-department-of-health-and-human-services, last accessed on January 10, 2023.
[18] 42 CFR § 438.

- Managed care organization standards.
- Quality measurement and improvement.
- External quality review procedures.
- Grievance and appeal system.
- Additional program integrity safeguards.
- Sanctions.
- Conditions for Federal Financial Participation (FFP).
- Parity in mental health and substance use disorder benefits.

Capitation Rates

Capitation payments are the fixed payments MCOs receive from state and federal sources for covering a range of health benefits. The rate for these payments is determined annually and is referred to as "capitation rates." States set capitation rates through consultation with contracted actuarial firms.

The federal standards for capitation rate setting are found within 42 CFR §§ 438.3 through 438.5. The rate setting process must be actuarially sound. To be actuarially sound, capitation rates must be projected to provide for all reasonable, appropriate, and attainable costs required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time and the population covered under the contract.[19] The actuarial soundness of the capitation rate should adequately balance the chance of profit or surplus against the financial risk assumed by the MCO.[20] Capitation rates must be developed in accordance with the requirements under §§ 438.4 and 438.5 of Title 42 of the regulations.

Federal regulations also prescribe rate development standards and specifically mandate that states follow certain steps in developing the capitation rate. First, states must identify and develop baseline utilization and price data. This is accomplished by applying actual encounter data, fee-for-service (FFS) data, and MCO financial reports from the preceding three years. The baseline costs can be reasonably adjusted "to account for incurred but not reported claims, missing data, non-claims payments or recoupments such as pharmacy rebates, and the effects of differences between the baseline data and the expected covered population and services."[21]

After baseline utilization and price data are identified, the states develop what are known as rate cells. Rate cells are defined under federal law as "a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment…"[22] Characteristics include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under an established contract between the state and the MCO.[23] Different capitation rates are developed for each of these rate

[19] 42 C.F.R. § 438.4(b).
[20] *Medicaid Managed Care*, 1.
[21] *Medicaid Managed Care*, 3.
[22] 42 C.F.R. § 438.2.
[23] *Ibid*.

cells. After separating baseline costs into rate cells, states must account for future costs by applying trend assumptions to the costs. Trend assumptions must be actuarially sound and may account for inflation and changes in utilization patterns. However, trends must be developed primarily from actual experience of the Medicaid population or from a similar population.[24] In addition, adjustments can be made for programmatic changes, non-benefit components, and any other adjustments necessary. Each adjustment must reasonably support the development of accurate base data and programmatic changes must be appropriate. Adjustments must also reflect the health status of the enrolled population, or reflect non-benefit costs, and be developed in accordance with generally accepted actuarial principles and practices.[25]

The non-benefit component of the rate is established separately from the direct health care provision costs. Calculating the non-benefit component accounts for reasonable expenses related to MCO, PIHP, or PAHP administration; taxes; licensing and regulatory fees; contribution to reserves; risk margin; cost of capital; and other operational costs associated with the provision of state plan services to Medicaid enrollees.[26] All rate cells receive a portion of this calculation. This portion is either added as a percentage of premiums or a fixed amount applied to each rate cell.

In developing a capitation rate, states must also consider past medical loss ratio (MLR). MLR is essentially the proportion of premium revenues spent on clinical services and quality improvement.[27] Other special contract provisions can be added to developing the capitation rate, including "incentives, withholds, risk-sharing mechanisms, state directed payments, and pass-through payments…"[28] Each of these special provisions are subject to specific regulatory requirements. For example, if a state applies risk-sharing mechanisms or risk adjustments to its capitation rate, the state must select a risk adjustment methodology and apply it in a budget neutral manner across all MCOs, PIHPs, or PAHPs in the program to calculate adjustments to the payments as necessary.[29] It is important to note that the total payment of special incentives cannot exceed 105 percent of the capitation payment.[30]

After a state has determined a rate, the rate is submitted as a proposal to CMS for approval along with documentation to support the accuracy of the elements necessary for its development. Once the capitation rates are approved by CMS, an agreement between the state and an MCO will define the population served and the services covered by the MCO and the rates for a 12-month period.

States are also permitted to use a method called directed payments to require MCOs to pay providers above a certain minimum threshold for certain services. Pennsylvania recently began using directed payments to establish minimum rates for intensive outpatient, partial

[24] 42 C.F.R. § 438.5(d).
[25] 42 C.F.R. § 438.5(f).
[26] 42 C.F.R. § 438.5(b)(3).
[27] CMS.gov "Medical Loss Ratio," https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio, last accessed on January 24, 2023.
[28] *Medicaid Managed Care*, 4.
[29] 42 C.F.R. § 438.5(b).
[30] *Medicaid Managed Care*, 4.

hospitalization, residential, and inpatient services. The directed payment rate must be approved by CMS.[31]

In summary, to develop capitation rates in compliance with federal law, the following requirements must be satisfied:

- Rates must be developed in accordance with the standards specified in § 438.5 and generally accepted actuarial principles and practices.
- Rates must be appropriate for the populations to be covered and the services to be furnished under the contract.
- Rates must be adequate to meet the requirements on MCOs, PIHPs, and PAHPs.
- Rates must be specific to payments for each rate cell under the contract.
- Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- Rates must be certified by an actuary as meeting the applicable requirements of the federal rules.
- Rate proposals must be provided to CMS in a format and within a timeframe that meets the requirements of federal regulations.
- Rates must be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under § 438.8 of the federal regulations, of at least 85 percent for the rate year. The capitation rates may be developed in such a way that would reasonably achieve a medical loss ratio standard greater than 85 percent, if the rates are adequate for reasonable, appropriate, and attainable non-benefit costs.[32]

CMS Review

CMS is required to review and approve all MCO, PIHP, and PAHP contracts, including those risk and no risk contracts that, based on their value, are not subject to the prior approval requirement under federal law. All proposed final contracts must be submitted in the form and manner established by CMS.[33] Furthermore, § 438.3 of Title 42 of the federal regulations requires that each comprehensive risk contract held by MCOs include certain details, such as the final capitation rate (which CMS evaluates with the contract) and the receipt of capitation payments under the contract.[34] Federal regulations also require that proposed final contracts be submitted in

[31] *Medicaid Managed Care*, 10.
[32] 42 C.F.R. § 438.4(b).
[33] 42 C.F.R. § 438.3(a).
[34] 42 C.F.R. § 438.3(b)-(c).

the form and manner established by CMS. For States seeking approval of contracts prior to a specific effective date, the proposals must be submitted to CMS no later than 90 days prior to the effective date of the contract.[35] If CMS disagrees with certain considerations used by a state's actuaries, it can deny the proposed rate or prohibit the specific considerations used from being included in future rate setting proposals.

Plan Requirements

Part 438 (Subpart B) provides requirements for state managed care plans. The requirements specify what information plans must include, the assurances plans must make, as well as limitations on enrollment in such plans.[36] Other provisions covered under Subpart B include requirements on managed care enrollment, conflict of interest safeguards, state monitoring requirements, network adequacy standards, and stakeholder engagement.

Enrollee Rights and Protections

Federal regulations under Subpart C of Part 438 covers enrollee rights and protections. Among other things, the regulations in this subpart require that MCOs and other participating entities create and maintain written policies regarding enrollee rights, which must be consistent with federal rules.[37] Basic enrollee rights specified in the rules include the right to receive general information, be treated with respect and with due consideration for his or her dignity and privacy, receive information on available treatment options and alternatives, participate in decisions regarding his or her health care, and be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation.[38] Some other provisions include liability for payment, cost sharing, and provider-enrollee communications.

MCO, PIHP, and PAHP Standards

Under Subpart D of Part 438, regulations cover topics related to the standards of managed care entities and plans. One basic rule under Subpart D is that each state must ensure that all services covered in its state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely fashion. In addition, the rules require that states ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the state in accordance with § 438.68 of the federal regulations.[39]

States must also ensure, through their contracts, that each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers. Those policies and procedures must establish a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorders, and long-term services and supports providers, as appropriate.

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[35] 42 C.F.R. § 438.3(a).
[36] 42 C.F.R. § 438.50(b)-(d).
[37] 42 C.F.R. § 438.100(a).
[38] 42 C.F.R. § 438.100(b).
[39] 42 C.F.R. § 438.206(a)-(b).

Furthermore, each MCO, PIHP, and PAHP must follow a documented process for credentialing and recredentialing of network providers.[40]

Subpart D also requires that states ensure confidentiality for medical records and any other health and enrollment information identifying a particular enrollee. Each MCO, PIHP, and PAHP must use such individually identifiable health information in accordance with the federal privacy requirements.[41]

Quality Measurement and Improvement; External Quality Review

Subpart E covers quality measurement and improvement for care provided under the managed care programs and specifically requires that states must require, through their contracts, that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for services they furnish to their enrollees.[42] Subpart E also requires that states contracting with an MCO, PIHP, or PAHP draft and implement a written quality strategy for assessing and improving the quality of health care and services provided by those entities. The regulations provide specific requirements as to the contents of this quality strategy.[43]

Grievance and Appeal System

Subpart F of the regulations provides that each MCO, PIHP, and PAHP must have a grievance and appeal system in place for enrollees.[44] This subpart provides requirements for timely and adequate notice of adverse benefit determinations, handling of grievances and appeals, expedited resolution of appeals, recordkeeping requirements, and effectuation of reversed appeal resolutions, to name a few.

Additional Program Integrity Safeguards

Additional program integrity safeguards required under Subpart H include data, information, and documentation submission by MCOs, PIHPs, PAHPs and PCCM entities. Required data includes the basis of which the state certifies the actuarial soundness of capitation rates, the basis of which the state determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio, information on ownership and control from MCOs, PIHPs, and PAHPs, and other information pursuant to § 438.604(a) of Subpart H.[45] Additional state responsibilities related to enrollees in general, as well as source, content, and timing of certification, and prohibited affiliations is also covered under this subpart.

[40] 42 C.F.R. § 438.214(a)-(b).
[41] 42 C.F.R. § 438.224.
[42] 42 C.F.R. § 438.330(a).
[43] 42 C.F.R. § 438.340.
[44] 42 C.F.R. § 438.402(a).
[45] 42 C.F.R. § 438.604.

Sanctions

Subpart I of Part 438 addresses sanctions related to managed care providers and organizations. The regulations require that each state contracting with an MCO establish intermediate sanctions (which may include those specified in § 438.702) that they may impose if they determine the presence of any of the failures enumerated in the regulations. Determinations may be based on findings from onsite surveys, enrollee or other complaints, financial status, or any other source. Some enumerated failures warranting the imposition of sanctions per the regulations include when a state determines an MCO acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the state, to an enrollee.
- Imposes premium or charges on enrollees that are more than the premiums or charges permitted under the Medicaid program.
- Discriminates among enrollees based on their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS or to the state.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
- Fails to comply with the requirements for physician incentive plans.[46]

This subpart also provides requirements for types of intermediate sanctions, amounts of civil money penalties, and notices of sanctions and pre-termination hearings.

Conditions for Federal Financial Participation (FFP)

Subpart J covers the conditions necessary for MCOs to receive FFP in expenditures for payments under an MCO contract. Provisions under this subpart address basic requirements, prior approvals, exclusion of certain entities, expenditures of enrollment broker services, costs under risk and no-risk contracts, and other regulations.

[46] 42 C.F.R. § 438.700(a)-(b).

Parity in Mental Health and Substance Use Disorder Benefits

Regulations on mental health and substance use disorder parity are in Subpart K of Part 438. In general, § 438.905 requires that each MCO, PIHP, and PAHP providing services to MCO enrollees must comply with federal regulations for all enrollees of an MCO in states that cover both medical/surgical benefits and mental health, or substance use disorder benefits pursuant to a state plan. This section also further details the application of the parity requirements for aggregate lifetime and annual dollar limits.[47]

[47] 42 C.F.R. § 438.905(a)-(b).

State Statutory Authority

State Medicaid programs must comply with federal regulations; however, states do have legal authority to govern the creation and administration of their own Medicaid programs. The Human Services Code[48] (HSC) provides DHS the authority to act as the sole agency of the state when applying for, receiving, and using federal funds for the financing in whole or in part of programs in fields in which the department has responsibility, with the approval of the governor.[49]

With the approval of the governor, the HSC also authorizes DHS "to develop and submit State plans or other proposals to the Federal government, to promulgate regulations, establish and enforce standards and to take such other measures as may be necessary to render the Commonwealth eligible for available Federal funds or other assistance."[50] DHS can perform surveys and inventories of existing facilities and services as required in connection with such state plans, and assess the need for construction, modernization, or additional services for state plans.[51]

Moreover, the law permits DHS to conduct investigations of activities related to fraud, misuse or theft of public assistance moneys, medical assistance moneys or benefits, collect data on its programs and services, "including efforts aimed at preventative health care, to provide the General Assembly with adequate information to determine the most cost-effective allocation of resources in the medical assistance program,"[52] and submit a biannual report to the General Assembly regarding the medical assistance population related to the cost per service as well as total expenditures by service, and other relevant information.[53]

For DDAP and its role in funding drug and alcohol abuse treatment programs, the Pennsylvania Drug and Alcohol Abuse Control Act[54] (PDAACA) authorizes DDAP to develop and implement a state plan for the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of drug and alcohol abuse and dependency problems (with the advice and consultation of the Pennsylvania Advisory Council on Drug and Alcohol Abuse).

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[48] The Human Services Code of 1967, Act of June 13, 1967 (P.L.31, No. 21), art. 1, § 101 (hereinafter "HSC"); 62 P.S. § 101 *et seq*.
[49] *Ibid*. § 201; 62 P.S. § 201(1).
[50] *Ibid*. § 201; 62 P.S. § 201(2).
[51] *Ibid*. § 201; 62 P.S. § 201(3).
[52] *Ibid*. § 201; 62 P.S. § 201(5).
[53] *Ibid*. § 201; 62 P.S. § 201(6).
[54] The Pennsylvania Drug and Alcohol Abuse Control Act of 1972, Act of April 14, 1972 (P.L.221, No. 63), § 1; 71 P.S. § 1690.101 *et seq*.

In addition, the law permits the Department of Health to promulgate any regulations necessary to carry out its duties and allows for the establishment of funding priorities for drug and alcohol programs, as well as the allocation of funds for the control, prevention, intervention, treatment, rehabilitation, research or training aspects of drug and alcohol abuse and dependency problems.[55]

State Regulations

State regulations governing Pennsylvania's managed care programs primarily fall under Title 28 Health and Safety of the Pennsylvania Code. Specifically, Chapter 9 of Title 28 provides regulations for the operation and use of managed care organizations for the performance of medical management related to state plans. Section 9.675 of Title 28, Chapter 9 of the regulations permits a state plan to contract with an entity for the performance of medical management relating to the delivery of health care services to Medicaid enrollees. The plan must assure that the medical management contract meets the requirements of all applicable laws.[56]

Chapter 9 also provides regulations on topics concerning Medicaid managed care related specifically to health care providers[57], operational standards[58], enrollee rights[59], continuity of care[60], complaints and grievances initiated by health care providers[61], external grievance processes[62], appeals processes for grievances[63], and health care provider contracts[64], to name a few.

State regulations regarding the establishment and operation of SCAs are found under section 254.2 of Title 4 of the Pennsylvania Code. Specifically, section 254.2 expressly provides authority to the county commissioner to establish an SCA for "…the planning and evaluation of community drug and alcohol prevention, intervention, and treatment services."[65] Counties are provided the opportunity, under this provision, to work in concert with other counties to deliver said services. The SCA is a delegate agency of the county.[66]

[55] *Ibid.* § 3; 71 P.S. § 1690.103(e).
[56] 28 Pa. Code § 9.675(a).
[57] 28 Pa. Code § 9.681.
[58] 28 Pa. Code § 9.751.
[59] 28 Pa. Code § 9.676.
[60] 28 Pa. Code § 9.684.
[61] 28 Pa. Code § 9.706.
[62] 28 Pa. Code § 9.707.
[63] 28 Pa. Code § 9.704.
[64] 28 Pa. Code § 9.722.
[65] 4 Pa. Code § 254.2(a).
[66] *Ibid*.

The regulations further prescribe that an SCA is established when the county commissioners have informed the Council of their desire to enter the statewide prevention, intervention, and treatment program and have agreed to abide by the Council's regulations. The county commissioners must also appoint a citizens group consisting of 11 to 15 members to plan and evaluate those services. The commissioners must also designate a person to implement the plan prepared by the citizens group. The county commissioners serve as the final fiscal and management authority for the SCA programs under the regulations.[67]

State Agreements and Manuals

The operating agreements between DHS and managed care organizations, as well as the agreements held between DDAP and SCAs, also serve as a key authority of governance with the DHS and DDAP service funding. Both DHS and DDAP also publish operation manuals regarding the functional relationships between managed care organizations and providers. Specifically, these manuals include the current *HealthChoices Behavioral Health Program: Program Standards and Requirements* published by DHS, and the current *Operations Manual* published by DDAP, along with the XYZ Rate Setting Package. These resources are typically incorporated into the agreements held with managed care organizations and SCAs. All of these resources will be discussed in greater detail later in this report.

Funding Systems Overview

Behavioral HealthChoices Funding System

In Pennsylvania, individuals eligible for Medicaid may receive health benefits through the state's HealthChoices Managed Care program (akin to a health maintenance organization or HMO).[68] Identified in the literature as a "carve-out" program, the HealthChoices managed care program has two primary components: physical health and behavioral health.

A carve-out program is a Medicaid managed care financing model where a portion of Medicaid benefits are separately managed and/or financed. These Medicaid benefits include behavioral health services, dental services, and other health care services.[69] Within states utilizing Medicaid managed care organizations (MCOs), behavioral health care is typically "carved out" to a separate behavioral health managed care organization (BH-MCO in Pennsylvania).[70] In

[67] 4 Pa. Code § 254.2(b)-(c).
[68] Joint State Government Commission, *Behavioral Health Care System Capacity in Pennsylvania and Its Impact on Hospital Emergency Departments and Patient Health: Report of the Advisory Committee on Emergency Department Treatment and Behavioral Health*, (July 2020), p. 50.
[69] Which State Medicaid Plans Carve-Out Behavioral Health Benefits?" *Open Minds Market Intelligence Report*, (July 2016), p. 2.
[70] Christina J. Charlesworth, MPH; Jane M. Zhu, MD, MPP, MSHP; and Marcela Horvitz Lennon, *et al.*, "Use of Behavioral Health Care in Medicaid Managed Care Carve-Out Versus Carve-In Arrangements," *Health Services Research*, (Oct. 2021), 56(5): 805-816, doi:10.1111/1475-6773.13703.

behavioral health, benefits are often further divided into more specific categories of services, including mental health outpatient services, psychiatric inpatient services, addiction treatment services, and other categories.[71]

Carve-out programs have been criticized due to concerns they can lead to less coordinated care, as the individual does not receive all their physical and mental health and substance abuse disorder care from the same entity. Moreover, it is believed that these programs can lead to fragmentation, lack of coordination, missed symptoms, and overall increased costs to the state and federal government.[72]

Pennsylvania's carve-out program was introduced after an unsuccessful attempt at establishing a carve-in program in the 1980s.[73] As of 2019, Pennsylvania was listed as one of nine states with a behavioral health Medicaid carve-out model of funding.[74]

Pennsylvania's carve-out model, HealthChoices, has been recognized as having superior integration, quality of care, and cost savings relative to other states' models. These and other benefits of the HealthChoices carve-out model contributed to Mental Health America ranking Pennsylvania number one overall nationally based on lower prevalence of mental illness and higher rates of access to mental health care and addressing the mental health needs of the population. Regarding the ability to meet the mental health needs of the population, Pennsylvania was ninth in the adult ranking and second in the youth ranking.[75]

The Department of Humans Services administers Pennsylvania's HealthChoices program, which distributes federal Medicaid grants to primary contractors who then administer and coordinate physical and behavioral health care services. Physical health care services include hospital and physician services, while behavioral health care services include mental health services and drug and alcohol abuse services. Through its Office of Medical Assistance Programs (OMAP), DHS essentially purchases the health care services for more than 2.3 million Pennsylvania residents. DHS enrolls Medical Assistance providers who administer the care. In the behavioral health system, DHS also negotiates capitation rates with primary contractors, which are fixed amounts paid to a primary contractor for each member in their region which cover all services the member utilizes.[76]

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[71] *Supra*, n. 69.

[72] Joint State Government Commission, *Behavioral Health Care System Capacity in Pennsylvania and its Impact on Hospital Emergency Departments and Patient Health: Report of the Advisory Committee on Emergency Department Treatment and Behavioral Health*, (July 2020), p. 51.

[73] Carve-in programs are where the financing for behavioral health services are combined with a larger pool of Medicaid-covered services. Marcela Horvitz-Lennon, Jonathan S. Levin, *et al.*, "Carve-In Models for Specialty Behavioral Health Services in Medicaid: Lessons for the State of California," *Rand Corporation*, https://www.rand.org/pubs/research_reports/RRA1517-1.html, last accessed on May 24, 2023.

[74] *Supra*, n. 72.

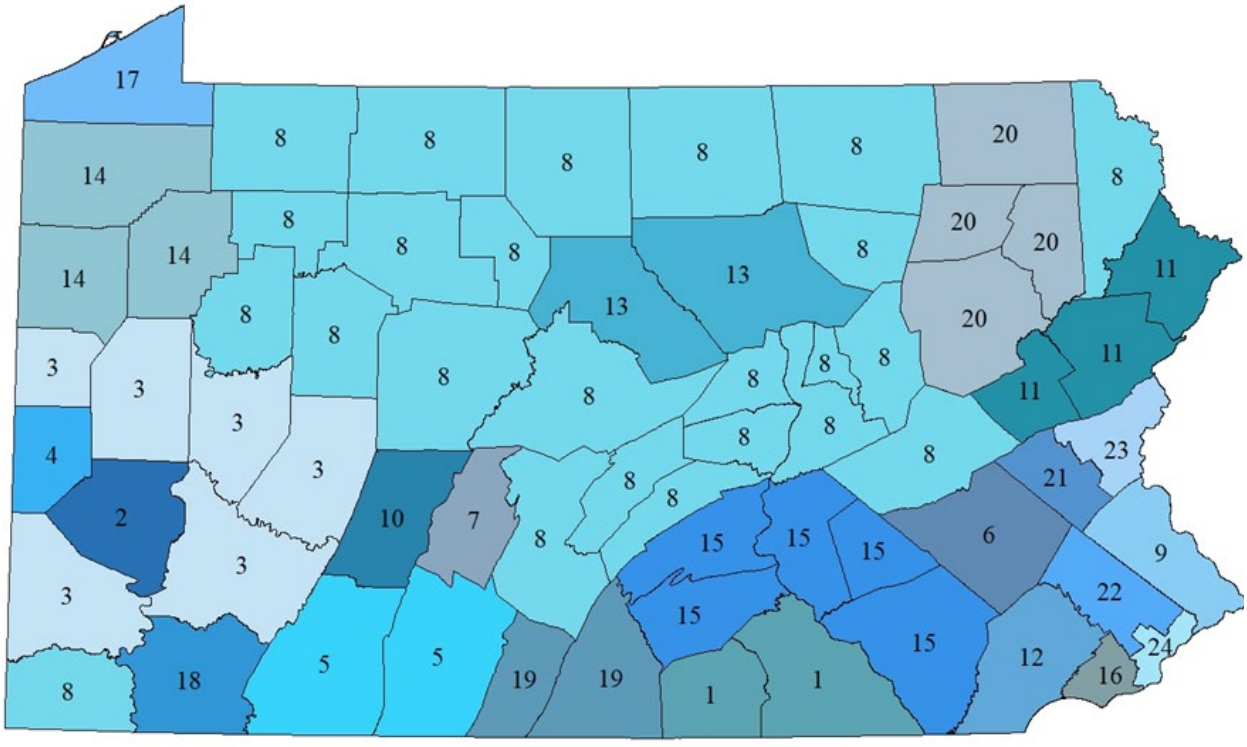
[75] *Ibid*.

[76] *HealthChoices Behavioral Health Program: Program Standards and Requirements: Primary Contractor* (Pennsylvania Department of Human Services).

For Medicaid-covered behavioral health services, DHS contracts with primary contractors, typically multi- or single county entities and sometimes directly with a BH-MCO. Primary contractors hold ultimate responsibility for the managed care contracts with DHS but can choose to share the risk and administrative functions in a variety of ways which will be discussed in further detail in the report. DHS holds 24 contracts with primary contractors in the Behavioral HealthChoices system, some contracts representing an agreement with a single county and some representing an agreement with a multi-county entity covering large swaths of the state.[77] See MAP #1 below.

Map 1

Map of Primary Contractor Agreements in Pennsylvania



Source: HealthChoices Behavioral Health Overview, provided by DHS.

[77] Information shared by Kimberly Butsch, DHS Director, Division of Medicaid Finance, February 16, 2023.

Table 1

Reference Key for Map of Primary Contractor Agreements in Pennsylvania

Number	Oversight
1	Primary Contractor: York/Adams HealthChoices Joinder Governing Board
2	Allegheny HealthChoices, Inc. (AHCI)
3	Primary Contractor: Southwest Behavioral Health Management, Inc. (SWBH)
4	Beaver County Behavioral Health
5	Primary Contractor: Behavioral Health Services of Somerset & Bedford Counties (BHSSBC)
6	Berks County MH/DD Program
7	Primary Contractor: Blair HealthChoices
8	Primary Contractor: Behavioral Health Alliance of Rural Pa BHARP
9	Bucks County Behavioral Health
10	Behavioral Health of Cambria County (BHoCC)
11	Primary Contractor: Carbon/Monroe/Pike Joinder Board
12	Chester County Department of Human Services
13	Lycoming/Clinton Joinder Board
14	Northwest Behavioral Health Partnership, Inc. (NWBHP)
15	Capital Area Behavioral Health Collaborative (CABHC)
16	Delaware County – "DelCare Program"
17	Erie County
18	Fayette County Behavioral Health Administration (FCBHA)
19	Tuscarora Managed Care Alliance
20	Primary Contractor: Northeast Behavioral Health Care Consortium (NBHCC)
21	Lehigh County HealthChoices Program
22	Montgomery County Behavioral Health
23	Northampton County HealthChoices Program
24	City of Philadelphia

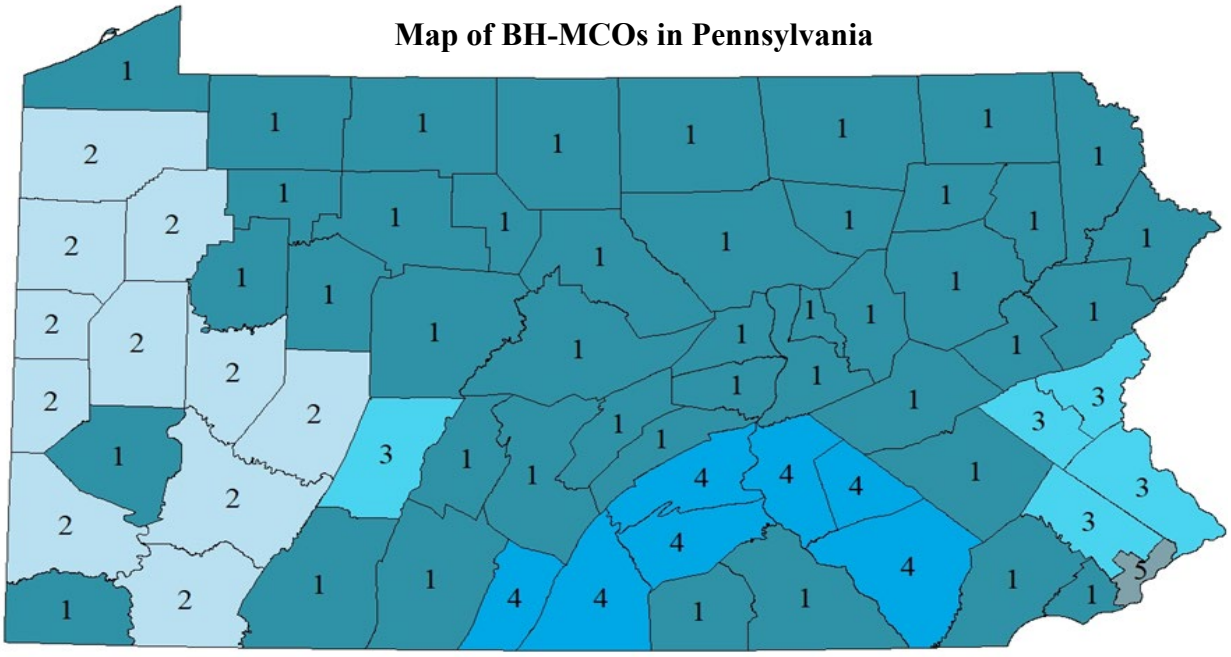
Source: HealthChoices Behavioral Health Overview, provided by DHS.

Each primary contractor contracts with one of five BH-MCOs authorized to provide managed care coverage in Pennsylvania. This means that most BH-MCOs will enter agreements with several primary contractors, leading to variation in the administrative functions performed by the same BH-MCO in different contracts. Consumers are assigned a BH-MCO based on their county of residence.[78] Consumers then can choose a behavioral health care provider within their BH-MCO's network to seek treatment or care from. See MAP #2 below.

As mentioned previously, the sharing of risk and administrative functions between BH-MCOs and primary contractors can vary. BH-MCOs are entities that can enter risk-based or administrative services only (ASO) agreements with primary contractors. Just as the name indicates, an ASO contract requires a BH-MCO to only provide administrative services such as management of claims and benefits, data collection and analytics, care coordination, provider delivery reform support, and customer service. If BH-MCOs operate under an ASO arrangement, primary contractors will own the financial risk within their managed care coordination arrangement with providers, instead of the BH-MCOs. The risk being that if costs (administrative, medical, etc.) exceed the amount of Medicaid funds allocated to the primary contractor, the primary contractor is responsible for those costs from its own coffers. Alternatively, if a BH-MCO holds a risk-based agreement with a primary contractor, the BH-MCO maintains this risk and must account for excess costs beyond the allocated funds.[79]

Map 2

Map of BH-MCOs in Pennsylvania



Source: "Behavioral HealthChoices Managed Care Organizations (BH-MCOs)," DHS, accessed May 10, 2023, https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/BehavioralHealth-MCOs.aspx.

[78] *HealthChoices Behavioral Health Program: Program Standards and Requirements: Primary Contractor* (Pennsylvania Department of Human Services).
[79] Meeting with Beacon Health Options, March 17, 2023.

Table 2

Reference Key for Map of BH-MCOs in Pennsylvania

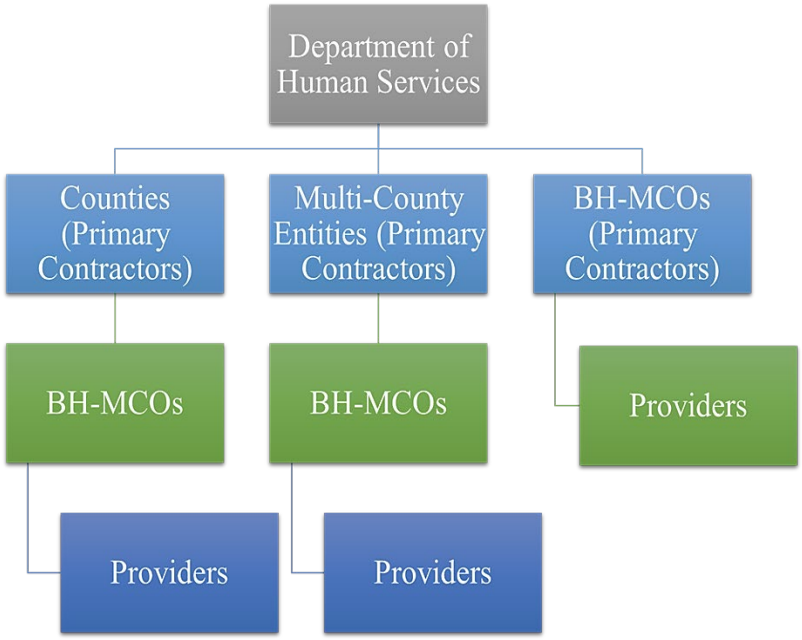
Number	Behavioral Health Managed Care Organization
1	Community Care Behavioral Health Organization (CCBHO)
2	Beacon Health Options (BHO)
3	Magellan Behavioral Health of Pennsylvania, Inc. (MBH)
4	PerformCare
5	Community Behavioral Health (CBH)

Source: "Behavioral HealthChoices Managed Care Organizations (BH-MCOs)," DHS, accessed May 10, 2023, https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/BehavioralHealth-MCOs.aspx.

BH-MCOs and primary contractors share the responsibility of setting reimbursement rates for individual services with individual drug and alcohol treatment providers; however the BH-MCOs make these payments to providers and typically have a provider liaison to communicate about these service rates. The funding model of HealthChoices is visually represented in Chart 1.

Chart 1

Behavioral HealthChoices Funding Flowchart



Source: Developed by Commission Staff.

Behavioral HealthChoices Administration

Primary Contractors

After Pennsylvania receives its federal Medicaid funds, it must distribute those funds to provide for physical and behavioral health care through its HealthChoices managed care program. For the behavioral health component of the HealthChoices program, DHS enters into an agreement with primary contractors, defined as "the county, multi-county entity, or BH-MCO to manage the purchase and provision of Behavioral Health Services."[80] BH-MCOs do not directly provide behavioral health care services to consumers. Instead, they are companies that contract with and coordinate care with the actual health care provider who treats the consumer. BH-MCOs own the contract for the services and make certain administrative and contractual decisions for the facilities providing services. The agreement between the primary contractor and DHS is "a full-risk prepaid capitated contract using a flat fee per Member in the counties."[81] Because this is a full-risk contract, the state does not cover additional costs incurred by the primary contractors.

For each county or multi-county entity, DHS will work with Mercer, the state's contracted actuary, and negotiate with the county or multi-county entity to determine an actuarily sound flat per-member fee for each rate cell. A rate cell represents a member population sharing certain defining characteristics. For the Behavioral HealthChoices program, the rate cells are:

- Temporary Aid to Needy Families (TANF)/MAGI – Child
- Temporary Aid to Needy Families (TANF)/MAGI – Adult
- SSI & Healthy Horizons w/ Medicare
- SSI & Healthy Horizons w/o Medicare – Child
- SSI & Healthy Horizons w/o Medicare – Adult
- HealthChoices Expansion – Newly Eligible (HCE – NE)[82]

If DHS contracts with a multi-county entity rather than each individual county and the entity submits one proposal, one entity must be named as the primary contractor. Each county represented within the entity must execute a contract with DHS. A capitation rate will be developed for each rate cell that applies in all counties under the multi-county entity. Counties participating in a multi-county entity do not need to be contiguous or in the same HealthChoices Zone. However, DHS requires HealthChoices behavioral health contractors to cover at least 10,000 members, therefore a single county or multi-county entity with less than 10,000 members must contract with a BH-MCO that covers at least 10,000 members.[83]

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[80] *HealthChoices Behavioral Health Program: Program Standards and Requirements: Primary Contractor* (Pennsylvania Department of Human Services), xiii.
[81] *Ibid.,* 1.
[82] Email Correspondence with Kimberly Butsch, DHS Director, Division of Medicaid Finance, April 21, 2023.
[83] *Program Standards and Requirements: Primary Contractor*, 2.

DHS makes monthly capitation payments for each member enrolled in a BH-MCO. This payment must be made by the 15th day of the month. The payment covers all services provided to the member within the previous month.[84]

These payments come through the Automated Clearing House (ACH) Network. The primary contractor must utilize a user profile in the PA Supplier Portal, Pennsylvania's procurement system, and have member information submitted to the user profile. Maintaining the accuracy of this information is the responsibility of the primary contractor.[85] DHS releases historical cost data by rate cell and category of service.[86]

Counties or multi-county entities that are primary contractors must establish an administrative structure for management of the program. This structure "must include clearly defined and assigned responsibility for monitoring the BH-MCO's fiscal, program/quality management and management information systems. The Primary contractor oversees and is accountable for any functions and responsibilities it delegates to the BH-MCO or any Subcontractor."[87]

The primary contractor and BH-MCO can split responsibility for roles as they choose, as long as they have between them:

- a CEO with authority over the BH-MCO,
- a medical director with at least five years of combined experience in mental health and substance use services,
- a CFO for the managing of finance and budget,
- a full-time director of quality management,
- utilization management,
- management information systems,
- prior authorization for assessment and substantiation of need for psychiatric and behavioral services provided by a mental health professional, and
- drug and alcohol treatment services provided by a drug and alcohol addictions professional.[88]

[84] *Ibid.,* 70.
[85] *Ibid.,* 72.
[86] *Ibid.,* 3.
[87] *Ibid.,* 40.
[88] *Ibid.,* 42.

The primary contractor or BH-MCO must also provide members services to cover the complaint and grievance process and provider services to facilitate communication between providers and BH-MCOs.[89]

Primary contractors and their BH-MCOs must demonstrate certain features that the provider network has, including the providers' ability to deliver quality services promptly. Providers are also expected to represent cultural and ethnic diversity of the member population and provide culturally affirmative care to LGBTQIA members. BH-MCOs must demonstrate evidence of a cooperative relationship between it and providers, indicated by providers being involved in the development of clinical protocols and provider profiling. Primary contractors and BH-MCOs must know the number of network providers not accepting new members, the anticipated MA enrollment, and the expected utilization of services. They should also know the number and types of providers required based on the training and experience and special services offered to fulfill their services to members.[90]

Primary contractors or BH-MCOs must enter agreements with providers that include the following:

a. Maintenance of clinical records which conform to program specific regulations and release of clinical records in conformance with applicable federal and state confidentiality laws and regulations.

b. Criteria for Provider's clinical privileges, as applicable.

c. Clinical performance standards and data reporting requirements.

d. Financial performance standards and data reporting requirements.

e. Complaint procedures for Providers.

f. Requirements for referral, coordination of treatment planning, and consultation (including participation during Interagency Team meetings) in the diagnosis and treatment of psychiatric, substance abuse and behavioral disorders.

g. Requirements for coordination and continuity of care of Behavioral Health Services with social services; e.g., intellectual disabilities, area agencies on aging, juvenile probation, housing authorities, schools, child welfare, juvenile and county and state criminal justice.

h. Requirements for coordination, credentialing, and continuity of care with PHSS and PCPs or prior approved specialist (in accordance with the Department of Health Technical Advisory #95-1 or most current reference).

i. Procedures for approving demonstration projects for State Plan Service and treatment alternatives/innovations.

[89] *Ibid.,*42.
[90] *Ibid.,* 47.

j. Compliance with The Child Protective Services Law, 23 Pa.C.S. § 6301-6385.[91]

k. Compliance with The Older Adults Protective Services Law, 35 P.S. § 10225.101 et. seq.[92]

l. Authorization of State Plan Services in accordance with DHS approved Medical Necessity criteria and Prior Authorization procedures.

m. Assurance that Providers delivering State Plan Services to Members *via* a subcontractual arrangement with a Network Provider, meet the same requirements and standards as a Network Provider.

n. Procedure to provide access to client records for quality of care and access reviews.

o. Prohibition against the use of prone restraints by Child Residential and Day Treatment Providers (both in and out of network).

p. Provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities.[93]

The program standards and requirements call for the primary contractor or BH-MCO to report their rate setting process to the department:

> The Primary Contractor (PC)/BH-MCO shall develop a policy and procedure for considering Provider rate setting for review and approval by OMHSAS. The policy shall include the opportunity of Providers to request a rate increase, summarize information the Provider must submit to justify a rate increase, describe the finance strategies the PC/BH-MCO may use in rate setting such as performance incentives, preferred Provider network, or other strategies.[94]

Primary contractors or BH-MCOs must also have a system to assess provider satisfaction with network management. The areas that must be assessed are "claims processing, Provider relations, credentialing, Prior Authorization, Service Management and Quality Management."[95] There is no requirement for them to assess provider satisfaction with rates.

[91] The Child Protective Services Law of 1990, Act of December 19, 1990 (P.L.1240, No. 206), § 2; 23 Pa.C.S. § 6301 *et seq*.
[92] The Older Adults Protective Services Law of 1987, Act of November 6, 1987 (P.L.381, No. 79), § 2; 35 P.S. § 10225.101 *et. seq.*
[93] *Program Standards and Requirements: Primary Contractor,* 48-49.
[94] *Ibid.,* 49.
[95] *Ibid.,* 59.

DHS will monitor the financial performance of the primary contractor, BH-MCO, and major subcontractors. This monitoring must keep track of "financial viability, profit, and appropriateness of medical and administrative expenses."[96]

Reinvestment Funds. Primary contractors can obtain reinvestment funds subject to certain limitations. Reinvestment funds are defined by the program standards and requirements as:

> Capitation revenues from DHS and investment income… not expended during an Agreement period by the Primary Contractor for purchase of services for Members, administrative costs, Risk and Contingency Funds, and equity requirements but may be used in a subsequent Agreement period to purchase start-up costs for State Plan Services, development or purchase of in lieu of and in addition to services or non-medical services, contingent upon DHS prior approval….[97]

Counties or multi-county entities that are primary contractors are not allowed to retain any discretionary funds from DHS. All funds not included in subcontracts or DHS-approved reinvestment plans must be returned to DHS. BH-MCOs are allowed to retain profit as agreed upon in their contract with a primary contractor, or DHS if the BH-MCO is acting as the primary contractor. DHS will monitor the profit collected and factor this information into future payments to primary contractors.[98]

Reinvestment funds held by primary contractors must be kept in a restricted account separate from other HealthChoices funding. The expenditure plan must be approved by DHS and the expenditures will be tracked by DHS. DHS can approve the carryover of funds from one agreement to the next, but the expenditure plans for the agreements will be tracked separately. Reinvestment funds can be maintained for no more than six months past the time specified in the expenditure plan unless an exception is made by DHS. If no exception is made, unspent funds must be returned to DHS.[99] If an agreement with a primary contractor ends, all funds except for those in reinvestment funds approved by DHS must be returned.[100]

Risk and Contingency Funds. Because of the risk assumed by primary contractors in their capitation contracts, they must retain risk and contingency funds. Risk and contingency funds are defined as:

[96] *Ibid.,* 69.
[97] *Ibid.,* xiv.
[98] *Ibid.,* 18.
[99] *Ibid.,* 41.
[100] *Ibid.,* 78.

> Capitation payments received by the Primary Contractor pursuant to the Agreement, which are not expended on services (State Plan, in lieu of and in addition to services) or administrative functions and which are in excess of the Equity Reserve required to be maintained under the Agreement. Risk and Contingency Funds do not include Reinvestment Funds, or funds designated in a reinvestment plan submitted to DHS.[101]

Essentially a risk and contingency fund is a reserve of funds allocated to mitigate the risks of unanticipated cost increases and possible insolvency. To retain risk and contingency funds, a primary contractor must submit a written request to DHS designating the funds as risk and contingency funds and explaining why they are set aside for this rather than placed in a reinvestment fund. Once this amount is approved by the department, it must be placed in a risk and contingency account within 30 days. If the DHS capitation payment is delayed, the risk and contingency funds may be used by the primary contractor without DHS approval to cover payments to BH-MCOs if the amount of the funds are returned to the account within 60 days. With prior written approval, the primary contractor may use these funds to provide state plan services and administrative functions if the fluctuations in enrollment revenue and utilization cause the costs to be higher than the monthly capitation payment. The funds can also be used to meet the primary contractor's insolvency plan or the reinvestment plan. These funds should not exceed the equivalent of 45 days of paid claims, unless the funds are being used for the insolvency arrangement, in which case varying caps for the days of paid claims exist. Risk and contingency funds must be kept in a separate account, statements from which are reported to DHS monthly, and must be reported on a separate line of the financial report.[102]

Primary contractors must submit insolvency plans 60 days before an agreement starts. This plan must include a secondary liable party that will pay providers through the last day for which DHS paid a capitation payment to the primary contractor in the event of bankruptcy or insolvency. At a minimum, this must be two months of paid claims or two months of expected capitation revenue. This insolvency plan can be made with either:

> Insolvency insurance, an irrevocable, unconditional and automatically renewable letter of credit for the benefit of DHS, or the county or Multi-County Entity…determined on a case-by-case basis…in place for the entire term of the Agreement; a guarantee from an entity, acceptable to the Department, with sufficient financial strength and credit worthiness to assume the payment obligations of the Primary Contractor in the event of a default in payment resulting from bankruptcy or insolvency; or other arrangements, satisfactory to the Department….[103]

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[101] *Ibid.,* xv.
[102] *Ibid.,* 75-77.
[103] *Ibid.,* 63-64.

The plan must only be used in the event of bankruptcy or insolvency and must be submitted and approved by DHS annually before the agreement is signed. If the insolvency requirement is being met by a risk and contingency plan, the insolvency requirement can be waived by DHS.[104]

Providers

BH-MCOs contract with providers and can make recommendations on the reimbursement rates offered to providers for each service or activity, though the primary contractor has final approval of the rates for services. Primary contractors or BH-MCOs can handle payment of Medicaid funds to reimburse the providers for care provided to the consumers, appeals of rate increase request denials, credentialling of providers, provider quality of care, grievances of the provider and consumer, and other administrative aspects of the overall delivery of care.

Though DHS provides flexibility for primary contractors and BH-MCOs to negotiate rates with providers, there are some requirements that must be complied with. The primary contractor and BH-MCOs must agree to pay rates to Indian Health Care Providers (IHCPs), Federally Qualified Health Clinics (FQHCs), and Rural Health Clinics (RHCs) that are comparable to other providers in the primary contractor and BH-MCOs networks. Annual cost settlements and prospective payments are not allowed. Primary contractors and BH-MCOs must pay IHCPs a rate that is not less than what a non IHCP provider would receive. Members must receive access to FQHCs and RHCs in the provider network. The rates must not be less than the Fee-for-Service Prospective Payment System (PPS) rates. Any FQHCs and RHCs that accept PPS payments as payments in full are included in the primary contractor and BH-MCOs network. If the FQHCs and RHCs do not accept the PPS rate, primary contractors and BH-MCOs are not required to adhere to this rate. The rate would then be negotiated at a comparable rate to other comparable providers within the provider network. The primary contractor and BH-MCO are not required to pay providers for services unless the bill is received within 180 days of service.[105]

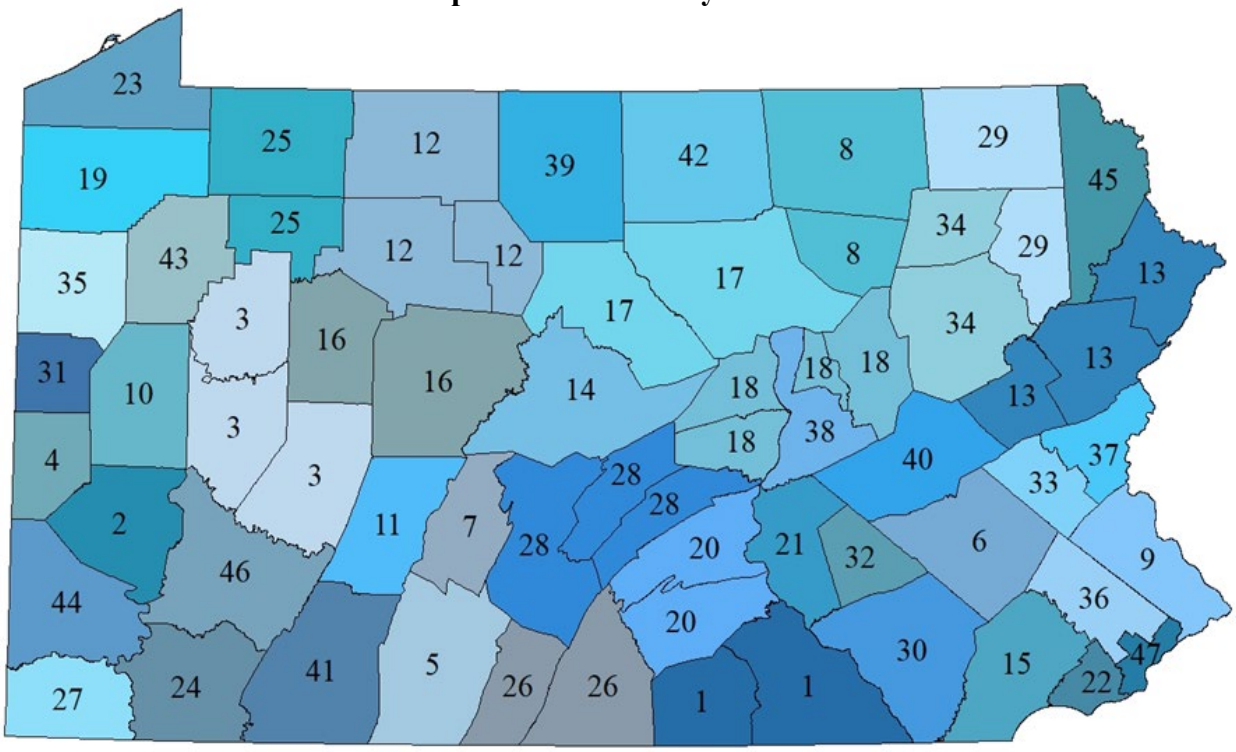
[104] *Ibid.,* 64.
[105] *Ibid.,* 73-74.

Funding for the Uninsured and Underinsured

To cover individuals who are uninsured or underinsured and behavioral health services not covered by Medicaid, DDAP contracts with 47 SCAs throughout the Commonwealth; some counties are in joinders to share administrative costs. See MAP #3 below, showing all 47 SCAs throughout Pennsylvania.

Map 3

Map of SCAs in Pennsylvania



Source: List of SCAs provided by Department of Drug and Alcohol Programs.

Table 3

Reference Key for Map of SCAs in Pennsylvania

Number	Single County Authority
1	York Adams Drug and Alcohol Commission
2	Allegheny County Department of Human Services /Office of Behavioral Health/ Bureau of Drug and Alcohol Services
3	Armstrong-Indiana-Clarion Drug and Alcohol Commission, Inc.
4	Beaver County Behavioral Health Drug and Alcohol Program
5	Personal Solutions Inc (Bedford)
6	Berks County Council on Chemical Abuse
7	Blair County Drug and Alcohol Program, Inc
8	Bradford/Sullivan Drug and Alcohol Programs
9	Bucks County Drug & Alcohol Commission, Inc.
10	Butler County MH/MR Drug and Alcohol
11	Cambria County Drug and Alcohol Program
12	Cameron Elk McKean Counties Alcohol and Drug Abuse Services Inc
13	Carbon Monroe Pike Drug and Alcohol Commission
14	Centre County Mental Health/Intellectual Disabilities/Early Intervention and Drug and Alcohol
15	Chester County Department of D&A Services
16	Clearfield Jefferson Drug and Alcohol Commission
17	Lycoming Clinton West Branch Drug and Alcohol Abuse Commission
18	Columbia Montour Snyder Union Drug and Alcohol Program
19	Crawford County D&A Executive Commission, Inc.
20	Cumberland Perry Drug and Alcohol Commission
21	Dauphin County Department of Drug and Alcohol Services
22	Delaware County Office of Behavioral Health
23	Erie County Office of Drug and Alcohol Abuse
24	Fayette County Drug and Alcohol Commission Inc
25	Forest -Warren Human Services D&A Program
26	Franklin Fulton County Drug and Alcohol Program
27	Greene County Human Services Program
28	Juniata Valley Tri-County Drug and Alcohol Abuse Commission
29	Lackawanna/Susquehanna Office of Drug and Alcohol Programs
30	Lancaster County Drug and Alcohol Commission
31	Lawrence County Drug and Alcohol Commission Inc
32	Lebanon County Commission on Drug and Alcohol Abuse
33	Lehigh County Drug & Alcohol Services

Table 3

Reference Key for Map of SCAs in Pennsylvania

Number	Single County Authority
34	Luzerne Wyoming Counties Drug and Alcohol Program
35	Mercer County Behavioral Health Commission Inc.
36	Montgomery County Department of Health & Human Services
37	Northampton County D&A Division
38	Northumberland County BH/IDS
39	Potter County Drug and Alcohol
40	Schuylkill County Drug and Alcohol
41	Somerset SCA for Drug and Alcohol
42	Tioga County Department of Human Services
43	Venango County Substance Use Disorder Program
44	Washington D&A Commission, Inc.
45	Wayne County Drug and Alcohol Commission
46	Westmoreland Drug and Alcohol Commission, Inc.
47	Office of Addiction Services

Source: List of SCAs provided by Department of Drug and Alcohol Programs.

The Pennsylvania Drug and Alcohol Abuse Control Act (PDAACA),[106] requires DDAP to develop a State Plan for the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of drug and alcohol misuse and dependence programs. Most of DDAP's funding is federally provided. Much of the federal funds come from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), which was just under $80 million in the 2022-2023 budget. The State Opioid Response (SOR) Grant[107] provided almost $120 million in the 2022-2023 budget.[108] In addition, DDAP receives some funding appropriations from opioid settlements negotiated by the Pennsylvania Office of Attorney General, state gambling revenues and state liquor store sales, as well as the state medical marijuana fund. Each funding stream has limitations and requirements. Blending funding streams is a challenge due to the competing limitations and requirements.[109]

[106] *Supra*, n. 54.
[107] State Opioid Response Grants are federal grants offered to states to support the continuum of care of opioid use disorders and concurrent substance use disorders. "State Opioid Response Grants," *SAMHSA*, accessed May 23, 2023, https://www.samhsa.gov/grants/grant-announcements/ti-22-005.
[108] *Governor's Executive Budget: Fiscal Year 2022-2023* (DDAP, 2022), https://www.ddap.pa.gov/Documents/Budget/2022-2023%20DDAP%20BLUEBOOK.pdf, 10.
[109] Meeting with Ellen DiDomenico, DDAP Deputy Secretary, December 6, 2022.

Since 1972, Pennsylvania has engaged SCAs to plan drug and alcohol treatment in Pennsylvania. DDAP creates a state plan for the programs that SCAs fulfill on a local level. Once DDAP provides funds to the SCAs, they use the state and federal dollars to "plan, coordinate, programmatically and fiscally manage, and implement the delivery of drug and alcohol prevention, intervention and treatment services to respond to the needs at the local level."[110] SCAs cover the drug and alcohol treatment costs of uninsured or underinsured (including those with high copays or deductibles) individuals as a "payor of last resort;" the individual must have already applied for Medical Assistance (i.e. Medicaid).[111]

SCAs receive annual funding from DDAP based on historical cost data, though this can be adjusted if an SCA requests additional funding. Counties that hold DDAP contracts are required to match 10 percent of funding when the funds are expended on activities identified in the fiscal manual, but private or independent SCAs are not required to receive any county match. SCAs can also receive additional funding by agreeing to work on special improvement projects supported by DDAP. SCAs can also ask for additional funding at a mid-point during the year if they identify new areas of need or priority.[112]

The funding given to providers by SCAs is determined by the XYZ Rate Setting Package, which is named in DDAP's contracts with SCAs. This is a cost-based package that goes to any providers of residential services that wish to contract with the SCAs. The SCA for the home county of the provider is responsible for the management of the rate setting and contract.[113]

In 1988, the Pennsylvania General Assembly amended the Administrative Code of 1929regarding medical assistance payments.[114] The amendment, commonly referred to as Act 152 was intended to provide "…a continuum of alcohol and drug detoxification and rehabilitation services to persons eligible for medical assistance."[115] To accomplish this purpose, the law provides for an allocation of state funds to SCAs for inpatient nonhospital withdrawal management and rehabilitation services to recipients of Medicaid. Act 152 funding is used for residential treatment services during the gap between determining whether a client is eligible for Medical Assistance and their actual enrollment date in managed care. The determination period can vary significantly based on the county and is influenced by staffing patterns and administrative procedures utilized by each county. Prior to this amendment, recipients were limited to outpatient or hospital-based substance use disorder treatment services through their Medicaid. In other words, Medicaid funding was not available for the continuum of care for residential services in nonhospital facilities. After January 1997, Act 152 funding for the Commonwealth's five southeastern counties was rolled into their capitated Medicaid Managed Care contract with DHS.

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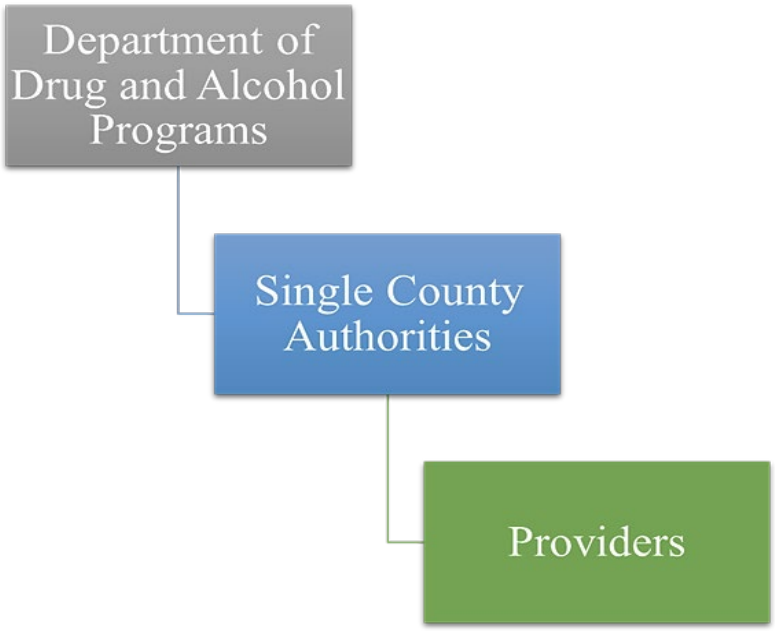
[110] Sheryl Andrews, *Single County Authority: What is an SCA?* (Washington Drug and Alcohol Commission, Inc.), https://www.whamglobal.org/list-documents/41-mat-panel-scas/file, 3.
[111] *Ibid*., 11.
[112] Email Correspondence with Ellen DiDomenico, DDAP Deputy Secretary, March 22, 2023.
[113] Meeting with Ellen DiDomenico, DDAP Deputy Secretary, December 6, 2022.
[114] The Administrative Code of 1929, Act of April 9, 1929 (P.L.177, No. 175) (Hereinafter "AC").
[115] AC, Act of April 9, 1929 (P.L.177, No. 175) *as amended by* Act of December 15, 1988 (P.L. 1239, No. 152), § 2*;* 71 P.S. § 611.14(a).

For the allocations of funds for alcohol and drug treatment, the Act 152 amendment recognized providers such as hospital and nonhospital drug detoxification and rehabilitation facilities, and hospital and nonhospital drug and alcohol detoxification and rehabilitation facilities and outpatient services licensed by the Office of Drug and Alcohol Programs, the precursor to the current DDAP.

The flow of funding through DDAP is visually represented in Chart 2.

Chart 2

Department of Drug and Alcohol Treatment Funding Flowchart



Source: Developed by Commission Staff.

THE RATE SETTING PROCESS

A key part of the managed care system is the process of setting what are known as "capitation rates." Medicaid managed care programs in states like Pennsylvania reimburse primary contractors to work with BH-MCOs to cover a defined package of benefits for a population of Medicaid enrolled individuals through fixed periodic capitation payments. Generally, capitation rates are determined prospectively on an annual basis and remain in effect for a 12-month rating period regardless of changes in health care costs or use of services.[116] In Pennsylvania, DHS sets capitation rates in consultation with its contracted actuarial firm, Mercer.[117] Capitation rates must comply with federal regulations and once established, rates must undergo a detailed federal review process at the CMS. To be effective, CMS must approve the proposed capitation rates.

Capitation payment rates have a significant impact on a managed care program. For example, the rates can influence a primary contractor's willingness to contract with a state, the solvency of a primary contractor operating within the state's system, a BH-MCO's financial means to reimburse providers for health care provision, the potential to save costs relative to FFS, enrollee access to care, and quality of care delivered to enrollees.[118]

The goal of the capitation rates is to approximate actual contract costs. Failure to do so could result in the Commonwealth overpaying primary contractors or BH-MCOs with excessive profit margin. Alternatively, a failure to adequately approximate actual contract costs could result in the underpayment of primary contractors or BH-MCOs, leaving them unable to provide services to enrollees. Adequate rates should be able to cover costs under the contract and provide a reasonable expectation of profit or surplus for a primary contractor or BH-MCO to balance the financial risk assumed under the plan. Primary contractors and BH-MCOs in turn must manage benefit and administrative spending to stay within the total capitation.[119] To ensure that adequate capitation rates are achieved, DHS actuaries perform an extensive rate setting process, which is discussed in greater detail below.

BH-MCOs then negotiate the reimbursement rates with treatment providers for individual treatment services provided to their members. DHS created a directed payment which allows them to set a minimum rate for residential services, but other services are either individually negotiated between providers and BH-MCOs, or set as a flat rate for all providers in the BH-MCOs network.

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[116] 42 C.F.R. § 438.2.
[117] Mercer is a global consulting firm that contracts with DHS to provide actuarial services for the HealthChoices Program.
[118] MACPAC, Issue Brief, (March 2022), https://www.macpac.gov/wp-content/uploads/2022/03/Managed-care-capitation-issue-brief.pdf, last accessed on April 28, 2023.
[119] *Ibid*.

SCAs develop analogous rates for their own contracts with providers. The cost-based XYZ Package involves a process that providers complete to open the conversation on a rate increase. SCAs review these requests and can approve, deny, or counter them.

DHS Capitation Rates

In consultation with its actuaries, DHS develops capitation rates for each of the rate cells covered by Behavioral HealthChoices. This rate is used by DHS to set the value of contracts with primary contractors by considering the services that are covered in the program, the population covered, and other factors. Primary contractors are paid on a per member/per month (PMPM) basis.[120]

To set the capitation rate, Pennsylvania must comply with federal regulations on rate setting and development. DHS's contracted actuarial firm, Mercer, determines their capitation rates and ensures that they are actuarially sound. Mercer's process begins with reviewing base data including eligibility data, encounter data, financial reports, and special data requests.[121] This information is provided by primary contractors in May of each year, with some primary contractors electing to provide more information than is required, like changes based on lag in data.[122] Eligibility data includes age, gender, eligibility group, and other factors. Encounter data includes member ID, date of service, provider ID, units, and more. Financial reports are made up of summarized information with revenue, profits, and loss. Mercer can also collect other pertinent information from providers.[123]

For efficiency adjustments, Mercer then performs a cross-discipline analysis, presents the state with the results for feedback, then adjusts the data based on the results and conversations with the state.[124]

Mercer then reviews policy and programmatic changes, including changes to service definitions and requirements, new demonstration programs, new populations, regulatory changes, and other changes.[125]

Mercer develops a trend expressed in a two or three year annualized average rate. The trend is based on observed experience, taken from HealthChoices encounter data and financial reports, market experience based on other states Medicaid systems with similar populations and services and commercial market experience. The trending is also based on industry reports like that of the Health Care Cost Institute, and federal reports like the National Health Expenditures from the Office of the Actuary and the Bureau of Labor Statistics Consumer Price Index data.[126]

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[120] Email Correspondence with Kimberly Butsch, DHS Director, Division of Medicaid Finance, February 28, 2023.
[121] *Ibid.*
[122] Meeting with the Behavioral Health Alliance of Rural Pennsylvania, BHARP, March 20, 2023.
[123] *Capitation Rate Setting*, (Commonwealth of Pennsylvania, Mercer Government, July 20, 2021), 5.
[124] *Ibid.*, 7.
[125] *Ibid.*, 9.
[126] *Ibid.*, 11-12.

The non-benefit portion of the capitation rate—the costs associated with administration and care management—considers administrative functions like claims processing, encounter and financial reporting, utilization management, and call centers/grievances and appeals. This portion also anticipates future expenses by reviewing historical administrative costs, Full-Time Equivalent (FTE) administrative staffing model, and including care management. In accounting for underwriting gain, Mercer considers actuarial standards of practice, required capital, and risk margin. The surplus will increase to track with the NAIC's Risk-Based Capital levels and Mercer will calculate the gain needed to fund increases in required capital.[127]

ASAM Adjustment

In 2017, DHS transferred the Commonwealth from the Pennsylvania Client Placement Criteria (PCPC) to the American Society of Addiction Medicine (ASAM) criteria as the evidence-based clinical treatment guidelines. The ASAM Criteria is the most utilized set of guidelines by treatment providers for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions. The criteria were created through a 1980s collaboration to define one uniform set of criteria nationwide for providing outcome-oriented and results-based care treatment of addiction.[128]

Mercer included an adjustment to capitation rates in CY 2022 to account for additional costs related to the realignment. To do this, Mercer reviewed historical encounter data and converted claims from PCPC labels to ASAM labels. The historical unit costs were then calculated by ASAM label. Then, the Office of Mental Health and Substance Abuse (OMHSAS), DDAP, and Mercer developed specific ASAM unit costs to project future capitation costs, taking into account Pennsylvania-specific staffing wages, staffing supervisor ratios by ASAM Levels of Care,[129] bed facility sizes, training/certifications/productivity, and provider administrative expenses. Mercer took the difference between the historical unit costs and the new ASAM unit costs and multiplied it by the number of units to calculate the adjustment added to the capitation rates.[130]

Final Rates

Based on all these factors, Mercer will develop a range of actuarily sound rates and present them to OMHSAS for consideration. OMHSAS chooses a rate, then the primary contractor or BH-MCO evaluates the rate and either accepts it or requests a formal negotiation. The rates will be issued in September to allow a few weeks for concerns to be voiced.[131] Once the rates have been decided, they will be submitted to the Centers for Medicare and Medicaid Services (CMS) for

[127] *Ibid.*, 14-15.
[128] American Society of Addiction Medicine, "About the ASAM Criteria," https://www.asam.org/asam-criteria/about-the-asam-criteria, last accessed on April 5, 2023.
[129] ASAM Levels of Care are the criteria used by treatment providers and clinicians to assess a patient's risk level, create a treatment plan, and determine the patient's care needs. The Levels of Care are used by managed care providers to categorize levels of treatment along the treatment continuum. The Levels of Care utilized in Pennsylvania will be detailed later in the report.
[130] *Capitation Rate Setting*, 23-24.
[131] Meeting with the Behavioral Health Alliance of Rural Pennsylvania, BHARP, March 20, 2023.

approval along with a certification letter of actuarial soundness from Mercer.[132] Each primary contractor will be paid the rate agreed upon for each member enrolled each month.[133]

Primary Contractor's Contracts with BH-MCOs

Subcontracts between the primary contractors and BH-MCOs will vary from contract to contract based on the amount of administrative load that the BH-MCO takes on. One BH-MCO summarized this level of the system by explaining that the contract between the primary contractor and DHS outlines in its Program Standards and Requirements certain administrative functions that must be fulfilled in order to comply with federal standards for managed care models. The primary contractor and the BH-MCO then come to an agreement on how the functions will be delegated between them, with some BH-MCOs offering administrative function and not assuming any risk (ASO) and others assuming risk. Since most BH-MCOs are involved in contracts with multiple primary contractors, one BH-MCO's split in function and in funding could be different in its different contracts.[134] However, the medical spending should be generally consistent throughout contracts because of the Medicaid Medical Loss Ratio (MLR) requirement, which allows no more than 15 percent of funds to be used for administration or profit.[135] Additionally, as an appendix to each contract, DHS holds primary contractors to a Reinvestment Sharing Arrangement which states that primary contractors cannot keep more than 3 percent of capitation for reinvestment funds; all funding over this threshold must be returned to DHS.[136] Commission staff were not able to meet individually with all 24 primary contractors in Pennsylvania but heard from each of the five BH-MCOs about the variety of administrative splits in their contracts and what factors would affect the eventual negotiated rate paid by the primary contractor.

SR 352 requested information on the portion of the BH-MCOs' capitation funding that was used to reimburse drug and alcohol addiction treatment providers for services provided. BH-MCOs offered information to respond to this request but added a few important nuances to the discussion. First, capitation funding is not allocated by type of care. The BH-MCOs use funding where utilization demands it; they are required to cover the necessary services for their enrollees. Historical data on the portion of capitation funding spent on Substance Use Disorder (SUD) services will indicate a rise in utilization over the past 20 years because of Medicaid expansion. Second, BH-MCO representatives noted that since BH-MCOs cover mental health and substance use services, and often these conditions can be cooccurring, some treatment for SUD clients may not be counted in SUD services if it could instead be categorized as a mental health service. Based on these caveats, the percentage of medical spending paid for SUD services is a helpful estimate for the portion of capitation funding spent on SUD services, but it is an imprecise representation

[132] *Capitation Rate Setting*, 18.
[133] Conversation with Kimberly Butsch, DHS Director, Division of Medicaid Finance, February 28, 2023.
[134] Meeting with Beacon, March 17, 2023.
[135] *Medical Loss Ratios in Medicaid Managed Care* (MACPAC, January 2022), https://www.macpac.gov/wp-content/uploads/2022/01/Medical-loss-ratio-issue-brief-January-2022.pdf.
[136] Pennsylvania Department of Human Services HealthChoices Behavioral Health Agreement, provided by Pennsylvania Department of Health.

of the split, and is only indicative of the portion of BH-MCO members who need SUD services each year.[137]

Administrative Splits by BH-MCO

PerformCare. PerformCare operates under an Administrative Services Only (ASO) agreement, meaning it performs administrative functions but holds no risk. PeformCare's primary contractors hold the risk and contingency funds and reinvestment funds. The administrative funding is determined by a rate of the total non-benefit load negotiated between the BH-MCO and the primary contractor. The medical funding is based on actual experience. The percentage of medical spending in their contracts that was spent on Drug and Alcohol Treatment Reimbursement in 2021 was 23.1 percent for the Capital Area Behavioral Health Collaborative and 14.2 percent for the Tuscarora Managed Care Alliance. In 2022, the percentages were 23.3 and 15.8 respectively.[138]

Beacon Health Options. Beacon Health Options is another BH-MCO that operates under an ASO model. The size of their contracts depend on the size of the contract between the different primary contractors and DHS, which is determined on a per member per month (PM/PM) basis. The services Beacon provides can vary from contract to contract, which also determines the portion of capitation funding they receive. The counties contracting with Beacon manage the funding and hold risk and contingency and reinvestment funds. Twenty-nine percent of capitation funding went to SUD services in 2019. Eighty-five to ninety percent of capitation funding goes to medical spending. Around ten percent make up the administrative spending. This has become more challenging over time because expectations for quality and success of care are increasing while capitation rates are not. Beacon leverages funds from other sources to meet demands.[139]

Community Care Behavioral Health Organization. Community Care Behavioral Health Organization (CCBHO) holds contracts with 12 primary contractors, ultimately making up for 43 of Pennsylvania's 67 counties. The contractors hold a small portion of administrative funds, but most of the funding flows through to CCBHO. The amount that makes up the contracts is dependent on the demand for services. Around half of CCBHO's primary contractors pass risk onto the subcontract and around half hold the risk at the county level. Each of CCBHO's contracts with primary contractors separates administrative or non-benefit loads and medical expenses. Though it varies by contract, the medical expense ratio is on average from 88 to 91 percent, meaning 9 to 12 percent of the capitation funding is used on administrative expenses. Overall, of CCBHO's contracts with primary contractors in 2022, SUD services including outpatient, non-hospital rehab, hospital-based drug and alcohol treatment, made up around one quarter of medical expenses. Since CCBHO received $1.5 billion in net capitation in 2022, this amounts to approximately $325 million of capitation funding going toward SUD services. Additionally, some drug and alcohol treatment services do not fall under these core service categories, therefore the actual amount of capitation funding going toward SUD services is even higher.[140]

[137] Meeting with Magellan, March 24, 2023.
[138] Email Correspondence with PerformCare, March 22, 2023.
[139] Meeting with Beacon, March 17, 2023.
[140] Meeting with Community Care Behavioral Health Organization, March 17, 2023.

Magellan Behavioral Health of Pennsylvania. Magellan holds risk-based contracts with five counties. Magellan manages care and pays claims while the county performs some administrative functions. Because Magellan shoulders more of the administrative duties, the administrative split between the BH-MCO and the county leads to an aggregate county administrative percentage of 2.3 and a 7 percent administrative percentage for Magellan. These contracts meet the MLR requirement. Another factor that affects the amount of funding Magellan receives is the total of the primary contractor's DHS contract; those with lower PM/PM payments and less population served will have lower contract amounts.[141] Magellan's percentage of medical spending used on SUD services varies by county, but for Montgomery and Bucks County it was over 20 percent. For rural smaller counties, the percentages range from 18 to 20 percent. A broad average given by Magellan representatives put the overall percentage of medical spending used on SUD services at between 18 and 26 percent.

Community Behavioral Health. Community Behavioral Health (CBH) contracts only with the City of Philadelphia. Like the other BH-MCOs, the amount of the contract depends on the functions delegated to CBH. A budget is approved annually by the board of directors, and CBH submits expenses on a weekly basis to the primary contractor. CBH uses a case rate instead of FFS, meaning that the rate is calculated by finding the average expected expenses of services per person over the course of a month. Instead of reimbursing for each service for each member, providers will be reimbursed at the same rate for members who receive more services than those who receive fewer. These members can therefore receive treatment as many times in a month as medically necessary. The goal of the case rate is to incentivize quality of care over quantity, though providers must be monitored for under-utilization since they could provide less services and still receive the same reimbursement. This kind of alternative arrangement must be approved by DHS.[142] In the most recent calendar year, 15.2 percent of CBH's capitation was paid for drug and alcohol treatment reimbursement. In 2022, 8.4 percent of the funding was used for administrative expenses. Per the statutory cap of three percent in reinvestment funds, CBH kept 2.4 percent in reinvestment and risk and contingency funds. CBH is fully funded at 75 days of claims.[143]

BH-MCO Medical Rate Setting

BH-MCOs develop rates for the services provided by each provider they contract with. Some of these rates, sometimes referred to as standard rates, will be uniform across a network for any provider offering the service, while other specialized services might be individually negotiated and differ within in the same region depending on other pertinent factors. Some rates have a minimum set by the state, while others do not, though they may use state FFS rates as a starting point or factor in their own rate determination.

[141] Meeting with Magellan, March 24, 2023.
[142] Meeting with Community Behavioral Health, March 14, 2023.
[143] *Ibid.*

Outpatient and Methadone Maintenance Rates

For drug and alcohol outpatient services and methadone maintenance services, OMAP established rates that were used by Medical Assistance Fee-for-Service clients in the past, and they have not been adjusted often. BH-MCOs are not required to use these rates as minimums, but they are often named in rate setting policies as a starting point for negotiations.[144] For these rates, they are typically standardized across the network, and individual negotiation on them is rare. Because the MA FFS rates have not been adjusted often, many BH-MCOs pay well above the MA FFS rates.[145] OMAP originally established these rates; however, today, these rates would be adjusted by OMHSAS.[146] Providers that perform exclusively or mostly outpatient services reported more difficulty in receiving reasonable rates, as these rates are not typically individually negotiated and there is not a state established minimum for these rates.[147]

State Directed Payments

Because BH-MCOs are assuming the risk of spending more than their capitation funding for the year, Pennsylvania typically does not statutorily dictate provider reimbursement rates for each service. However, states are permitted to establish state directed payments with approval from CMS. These payments do establish a minimum fee schedule that BH-MCOs must adhere to. Pennsylvania's directed payment establishes a minimum fee schedule for services at or above the 2.0 ASAM Level of Care. The ASAM Levels of Care covered are:

- 2.0 Withdrawal Management (WM) (outpatient services),
- 2.1 (intensive outpatient services),
- 2.5 (partial hospitalization),
- 3.1 (clinically managed, low intensity residential services),
- 3.5 (clinically managed, high intensity residential services),
- 3.7 (medically monitored intensive inpatient), and
- 3.7WM (medically monitored intensive inpatient).[148]

For Pennsylvania's managed care contract rating period of January 1, 2022 through December 31, 2022, Pennsylvania paid an estimated $565,000,000 in federal and non-federal dollars in state directed payments. The federal share of this total was $444,000,000 and the non-federal share made up the remaining $121,000,000.[149] The total medical spending in the HealthChoices program for the previous year for drug and alcohol services was $740,000,000.[150]

[144] Email correspondence with Kimberly Butsch, DHS Director, Division of Medicaid Finance, April 21, 2023.
[145] Email correspondence with Dave MacAdoo, CEO Southwest Behavioral Health Management, Inc., February 1, 2023.
[146] Conversation with Kimberly Butsch, DHS Director, Division of Medicaid Finance, March 21, 2023.
[147] PA Counseling Meeting, February 22, 2023.
[148] CMS Approval Letter for Pennsylvania's Proposal for Delivery System and Provider Payment Initiatives, January 10, 2022, 2.
[149] *Ibid.,* 1.
[150] Email with Kimberly Butsch, DHS Director, Division of Medicaid Finance, January 17, 2023.

This number is larger than the state directed payment because not all drug and alcohol services are covered by the state directed payment.

For CY 2022, "ASAM rates were developed using Mercer's proprietary ASAM rate model with median statewide Pennsylvania [Bureau of Labor Statistics] BLS wages. The model also considered employee related expenses, staffing ratios, training, certifications, productivity, administrative expenses…. ASAM rates were also compared to historical BH-MCO paid rates and single county authority rates. Based on these comparisons and the methodology utilized, these rates are reasonable and appropriate."[151] The resulting minimum rates were as follows:[152]

Table 4

State Directed Payment Rates 2022

Service	Rate Type	Fee
2.0 WM	Per Hour	$99.99
2.1	Per 15 mins.	10.87
2.5	Per 15 mins.	10.10
3.1	Per diem	150.54
3.5	Per diem	245.04
3.7	Per diem	302.51
3.7 WM	Per diem	390.38

Source: CMS Approval of PA_Fee_BHI.BHO_New_20220101-20221231, provided by PA DHS.

The established directed payments mean that no BH-MCO can enter a contract for these levels of care at a lower rate than the ASAM rate, but BH-MCOs could negotiate a higher rate if they chose to.

[151] CMS Approval Letter for Pennsylvania's Proposal for Delivery System and Provider Payment Initiatives, January 10, 2022, 7.
[152] *Ibid.*, 11.

Rate Negotiation Policies

One responsibility of the primary contractor or BH-MCO, depending on the type of agreement between them, is to develop a policy for rate negotiation with providers and submit it for approval to OMHSAS.[153] The policy must include "the opportunity of Providers to request a rate increase, summarize information the Provider must submit to justify a rate increase, describe the finance strategies the PC/BH-MCO may use in rate setting such as performance incentives, preferred Provider network, or other strategies."[154]

These requirements in the Behavioral HealthChoices Program Standards and Requirements leave substantial room for variability in each BH-MCO's policy. BH-MCOs are permitted to exert significant discretion in crafting their individual policies. Some BH-MCOs only allow requests for increases once a year, some allow them to be submitted at any point throughout the year, and some allow requests to be submitted at any time, but typically only review rates at certain points throughout the year for multiple providers.

Rate Negotiations by BH-MCO

PerformCare. PerformCare holds contracts with the Capital Area Behavioral Health Collaborative, which is a primary contractor that includes Dauphin, Cumberland, Perry, Lancaster, and Lebanon counties, and the Tuscarora Managed Care Alliance, the primary contractor for Franklin and Fulton counties. Ambulatory service rates like outpatient and partial hospitalization are determined by a HealthChoices county-specific fee schedule. Primary contractors and PerformCare meet monthly to reevaluate network priorities and may offer a special rate for a program providing specialized services. For inpatient and residential services, rates are negotiated with providers and rate increase requests are to be addressed fairly and consistently.[155]

For the county fee schedules, PerformCare will regularly review the fee schedule and increase rates in areas where there is a specific need or specific plans for improvement of service. Programs that can prove a need beyond the fee schedule may be granted a unique rate. These providers would need to submit financial documentation demonstrating the additional need.[156]

For negotiated rates for new providers, PerformCare will pay MA FFS rates or XYZ rates and providers cannot request a rate adjustment within the first year. For Substance Abuse Supplemental Service, PerformCare uses the rates agreed upon with the SCA in the home county of the provider. If a new provider asks for a higher rate than the MA FFS Service rate, PerformCare will consider utilization and cost impact, a budget narrative submitted by the provider, the range

[153] *HealthChoices Behavioral Health Program: Program Standards and Requirements: Primary Contractor* (Pennsylvania Department of Human Services), 49.
[154] *Ibid.,* 49.
[155] PerformCare Policy and Procedure.
[156] *Ibid.*

of current rates of contracted providers for similar services, specific reasons the provider does not feel the rate is adequate, and other special mitigating factors.[157]

Existing providers looking for a rate increase are subject to a performance review by the PerformCare's Clinical Department and Quality Department. The staff will "analyze and rate provider performance based on review of quality of care concerns and administrative compliance."[158] Facilities are evaluated with a Quality and Clinical Input Sheet which rates them on certain metrics from the past 12 months. Indicators include:

- Restraint statistics
- Complaints ratio
- Critical incidents ratio
- Most current quality chart audit results
- Diagnostic complexity indicator
- UM review and discharge planning
- Total unplanned discharges
- Admits to higher [level of care] during [residential treatment facility] stay
- Administrative treatment and quality concerns[159]

There are 50 points available through evaluation of quality indicators and 50 points available through the financial review. To qualify for a rate increase, providers must earn 70 points out of the 100 total available.[160]

The residential rate request tool used by PerformCare immediately disqualifies providers without a clear license and with credentialing sanctions within the past 12 months. The financial review requires a narrative explanation of the request and a budget with acceptable occupancy assumptions, which is defined as 80 percent occupancy target. It also asks if other payers have approved the increase and what percentage of the entity's revenue is from PerformCare. The 100-point scoring system informs the rate increase offered; if the provider earns less than 70 points between the financial and quality evaluations, it will not receive any increase. If the score is above 70 points, there is a possibility of up to a two percent increase for each 10 points earned. The cap on increase is six percent unless other mitigating factors are involved.[161]

These rate increases may only be requested once every two years. If the provider fails to maintain a full license or had a Credentialing Committee Sanction within the past 12 months, it is not eligible for a rate increase. Generally, the factors considered when granting a rate increase are derived from the information included in the Quality and Clinical Input Sheet and include:

- Most current provider profiling results

[157] *Ibid*.
[158] *Ibid*.
[159] PerformCare Quality and Clinical Input Sheet.
[160] *Ibid*.
[161] PerformCare RTF Rate Request Tool.

- Most current quality audit results
- [Consumer/ Family Satisfaction Team] Results/responsiveness
- Number of member complaints
- Provider performance entries
- Quality of care concerns
- Credentialing referrals and disposition[162]

PerformCare will consult with county partners and provide a written decision to a rate increase request within 30 days of a complete request. There are no specifications in PerformCare's policy and procedure that detail what a response will contain.[163]

Beacon Health Options. Beacon Health Options is a BH-MCO operating under an ASO agreement. Primary contractors contracting with Beacon Health Options hold the risk. Beacon serves as a liaison between the primary contractors and providers, therefore though they act as the go-between during rate increase conversations, they do not advise primary contractors on whether to approve an increase. Instead, Beacon simply provides data collection and analysis directly to the primary contractor and the primary contractor makes its own subsequent determinations. Beacon holds contracts with Fayette County, Beaver County, and two contracts with the Northwest and Southwest Behavioral Health Alliance.[164]

Beacon allows providers to submit a Rate Review Request for Information Form, which requires providers to include their name, service code and description of the program, service locations and addresses, the counties affected, current rate and requested rate, and the provider budget.[165] In Fayette County, Beacon reviews trends and utilization factors each year during the annual rate setting process to project future expenses. Rate increases can also be requested throughout the year and will be reviewed monthly by a rate committee. The information taken into consideration by Beacon includes whether providers are on corrective action plans, suspension of referrals, having a provisional license, and other provider specific issues. The decision reached by the committee will be shared with the primary contractor and can be considered either immediately or during the next annual rate setting process. If the primary contractor approves the increase, the contract will be amended. If not, Beacon will send a denial letter to the provider within 30 days of the denial. The policy does not detail the contents of a denial letter.[166]

In Beaver County, the Beaver County Behavioral Health (BCBH) Fiscal Department reviews programs once a year by evaluating trends and determining if a rate increase can be granted. In addition to this process, rate increase requests can be submitted throughout the year. The Beacon-PA Rate Committee will meet monthly to review requests and send their determination to the primary contractor. This response can be considered at any time or within the annual increase timeframe. Networks will send a letter to Account Executives detailing the

[162] PerformCare Policy and Procedure.
[163] *Ibid*.
[164] Meeting with Beacon March 17, 2023.
[165] Beacon Health Options Rate Review Request Form.
[166] Beacon Health Options Process for Addressing and Developing Provider Rates-Fayette County.

increase request and Beacon's response. This will be passed on to the primary contractor. If the primary contractor does not respond in two weeks, the Account Executive will follow up. The primary contractors' response will be recorded. The approval or denial will be recorded and communicated to the provider. In making their determination, BCBH will determine whether the provider has been placed on a corrective action plan, had a suspension of referrals, has a provisional license, and other provider specific issues. If a rate increase is issued, Beacon presents to the County Administrator the proposed increase and what providers and services will be affected. The approved increases will be sent to the provider by BCBH within 30 days of the decision.[167]

The Southwest Behavioral Health Alliance rate increase policy states that a rate increase request must be submitted with a narrative describing the need for an increase. The Chief Financial Officer (CFO) of Beacon will respond within 10 days of receiving the letter, saying whether the rate increase can be considered or not. If it is considered, the CFO may request in addition to the narrative: the number of patients covered by Beacon served in the past year, the counties included, types of service provided and their locations, financial information including operating expenses, internal financial schedules, cost reports, annual operating budgets, independent audit reports, and tax returns, and lastly quality management activities and outcomes.[168]

Beacon will consider input from quality management, clinical services, and provider networks as well as evaluating the number of complaints filed against the provider, whether the provider is on a corrective action plan, licensing issues with DHS, provider driven authorization or claims payment issues, and other quality issues. The internal discussion with Beacon-PA department directors will result in a recommendation from Beacon within 30 days of receiving all pertinent information, which must be approved by the affected counties. If the increase is more than 2.5 percent of the total medical cost, Beacon has final discretion for approving the rate increase. Beacon will issue a counteroffer if it presents a rate less than the requested amount. If the request is denied, the CFO of Beacon will provide written notification of the denial within 60 days of receiving the provider documentation. The policy does not specifically require Beacon to justify a denial of a rate increase in the notification of the new approved rate.[169]

Community Care Behavioral Health Organization. Community Care Behavioral Health Organization sets base fee schedules for State Plan services and negotiates rates with providers for residential and other specialized services. The primary contractor is involved in setting base fee schedules and exercises final discretion over the rates agreed to. CCBHO reviews the fee schedule with each primary contractor each year before DHS's rate setting process conversations. It reviews utilization trends and strategic priorities to prepare for their negotiations with DHS. CCBHO seeks input on priorities in rate changes from primary contractors through the Provider Advisory Committees and holds ongoing meetings with local providers in anticipation of the DHS rate setting process at least once annually. Providers can submit rate increase requests at any point throughout the year, but the requests are generally considered at an appropriately deemed time

[167] Beacon Health Options Rate Increase Policy and Procedure for Beaver County Behavioral Health (BCBH).
[168] Beacon Health Options Process for Addressing and Developing Provider Rates-SWBHM Counties.
[169] *Ibid.*

with other provider rate increase requests. Requests for each year must be submitted by March 1st will be responded to by September 1st.[170]

The policy lists the information a provider must give for any rate increase request, including different standards for residential and ambulatory care. For residential levels of care, the provider must include:

- Number of licensed beds.
- Percentage occupancy for past 12 months.
- If there has been a change in occupancy, please indicate the change and the reason.
- Staffing costs for past 12 months plus budgeted costs for upcoming year.
- If more than a 10 [percent] variance, indicate the reason.
- Operating costs for past 12 months plus budgeted costs for upcoming year.
- If there are any specific operating costs that have more than a 10 [percent] variance, provide the specific detail about what that operational activity is and the reason for the increase.
- Total Revenue for the past 12 months.
- Total Expenses for the past 12 months.
- Information about quality improvement activities related to the service for which the rate increase is being requested.[171]

For ambulatory levels of care, the following information is required:

- The specific rate request per unit for each code.
- Total Revenues and Total Expenses for this program for the past 12 months.
- The cost drivers associated with this program.
- The [percentage] increase in cost year over year for the past 3 calendar years.
- Information about quality improvement activities related to the service for which the rate increase is being requested.
- Any additional details about what the issues are related to the existing rates.[172]

[170] Community Care Behavioral Health Policy and Procedure Manual.
[171] *Ibid.*
[172] *Ibid.*

Other information can be requested by the primary contractor or CCBHO while it is in the rate review process.[173] Interviews with stakeholders determined that primary contractors might give an increase for specific services based on the priorities of the network as well as quality of care and delivery of evidence-based practices. They would reach out to the provider and ask what the incremental cost increase would be for offering that service.[174]

CCBHO's Policy and Procedure Manual, accessible from its public website, does not spell out how CCBHO reviews rate increase requests and determines their validity, or any requirement for providing justification for denials to providers. [175] CCBHO policy outlines what materials a provider would need to include to receive a rate increase request, and the subsequent negotiations for residential or specialized services would outline why the provider would be denied an increase. In the case of outpatient services that are set by the base fee schedule, those rates are typically standardized throughout the network and therefore these rate increase requests may be denied with less explanation or communication.[176]

CCBHO has a separate rate setting policy with one of their primary contractors, the Northeastern Behavioral Health Care Consortium (NBHCC), which represents Lackawanna, Luzerne, Susquehanna, and Wyoming Counties. Providers must submit requests for rate increases by September 1st each year and the requests will be considered on January 1st. For an increase request for an MA approved rate, providers must include the documentation submitted to MA to request a rate increase. For a request that is not for an increase to an MA approved rate, the provider must submit the following documentation:

- Personnel costs (salaries, benefits, other)
- Occupancy expenses (rent, utilities, maintenance and other)
- Other operating expenses, as appropriate
- Depreciation and amortization (buildings, major moveable equipment)
- Projected units of service for all payors.[177]

Providers should also include the most recent internal financial statement or cost center report for the specific service for which they are requesting an increase.

NBHCC will review the request with CCBHO and determine if the increase is appropriate and financially feasible. The Program Development/Network Committee will make a recommendation regarding approval or denial to the NBHCC Board of Directors, which will then deliver the final decision.[178]

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[173] Community Care Behavioral Health Policy and Procedure Manual.
[174] Meeting with Community Care Behavioral Health Organization, March 17, 2023.
[175] Community Care Behavioral Health Policy and Procedure Manual.
[176] Meeting with Community Care Behavioral Health Organization, March 17, 2023.
[177] Northeastern Behavioral Consortium, Inc. Polices & Procedure-Administration.
[178] *Ibid*.

In some cases, NBHCC may approve a performance incentive or other alternative payment arrangement to increase quality of care. The arrangement would be reviewed and approved by the CCBHO Network Department and NBHCC's Finance Department. The Program Development/Network Committee would again make a recommendation to the NBHCC Board of Directors, which will act on the final decision and submit the information to OMHSAS. A network-wide rate change would go through the same review process.[179]

Magellan Behavioral Health of Pennsylvania. Magellan Behavioral Health of Pennsylvania uses a strategic market evaluation of rates by level of care annually to anticipate needs for increases and reduce provider-initiated rate increase requests. Using the results of this analysis and the different PM/PM rates for each county, Magellan will make their annual adjustments to rates. For all rate review, Magellan utilizes a Rate Setting Workgroup. This group includes their CEO, COO, Director of Finance, Field Network Director, Senior Network Manager, Account Executives, Director of Quality, Director of Quality, Director of Clinical, Director of System Transformation, and Compliance Manager.[180] This group can request the following information from providers requesting a rate increase: utilization trending, quality indicators, service provision data, outcomes reports, quality investments the provider has made to improve services, and service differentiators.[181] For scheduled initiatives, in which increases are determined in advance and are able to be budgeted and planned for, the Network Team creates a financial analysis of the requested increase. After reviewing this analysis, the full workgroup will decide to either approve the increase in whole or in part or disapprove the request.[182]

In the case of a provider-initiated request, the information the workgroup will consider includes a budget, a history of recent rate increases, quality indicators, comparison to other rates for similar services, and county input. As with scheduled increases, the Network Team will prepare a financial analysis of the rate increase. The Workgroup will consider "provider budget information, utilization data, quality indicators, anticipated financial impact of the requested rate, remaining budget for rate increases and date of last rate change are all data that may be used in consideration of a rate increase request made by the provider."[183] After reviewing the financial analysis and other relevant information, the Workgroup will either approve, approve in part, approve at a later date, or disapprove an increase. This decision is subject to approval by the county, and then the provider will be notified of the decision with a rate amendment that must be signed by the provider. The policy and procedure document did not detail the content required in a notification, but in interviews Magellan representatives stated that their denials do contain an explanation for the denial.[184] If a county initiates a rate increase request, the same process will be followed.[185]

[179] Northeastern Behavioral Consortium, Inc. Polices & Procedure-Administration.
[180] Magellan Health Provider Rate Changes and Rate Setting.
[181] *Ibid*.
[182] *Ibid*.
[183] *Ibid*.
[184] Meeting with Magellan, March 24, 2023.
[185] Magellan Health Provider Rate Changes and Rate Setting.

Community Behavioral Health. Community Behavioral Health (CBH) separates the rates into standard and non-standard rates. Standard rates apply to outpatient psychiatric, outpatient drug and alcohol, behavioral health rehabilitation services for children, and laboratory. These rates are rarely negotiated and is only done in cases of specialized services for specialized populations. For non-standard rates including Inpatient Psychiatric and Inpatient D&A Services, requests are reviewed by considering the amount of time since the last increase—limited to one increase per year—and the rates determined by DHS. CBH may match the MA rates for these services, but it caps the rate at the MA figure barring other rate issues. For new providers, the original rate is negotiated through evaluation of "budgeted financial data, market conditions, financial considerations and other factors."[186]

For non-hospital drug and alcohol, Residential Treatment Facilities (RTFs), Host Homes, and other residential programs, rates are negotiated with providers and increases are based on the timing of the last increase—only one every three years—and funding available, as well as financial data submitted by the provider and clinical assessment of the quality of care provided. If a provider is requesting an increase within three years of the most recent increase, it must provide an economic reason for the request, for example "changes in the marketplace, staff hiring issues, and the inability to operate as a going concern."[187] Requests for increases can be submitted at the end of each quarter, in January, April, July, and October. The request for rate increase sheet must be filled out, indicating the name of the provider, the location of service, the level of care, and contact information. The following documentation must be attached:

- Corresponding letter justifying the need
- Certification Statement (Appendix A)
- Expenditure Summary (Appendix B)
- Personnel Invoice Schedule (Appendix C)
- Miscellaneous Item Detail (Appendix D)
- Most recent audited Financial Statement
- Expected Clinical Outcomes and Monitoring Methods (Appendix E)[188]

All requests for rate increases are reviewed by at least the City of Philadelphia Department of Community Behavioral Health and Intellectual Disability Services (DBHIDS) Finance Committee, and possibly other clinical and finance committees. The factors that influence the final decision include funding available based on DHS capitation rates, rate equity with other providers, provider financial data, timing of the last rate increase, and other factors based on information supplied by providers. CBH will send a letter notifying providers of the final decision. There is no requirement in the policy for explaining the decision to providers.[189]

[186] CBH Request for Rate Increase Policy and Procedure.
[187] *Ibid*.
[188] CBH Provider Request for Rate Increase Cover Sheet.
[189] CBH Request for Rate Increase Policy and Procedure.

Value Based Purchasing

DHS has moved to encourage the utilization of Value Based Purchasing (VBP) in both the physical and behavioral health realms. VBP would tie certain provider payments to the outcomes of their patients and the quality of their health care provision. The concept of VBP came about when industry stakeholders started drawing attention to the fact that healthcare providers have always been reimbursed for the services they perform, regardless of the outcome of their patients. Some hospitals and other care facilities became revolving doors for many of their patients. This initiative incentivizes providers to provide quality care by providing financial reward for meeting certain measures and patient outcomes.[190]

Pennsylvania's framework of VBP allows for payment strategies that are categorized as either low, medium, or high risk. Different models can be used by providers and BH-MCOs if they fall within the approved payment strategies. In contract year 2022, primary contractors must ensure that 30 percent of medical expenses are expended through a value-based model. Of those 30 percent, 50 percent must be medium or high-risk payment strategies.[191]

The approved payment strategies include performance-based contracting, shared savings, shared risk, bundled payments, and global payments. Performance-based contracting is a low-risk strategy that incorporates incentives or penalties based on performance into FFS contracts. Shared savings is a medium-risk strategy in which the provider would receive supplemental payments for reducing healthcare spending in either a specified member group or the total member population. This payment would be a percentage of the net savings. Shared risk is a medium-risk strategy that also gives providers supplemental payments for reducing spending. However, in this plan, the provider could receive a lower payment if there are no healthcare savings. Bundled payments are a medium-risk strategy in which all payments for a member with a specific condition during a specific time period which can be paid for at one time or throughout regular predetermined intervals. Global payments are a high-risk strategy in which a provider receives a population-based payment that covers all services rendered by the provider. These payments can either be in bulk or at predetermined intervals or based on FFS payments with retrospective reconciliation to the overall global budget.[192]

DHS's VBP required model is Standardized Transitions to Community. This model standardizes performance measures of the transition for psychiatric inpatient care to community-based services. The standardized performance measures are follow-up after hospitalization, which records the percentage of members who received follow-up within 7 days and 30 days of discharge, and the Pennsylvania-specific readmission statistics within 30 days of discharge.[193]

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[190] *HealthChoices Program Standards and Requirements: Appendices*, Appendix U, 314.
[191] *Ibid*., 305.
[192] *Ibid*., 305.
[193] *Ibid*., 306.

An important piece of VBP is the incorporation of Community-Based Organizations (CBOs). CBOs are:

> Nonprofit organizations that work at a local level to improve life for residents and normally focus on building equality across society in many areas, including but not limited to access to social services. These organizations must also be registered as a 501(c)(3) nonprofit corporation in Pennsylvania. A health care provider is not considered a CBO.[194]

Eighty-five percent of medium to high-risk strategies must incorporate CBOs. The CBO must address at least one of these Social Determinants of Health:

- Childcare access and affordability
- Clothing
- Employment
- Financial strain
- Food insecurity
- Housing instability/homelessness
- Transportation
- Utilities.[195]

BH-MCOs must incorporate CBOs into their contracting either through a provider that contracts with the CBO or they may contract with the CBO directly using the savings earned through the VBP arrangement. Medicaid capitation dollars are not allowed to be used to contract with CBOs.[196] When considering contracting with a CBO, BH-MCOs must consider the following factors:

- Types of services provided.
- Accessibility to community members, including hours of operation, location, staffing capacity, accommodations for individuals with special needs, including physical disabilities and language barriers.
- Number of MA participants served.
- Quality of social services provided and experience addressing [Social Determinants of Health].
- Soundness of fiscal, operational, and administrative practices and capacity.

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[194] *Physical and Behavioral Health HealthChoices: Incorporating Community-Based Organizations into Value-Based Purchasing FAQ* (Pennsylvania Department of Human Services December 14, 2020), https://www.dhs.pa.gov/HealthInnovation/Documents/12.14.20%20CBO%20FAQ.pdf.
[195] *HealthChoices Program Standards and Requirements: Appendices*, Appendix U, 314.
[196] Meeting with OMHSAS, March 31, 2023.

- Service area and populations served.
- Capacity for increased referrals from Providers or the BH-MCO.
- Ability to capture and report SDOH data.[197]

A VBP plan must be submitted to DHS by October of the preceding contract year. The primary contractor must monitor the contracts on a no less than quarterly basis and submit a summary of the contract each year that includes:

- A review of the accomplishments and outcomes from the prior Contract Year;
- A report on the percentage of medical expenses expended through VBP strategies and the associated levels of financial risk; and
- A VBP detailed report by Provider that identifies the following:
    - Level of financial risk (no, low, medium, high) and dollar amount spent for medical services expended;
    - VBP Payment Strategy/Model(s) used;
    - Program type(s) included (Federally Qualified Healthcare Centers (FQHC), Assertive Community Treatment (ACT) and Behavioral Heath Homes, etc.), if applicable;
    - CBOs and SDOH domains included; and
    - Evidence-based Practices and Programs (EBPP) [must be on the Substance Abuse & Mental Health Services Administration (SAMHSA) list of approved EBPPs and adhere to fidelity requirements.][198]

Primary contractors are also required to distribute timely and actionable data to providers on their progress toward meeting their predetermined benchmarks.[199]

One BH-MCO provided examples of its 2023 VBP models. One is the Inpatient Mental Health (IPMH) & Ambulatory Transitions Shared Savings Model. In this financial model, providers can earn their market share of the savings pool by reducing the total cost of care. The performance measures are improving 30-day readmission to IPMH and improving 7-day ambulatory follow-up post-discharge from IPMH. The Residential Treatment Facilities (RTF) Transformation Performance-Based Contract is another model in which providers will receive a bonus of 2.5 percent of their total annual revenue with a cap of 10 percent. The performance measures are the 7-day ambulatory follow-up rate, the 30-day ambulatory follow-up rate, the rate of overlap of ambulatory services 30-days prior to RTF discharge, and the rate of Inpatient Mental Health Care within 30-days after RTF discharge. A Medication-Assisted Treatment (MAT) Performance-Based Contract model gives five percent rate enhancements for improvements in 90-day retention in methadone opioid treatment programs and buprenorphine office-based opioid treatment. The Centers of Excellence for Opioid Treatment model is a performance-based contract

[197] *HealthChoices Program Standards and Requirements: Appendices*, Appendix U, 314.
[198] *Ibid*., 315.
[199] *Ibid*., 315.

with a PM/PM rate with bonus. The bonus is paid once at the end of the contract year for patients that were retained for 1, 2, 3, 4, 6, 9, and 12 months.[200]

One regional model is the Assertive Community Treatment (ACT) Shared Risk model, in which 20 percent of the contract rate is withheld and a 10 percent bonus is paid as a lump sum if measures are achieved. The measures are reduction in average IPMH cost per ACT recipient, meeting the threshold in average cost per user and average IPMH cost, the use of the transition readiness tool, and competitive employment rates.[201]

SCA Rate Setting

For uninsured and underinsured clients, DDAP provides funds for SCAs to contract with providers to ensure drug and alcohol services are delivered to those in need. The grant agreement between DDAP and SCAs requires that SCAs contract with providers enrolled in a Medicaid program; either an BH-MCO or the FFS program. If the provider is not enrolled in a Medicaid program, the SCA must refer Medicaid eligible clients to an enrolled Medicaid provider.[202] Outpatient, intensive outpatient, and partial hospitalization rates are developed through negotiation and consideration of a budget that "defines staffing, operating, and fixed asset costs for the delivery of services."[203] The other rate development process outlined includes these services:

- Medically Monitored Inpatient Withdrawal Management,
- Clinically Managed Low-Intensity Residential Services (Halfway House),
- Clinically Managed High-Intensity Residential Services (adult); and
- Clinically Managed Medium Intensity Residential Services (adolescent).

For these rates, SCAs are required to use the XYZ Package to determine the rate.[204] This is a cost-based package for any residential providers that wish to contract with the SCAs. The SCA for the home county of the provider is responsible for the management of the rate setting and contract.[205]

The review process begins once providers have submitted their completed XYZ Package. Three SCAs must be involved in the rate setting review process. Each SCA must contribute an SCA administrator and fiscal officer. At least one representative must have programmatic knowledge of the treatment. Once the rates are agreed upon, the Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA) must post them publicly on their website by June 1st.[206] The XYZ Package collects cost information from providers. Each provider must fill out an XYZ Package for any activity for which they are requesting a rate increase.

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[200] Community Care Behavioral Health 2023 VBP Models.
[201] *Ibid*.
[202] *2020-2025 Operations Manual* (DDAP, December 3, 2021), 7.01.1.
[203] *2020-2025 Operations Manual* (DDAP, December 3, 2021), 7.02.1.
[204] *2020-2025 Operations Manual* (DDAP, December 3, 2021), 7.02.1.
[205] Meeting with Ellen DiDomenico, DDAP Deputy Secretary, December 6, 2022.
[206] *SCA-Provider XYZ Package: Uniform Rate Setting Packet Fiscal Year 2022-23* (December 2021), 2.

XYZ Package Process

Each program seeking a rate increase must submit a DDAP or home state license and a DHS license if applicable, as well as the previous year's audit report and management letter, documentation of 60 day cash operating capability, a notarized statement that there have been no criminal violations by the management or employees in the past two years, a program organizational chart, a tax/compensation attestation form, and a certificate that the agency is in compliance with Child Protective Services Law if it is treating adolescents.[207]

Also included in the submission is a general program description section. This section must include demographic information on the population served in the last six months, including race, ethnicity, gender, age, and pregnancy status. It also requires the program to document staff composition and differentiate clinical staff from administrative staff. Providers must submit evidence of persons in recovery representing the governing or advisory board and describe the makeup of the board. Providers must prove experience working with MA using socio-economic data to determine the percentage of clients on MA, SCA, or percentages of clients by income level. The provider must name an individual to be responsible for responding to questions on reporting and auditing, and an individual who will be responsible for the daily decision making at the local level.[208]

The specific program description asks for several narrative sections to be filled for each unique service offered at a facility. First, the provider will furnish the philosophy or mission statement, the target population, admission criteria and protocol, specialty services, and client bio-psychosocial history process. Then, the provider will list the services offered and the minimum frequency of each service. If the service package includes transportation, the provider will specify the type of transportation offered (i.e. pick-up for admission, to and from services, drop-off at discharge, etc.) and any limitations on transportation.[209]

The staffing section of the specific program description includes a list of all staff and their daily schedule and availability and compliance with typical client ratios, or an explanation of variances. If the program deals with withdrawal management, they must state whether they always have a physician on-call, and if not, explain why. They must also have 24-hour awake staff coverage or explain why they do not. The provider must furnish the turnover rates for administrative, clinical, and combined staff. The program must justify in writing a turnover rate of over 30 percent, if a position remained vacant for more than 60 days, the provider must identify the position and explain why the position was unfilled.[210]

The provider must detail the policy and procedure for initial privileging/credentialing of clinical staff, identify evidence-based treatment protocols being utilized, withdrawal management protocols if applicable, and explain how they measure outcomes for programs. They must include reports from the previous year that measure outcomes for programs. Providers must include any grievances, complaints, or appeal processes distributed to clients and attach a copy of the policy

[207] *Ibid*., 4; *Supra*, n. 91.
[208] *Ibid*., 7.
[209] *Ibid*., 9-10.
[210] *Ibid*., 11-12.

and procedures for dealing with grievances or complaints. For the previous fiscal year, providers must also include the percent of clients that completed the program out of the number of clients admitted to the program.[211] The program must indicate the populations they target out of the following grid:[212]

Facility #	Type of Service	Adult	Adolescent	Co-occurring	Male	Female	Pregnant Female	IDU	Rate Requested

For programs for women with children, the program must list prevention services and programming for children along with the age ranges accepted and the frequency of the programs. They must also describe the role of the mother in the prevention services.

The last section of the specific program description asks providers four questions about Medication-Assisted Treatment (MAT) practices within the facility:

1. How do you ensure that individuals on MAT are not excluded from admission to treatment within your facility?

2. How do you make available all forms of FDA approved medications for MAT within your facility?

3. How do you ensure coordination of care for clients on MAT when the prescriber is not your facility?

4. How do you educate individuals within your facility about MAT options?[213]

Rate Development

For the rate development portion of the XYZ Package, providers must submit a personnel roster, a facility-based budget, a budget narrative, and a rate request form. The personnel roster must have staff separated as administrative or client oriented. Administrative staff includes any staff engaged in marketing functions, regardless of their title. For each staff member, the roster must include the member's name, position, and their salary for the upcoming year.[214]

[211] *Ibid*., 12-13.
[212] *Ibid*., 13.
[213] *Ibid*., 13.
[214] *Ibid*., 14.

The facility-based budget must include an itemization of projected expenses and revenues broken down by activity offered at the facility based on two forms provided by the XYZ Package.[215] The forms break down expenses by the modified DDAP Uniform Chart of Accounts budget categories and include three years of fiscal information: actual expenses for the prior year, current/projected expenses for the current year, and the budget for the upcoming year. If there is more than a 10 percent increase from the current year projection to the upcoming budget, the budget must justify in writing a detailed and specific reason for the increase. [216] This budget must be submitted for all activities, even ones that the provider is not requesting an SCA rate for. Only 20 percent of costs are allowed to be administrative costs, so this budget must label costs as either administrative or client oriented.[217]

The XYZ Package provides a strict definition of administration:

> Administration is defined as general managerial functions or activities which are supportive to, but not an intrinsic part of the provision of direct services. Administrative functions or activities include: executive supervision, personnel management, accounting, auditing, legal services, purchasing, billing, community board activities, activities associated with management information systems (does not include maintenance of individual client case records), and clerical activities which are supportive to these administrative functions or activities.
>
> Clerical activities which provide direct support to the program activity are to be reported as direct costs of the program activity. Room and board, including maintenance, are direct costs for residential programs. For rate setting, clinical and program supervision associated with direct client care is to be considered a direct program expense. Staff time associated with such supervision should be allocated among, and reported within, program activities as a direct program expense. The method of allocation is discretionary, if it is verifiable and results in an equitable distribution among program activities.[218]

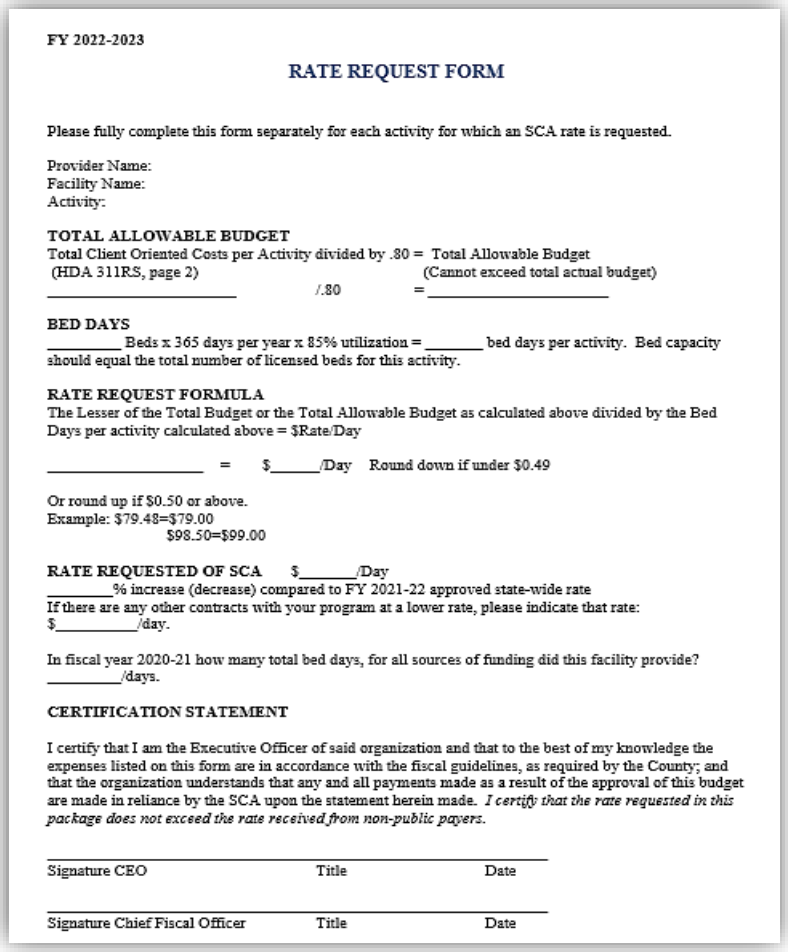
The budget narrative that providers submit includes a description of costs included in each budget category. Some categories require the provider to show methodology for allocating costs between administrative and client-oriented. The budget categories not requiring the explanation of methodology are: administrative benefits, client-oriented services salaries, client oriented services benefits, meeting and conference expense, consultant expense, miscellaneous personnel expense, medical supplies and drugs (not including medications used for MAT in the form of Buprenorphine, Vivitrol, or Methadone), food and clothing, program supplies, client transport,

[215] HDA 311RS pages 1 and 2, HAD 313RS, included in Appendices B, C, and D.
[216] *Ibid*., 14-15.
[217] *Ibid*., 14-15.
[218] *Ibid*., 15.

purchased client oriented services (including psychological consultants), motor vehicle maintenance expense, motor vehicle leases, and indirect cost.[219]

Those that require an explanation of methodology are: staff development, occupancy expense, insurance, communications, office supplies, minor equipment and furniture, staff travel, equipment maintenance expense, equipment leases, other operating expense, and indirect cost (depreciation).[220] Provider revenue and income falls under the following categories: provider revenues, provider charitable income, provider interest income, client fees, private health insurance, medical assistance, other third-party fees, and miscellaneous.[221] A full explanation of what should be included in each of these categories is included in the XYZ Package, which will be included as Appendix A.

Finally, the provider submits a rate request form for each activity for which a rate is requested. The formula is as follows: [222]



FY 2022-2023

RATE REQUEST FORM

Please fully complete this form separately for each activity for which an SCA rate is requested.

Provider Name:
Facility Name:
Activity:

TOTAL ALLOWABLE BUDGET
Total Client Oriented Costs per Activity divided by .80 = Total Allowable Budget
(HDA 311RS, page 2) (Cannot exceed total actual budget)
_____ /.80 = _____

BED DAYS
_____ Beds x 365 days per year x 85% utilization = _____ bed days per activity. Bed capacity should equal the total number of licensed beds for this activity.

RATE REQUEST FORMULA
The Lesser of the Total Budget or the Total Allowable Budget as calculated above divided by the Bed Days per activity calculated above = $Rate/Day

_____ = $_____/Day Round down if under $0.49

Or round up if $0.50 or above.
Example: $79.48=$79.00
$98.50=$99.00

RATE REQUESTED OF SCA $_____/Day
_____% increase (decrease) compared to FY 2021-22 approved state-wide rate
If there are any other contracts with your program at a lower rate, please indicate that rate:
$_____/day.

In fiscal year 2020-21 how many total bed days, for all sources of funding did this facility provide?
_____/days.

CERTIFICATION STATEMENT

I certify that I am the Executive Officer of said organization and that to the best of my knowledge the expenses listed on this form are in accordance with the fiscal guidelines, as required by the County; and that the organization understands that any and all payments made as a result of the approval of this budget are made in reliance by the SCA upon the statement herein made. *I certify that the rate requested in this package does not exceed the rate received from non-public payers.*

_____
Signature CEO Title Date

_____
Signature Chief Fiscal Officer Title Date

[219] *Ibid*., 17-20.
[220] *Ibid*., 17-20.
[221] *Ibid*., 25-26.
[222] *Ibid*., 27.

SCA Review Process

Pennsylvania regulations require that an aggrieved party have the right to appeal to an SCA decision. The current DDAP Operations Manual provides the procedural guidelines to be followed by an aggrieved party.[223] DDAP developed its Operations Manual to set forth the requirements for SCAs under the grant agreements between itself and the SCAs.

When reviewing rate increase requests from providers, SCAs must comply with the layered appeal process prescribed within the DDAP Operations Manual and current XYZ Package: Uniform Rate Setting Packet which is used for residential rates. However, it is worth noting that the provisional language outlining the appeals process has at times been interpreted differently by SCAs across the Commonwealth.

Though it varies by SCA, many SCAs surveyed by Commission staff described a collaborative effort with the provider through email or phone conversation to ensure that costs are accurately represented during the initial stages of a provider rate request. After a review and possibly some revisions to the original submission, the SCAs will send a notification of the approved rate to the provider. The notification may indicate a denial of a rate increase, a counteroffer of a lower number than the number originally requested, or an approval of the rate as requested. However, in this initial review of the requested rate, SCAs are not expressly required to formally explain a denial or counteroffer. Instead, they must only notify the provider of the rate approved or of a request denial.[224] Providers then have the right to formally appeal the denial to the SCA for a reconsideration.

First, the provider can submit a Level 1 Appeal in writing to an appeal committee made up of an SCA and SCAs from surrounding areas. If the provider does not agree with the results of this appeal, they can file a Level 2 Appeal in writing with DDAP. This appeal must include justification for not accepting the SCA rates and other documentation including the XYZ Package information and all correspondence related to the Level 1 Appeal. The appeal committee for a Level 2 Appeal includes the "DDAP Deputy Secretary, DDAP Special Assistant to the Secretary, DDAP Bureau Director, Quality Assurance and Administration, DDAP County Program Oversight (optional), and input may be requested of SCAs or additional stakeholders as needed by DDAP."[225] If an SCA cannot come to agreement with a provider, they can also submit a request for a final determination from DDAP. This must include all the documentation included in a provider's Level 2 Appeal, and the appeal committee is made up of the same members.[226]

Section 7.02A(6)(a) of the Pennsylvania DDAP Operations Manual (July 1, 2020 – June 30, 2025) explains the rate appeal process but does not mention an SCA's initial rate request denial determined by the review process. Instead, the section focuses on the procedural requirements starting with the Level 1 Appeal of the denial before the SCAs. There is no mention of any

[223] 4 Pa. Code § 254.20.
[224] Email Correspondence with Ellen DiDomenico, DDAP Deputy Secretary, March 14, 2023.
[225] Pennsylvania Department of Drug and Alcohol Programs Operations Manual (July 1, 2020 – June 30, 2025), § 7.02A(6)(a).
[226] *Ibid.*

obligation on the SCA to provide a justification (written or otherwise) for an initial rate denial to a provider. Specifically, section 7.02A(6)(c) of the manual provides the following:

> Documentation for consideration of an appeal must include all materials submitted to the SCA review committee, including the XYZ package, and all correspondence between the SCA review committee and the provider related to the Level 1 Appeal. Providers may also submit any additional materials such as financial documents to support their request.[227]

Below this paragraph of language, the manual prescribes that ***"SCAs must provide justification for refusing to accept the rate proposed by a provider."***[228] It is not clear as to whether this requirement applies broadly to all appeals (both Level 1 and Level 2) or narrowly to only Level 2 appeals, as the provision is not directly under the Level 1 Appeal heading.

Another example of similar procedural language can be found in the Provider XYZ packet, which provides the following:

> Documentation for consideration of an appeal to a disputed rate must include all materials submitted to the SCA review committee, including the XYZ Packet. All correspondence between the SCA review committee and the provider, related to the Level 1 Appeal to the SCA appeal committee, must also be provided. Finally, providers may submit any additional materials, such as financial documents that will further substantiate their request for a rate different from that offered by the SCA review committee.[229]

Nothing in the above text expressly requires the SCA to explain or justify the initial denial of provider's rate increase request. Instead, the language primarily lays out the required documentation for the provider regarding an appeal. However, the very next paragraph expressly provides "SCAs submitting an ***appeal to DDAP must provide justification for the non-acceptance of a rate or rates submitted by a provider***."[230]

The above language in this packet appears to indicate that the requirement of an SCA to provide a "justification" for the non-acceptance of a rate submitted by a provider only applies to an SCA once a provider files an appeal of the SCA's denial to DDAP at the Level 2 Appeal stage. Furthermore, the language indicates that said "justification" is only required to be provided to DDAP. In other words, the XYZ Packet does not expressly require the SCA to provide a justification for denial of a rate submitted by a provider to the provider when a rate is initially denied.

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[227] Pennsylvania Department of Drug and Alcohol Programs Operations Manual (July 1, 2020 – June 30, 2025), § 7.02A(6)(c).
[228] *Ibid (**Emphasis added**).*
[229] XYZ Package: Uniform Rate Setting Packet (FY 23-24), p. 3.
[230] *Ibid. (**Emphasis added**).*

This may explain why some providers stated that their SCAs do not provide any justification, written or otherwise, with their initial rate denials or counteroffers. However, when interviewed, some SCAs stated that they do provide a justification to the provider for an initial rate increase denial or counteroffer. One SCA representative interviewed by the Commission believed this was an obligation of an SCA, while other individuals familiar with the system held the understanding that the language noted above does not require SCAs to do so for initial denials.[231]

To reach further clarity on this subject, Commission staff developed a series of open-ended questions about the review and consequential appeal process and distributed these to all the SCAs with the help of PACDAA. Nineteen SCAs of the around 30 that set rates responded to the survey.

Most SCAs that responded to the survey stated that they review the XYZ Package internally first to find points where changes or clarifications are needed, including fiscal and program staff in the review. The SCA is contractually obligated to provide technical support if the provider is struggling with producing some of the information required in the package.[232] Once they are satisfied with the accuracy of the package, the package is reviewed by a group of SCA directors in the region. This group will come to a decision on the approval, counteroffer, or denial of the requested rate.

Most SCAs that responded to the survey notify the provider of the status of the requested rate through a letter or an email. One SCA schedules meetings with the provider, either virtually or in person, to talk through the approved rate. For all SCAs, the notification included the status of the request, but there is variability in how much detail about the final decision is included. Six SCAs specifically said the communication includes mention of the formal appeal process. Seven SCAs said the communication would include an explanation of a denial or counteroffer. Three SCAs specifically said they include an opportunity to meet with providers to discuss the results of the review. When asked directly if the letter would include an explanation, 14 SCAs said yes, two said no, and three said the question was not applicable.

When asked how many facilities submitted packages this year, seven SCAs had only one package submitted, two SCAs had two submitted, three SCAs had three submitted, and three SCAs had four submitted. One provider each had five, six, eight, and ten packages submitted. Eleven SCAs said they did not award a rate lower than requested and two SCAs were still in the review process. Three SCAs awarded a lower rate to one facility, one SCA awarded a lower rate to two facilities, and two SCAs awarded a lower rate to three facilities. Only three providers said facilities had gone through the formal appeal process to dispute the rate determined by the SCA regional group.

[231] Email with Ellen DiDomenico, DDAP Deputy Secretary, March 14, 2023.
[232] *2020-2025 Operations Manual* (DDAP, 2020), 7.02.

Relationship between BH-MCO Rates and SCA Rates

Though the two sides of the drug and alcohol reimbursement system, the BH-MCOs and the SCAs, receive different funding and have different requirements attached to the funding, sometimes the rates determined by the separate sides are used by the other, adding a level of complication to the system. As the XYZ Package is extremely thorough and attempts to account for the costs providers face, many BH-MCOs will accept the rates posted by PACDAA after the XYZ negotiation process rather than determining their own. However, BH-MCOs are not required to accept these rates. Additionally, if these XYZ rates are less than the ASAM minimum which governs BH-MCO funding, the BH-MCO is required to meet the ASAM minimum. Conversely, SCAs may choose to approve rates that correspond with the ASAM minimum if that minimum is higher than the XYZ rate, but they are not required to do so. Anecdotally, some SCAs and BH-MCOs that Commission staff spoke with said they would approve whichever rate was higher between the two, though this is not formalized policy and cannot be required because of the separate streams of funding.[233] Anecdotal information is challenging to rely on in this system as there are almost limitless possible combinations of personalities involved with SCAs, primary contractors, and BH-MCOs that could affect the relationships between these stakeholders and providers.

Provider Feedback

BH-MCO Negotiations Comments

Some BH-MCOs utilize the XYZ rates published on PACDAA's website rather than going through a separate negotiation process with providers. This would not be the case, however, if the ASAM minimum rate determined by DHS was above the cost-based rate produced by the XYZ Package. In that case, the BH-MCOs would comply with the ASAM minimum rate. In some cases, the XYZ rate agreed to by a provider may be higher than the ASAM minimum rate. In that case, the BH-MCO could agree to cover the service at the rate that is the higher of the two, though the use of the XYZ rate is not required for BH-MCOs.[234] A provider advocated for a formalization of this practice articulated by some BH-MCOs, requiring both SCAs and BH-MCOs to agree to pay the higher rate between the XYZ rate and the ASAM minimum rate.[235]

Because providers serve both managed care patients and uninsured or underinsured patients, they are faced with understanding two separate systems of funding and determining rates from these two sources that can vary by location based on the layers of oversight involved. Small providers may not have enough fiscal staff to navigate these processes smoothly, causing them to avoid requesting rate increases even when they are necessary.[236]

[233] Meeting with Primary Contractor, January 11, 2023.
[234] Correspondence with Primary Contractor, January 1, 19, 2023.
[235] Correspondence with Provider, February 14, 2023.
[236] Meeting with Provider, February 6, 2023.

For both the rates established with SCAs and the rates established with BH-MCOs, providers described the negotiation process as frustrating and lacking transparency. Providers stated that there was variability between different SCAs and BH-MCOs, but when the rate they requested was denied or countered, there would sometimes be no explanation provided for why the requested increase could not be granted.[237] The financial information required by SCAs and BH-MCOs to discuss a rate increase can vary, increasing the difficulty of appealing a denial or counteroffer. Providers felt that if the XYZ Package is a cost-based package, negotiations or counteroffers are asking providers to acquiesce to less than break-even rates.[238]

Providers stated that because of the administrative costs of the rate appeal process, many that received a lower rate than requested, but would not appeal because of the amount of time and effort it would take to go through the appeal process. Anecdotally, providers did not experience success with appeals. Primary contractors and SCAs indicated in interviews that they received a small number of appeals, assuming that this indicated satisfaction with the established rates.[239] However, the perceived lack of dissatisfaction based on the low number of appeals may not be representative of actual provider satisfaction with rates; it may be an indication of how ineffective the appeals are perceived to be.[240]

Providers shared frustration with the inconsistency in the system because of the varying levels of oversight. Providers with facilities in different counties that dealt with multiple BH-MCOs or SCAs experienced differences in the level of communication and transparency about the rate setting process.[241] Additionally, larger providers seemed to have more leverage in negotiations.[242] Though rates that are flexible by county are meant to account for regional differences in expenses, some providers felt that more consistent rates across the Commonwealth would streamline the rate setting process.[243]

XYZ Package Comments

Providers spoke of the XYZ process as being cumbersome and an administrative burden. Depending on the number of activities offered, providers can be tasked with preparing many XYZ Packages. One large provider with two dozen locations in Pennsylvania had to prepare 37 XYZ Packages. For this particular provider, because of its size, the regional differences in expenses that the XYZ Package can account for are less significant than the administrative burden of preparing the documents for 37 activities. For this provider, sometimes the XYZ Package rates do not fully cover expenses throughout the given year, but because they are a large provider, some funding from MA patient rates can be shifted around to cover the costs. The 2023 rate proposals could see a significant increase over the previous year because of the significant increase in inflation, workforce, and transportation costs. Additional concerns arose for this provider because the continuous enrollment status of Medicaid is set to phase out starting in March of 2023. With more

[237] Meeting with Providers, February 1, 6,10, and 22, 2023.
[238] Meeting with Provider, February 10, 2023.
[239] Meeting with SCA Representatives, December 14, 2022.
[240] Meeting with Providers, January 26, 2023 and February 1, 22, 2023.
[241] Meeting with Providers, February 1, 6, 10, and 22, 2023.
[242] Meeting with Provider, February 1, 2023.
[243] Meeting with Provider, February 6, 2023.

consumers being on Medicaid than those uninsured or underinsured, the BH-MCO rates shouldered the cost burden of facilities with their sometimes-higher rates. When continuous enrollment ends, there will likely be an increase in uninsured or underinsured patients, creating more pressure on DDAP funding, which is limited.[244]

Providers shared that some aspects of the XYZ Package did not accurately predict costs. The most shared and repeated difficulty for providers was the cost of labor and the difficulty of retaining staff. Especially since the COVID-19 pandemic, the personnel costs for medical professionals have grown at a high rate. Combined with the effects of inflation, many providers are struggling to maintain adequate staffing levels. One provider shared that many locations had a 20 percent increase in staffing costs for nurses and counselors, as well as offering sign-on bonuses of up to $20,000.[245] The XYZ Package asks providers to identify vacancies that have been open for more than 60 days and explain why the vacancy persists. While SCAs are reasonably hesitant to approve expenses on an unfilled position, the current workforce market complicates how to account for these persisting vacancies as they become more and more common.[246] Some SCAs and BH-MCOs have offered additional funding specifically to address the staffing shortage. However, these lump sum incentives cannot be counted on as a sustainable source of funding. Factoring rising staff costs into the rate increases would be preferred by providers.[247]

Staffing levels also affect occupancy levels. The cost-based XYZ Package assumes an utilization rate of 85 percent to cover providers' costs. If beds are not being filled, or there is not adequate nursing staff to support 85 percent or more beds being occupied, the provider will not be receiving enough funding to cover the costs of its patients.[248]

The recent ASAM realignment, which establishes the minimum for capitation rates for Medicaid customers, has been helpful in establishing the difference between levels of acuity of care and creating standardization in this way. However, a large provider advocated for review of the XYZ Package as well to eliminate inefficiencies and additional administrative costs.[249] One provider recommended an electronic version of this paperwork that could be filled in and automatically make calculations to streamline this process.[250]

[244] Meeting with Provider, January 26, 2023.
[245] Meeting with provider, February 10, 2023.
[246] Meeting with Provider February 6, 2023.
[247] Meeting with Provider, February 1, 2023.
[248] *SCA-Provider XYZ Package: Uniform Rate Setting Packet Fiscal Year 2022-23* (December 2021), 27.
[249] Meeting with Provider, January 26, 2023.
[250] Meeting with Provider, February 6, 2023.

SR 352 asked Commission staff to, "at the managed care organization level, using data from fiscal year 2019 as a reference, …[report] anonymized provider-level data on the percent change in provider reimbursement rates over the previous fiscal year." To respond to this directive, Commission staff spoke with each of the five BH-MCOs and asked if they could fulfill this directive. Through conversations with the stakeholders, Commission staff interpreted this directive as a request for the percentage change in reimbursement rates for each covered activity/service offered by each provider in 2018 and 2019. Given the previously demonstrated complex nature of the rate developing process, exacerbated by the amount of possible combinations of counties, BH-MCOs, and providers involved in each rate setting process, it was not possible to collect this information within the time allotted for the report. This would require a burdensome amount of data collection and analysis by the BH-MCOs and analysis by Commission staff that could not be accomplished in the time available. Some BH-MCOs were also reluctant to disclose proprietary information on such a specific level of detail. All the BH-MCOs were willing to provide overall percentage changes from 2018-2019, and some were able to break the percentage changes down by level of care to provide more detail without disclosing proprietary information.

BH-MCO Rate Changes

PerformCare granted a four percent rate increase for its contract with Franklin and Fulton County in 2020 for outpatient services. PerformCare provided a table of the Capital Area Behavioral Health Collaborative rate changes by service categories since 2010. The increases from 2018 to 2022 are as follows:[251]

Table 5

CABHC Ambulatory Service Rate increases since 2018

Effective date of Rate change	Service Category	% Rate increase
Jan 1, 2018	Mental Health Partial Hospitalization Program (Program Change to ends Non-Acute PHP)	36.0%

[251] Correspondence with PeformCare, March 22, 2023.

Table 5

CABHC Ambulatory Service Rate increases since 2018

Effective date of Rate change	Service Category	% Rate increase
April 1, 2018	Mental Health Outpatient, Psychiatrists, Psychologists	2.0
April 1, 2018	Mobile Psych Nursing	2.0
April 1, 2018	Multi Systemic Therapy	2.0%
April 1, 2018	Music Therapy	2.0
April 1, 2018	Assertive Community Treatment Team/Community Treatment Team	2.0
April 1, 2018	Family Based Mental Health Services	2.0
April 1, 2018	Peer Support Services	2.0
April 1, 2018	Mental Health and Substance Use Targeted Case Management	2.0
April 1, 2018	BHRS After School	2.0
April 1, 2018	BHRS Evals	2.0
April 1, 2018	BHRS Behavioral Specialist Consultation	2.0
April 1, 2018	BHRS Mobile Therapy	2.0
April 1, 2018	Substance Use Outpatient Clinic & Methadone Clinic	2.0
April 1, 2018	Substance Use Intensive Outpatient	2.0
April 1, 2018	Substance Use Partial Hospitalization	2.0
July 1, 2019	Mental Health Outpatient, Psychiatrists, Psychologists	2.0
July 1, 2019	Substance Use Outpatient & Methadone Clinic	2.0
July 1, 2019	Substance Use Intensive Outpatient	2.0
July 1, 2019	Mobile Psych Nursing	5.0
July 1, 2019	Clozaril Support	3.0
July 1, 2019	Assertive Community Treatment Team/Community Treatment Team	2.0
July 1, 2019	Peer Support Services	2.0
July 1, 2019	TCM- Mental Health and Substance Abuse	5.0
July 1, 2019	BHRS After School and STAP	2.5
July 1, 2019	BHRS Behavioral Specialist Consultation	5.0
July 1, 2019	BHRS Mobile Therapy	5.0
July 1, 2019	BHRS Therapeutic Staff Support	20.0
July 1, 2019	BHRS Music and Art Therapy	5.0
July 1, 2019	BHRS Flexible Outpatient	5.0
July 1, 2019	Mental Health CRR-Host Home and Group Home	2.5
July 1, 2019	Substance Use Outpatient & Methadone Clinic	2.0
July 1, 2019	Substance Use Intensive Outpatient	2.0
July 1, 2019	Substance Use Partial Hospitalization	2.0

Table 5

CABHC Ambulatory Service Rate increases since 2018

Effective date of Rate change	Service Category	% Rate increase
Jan 1, 2021	Mental Health Outpatient, Psychiatrists, Psychologists	2.5
Jan 1, 2021	Mental Health Partial Hospitalization	2.0
Jan 1, 2021	Substance Use Outpatient & Methadone Clinic	2.5
Jan 1, 2021	Clozapine Support Services	2.5%
Jan 1, 2021	Mobile Psych Nursing	2.5
Jan 1, 2021	Family Based Services C&A	2.5
Jan 1, 2021	Psychiatric Rehabilitation Services	2.5
Jan 1, 2021	Assertive Community Treatment Team/Community Treatment Team	2.5
Jan 1, 2021	Peer Support Services	2.5
Jan 1, 2021	Outpatient Substance Use Supplemental services including Partial, TCM, and IOP	2.5
Jan 1, 2021	Substance Use OP Other Supplemental (Recovery Support Services and Buprenorphine Care Coordination)	2.5
Jan 1, 2021	Mental Health General	2.5
Jan 1, 2021	Psychiatric Outpatient Mobile Services	2.5
Jan 1, 2021	IBHS MST/FFT	2.5
Jan 1, 2021	IBHS MT	2.5
Jan 1, 2021	IBHS BHT	2.5
Jan 1, 2021	IBHS BSC	5.0
Jan 1, 2021	IBHS STAP and After School	5.0
Jan 1, 2021	IBHS ABA BCBA and BA Services	5.0
Jan 1, 2021	IBHS IDT & JFACTS	8.0
July 1, 2021	Substance Use Outpatient Clinics	7.5
July 1, 2021	Substance Use Methadone Clinics	7.5
July 1, 2021	Substance Use Intensive Outpatient	7.5
July 1, 2021	Substance Use Partial Hospitalization	7.5
July 1, 2021	Mental Health Outpatient, Psychiatrists, Psychologists	7.5
July 1, 2021	Mental Health Partial Hospitalization	7.5
May 1, 2022	Mental Health Outpatient	5.0
May 1, 2022	Substance Use Outpatient	5.0
May 1, 2022	Outpatient Substance Use Methadone Maintenance: 5% increase	5.0
May 1, 2022	Clozapine Support Services: 5% increase	5.0
May 1, 2022	Mobile Psych Nursing: 10% increase	10.0

Table 5

CABHC Ambulatory Service Rate increases since 2018

Effective date of Rate change	Service Category	% Rate increase
May 1, 2022	Family Based Mental Health Services: 10% increase	10.0
May 1, 2022	IBHS: 5%, 10% 15% or 20% increase (please see specific procedure codes and rates)	15.0
May 1, 2022	IBHS Groups	10.0
May 1, 2022	MST: 15% increase	15.0
May 1, 2022	FFT: 15% Increase	15.0%
May 1, 2022	CRR HH: 20% increase	20.0
May 1, 2022	Music Therapy: 10% increase	10.0
May 1, 2022	Psychiatric Rehabilitation Services: 10% increase	10.0
May 1, 2022	ACT/CTT: 10% increase	10.0
May 1, 2022	Peer Support Services: 10% increase	10.0
May 1, 2022	MH TCM (RC, BCM, ICM): 10% increase	10.0
May 1, 2022	Substance Use TCM: 10% increase	10.0
May 1, 2022	Substance Use Other Supplemental (Recovery Support Services and Buprenorphine Care Coordination): 10% increase	10.0
May 1, 2022	Mental Health General: 5% increase	5.0
May 1, 2022	Psychiatric Outpatient Mobile Services: 5% increase	5.0

Source: Provided by PerformCare.

In September of 2022, PerformCare's Tuscarora Managed Care Alliance granted an 18 percent rate increase for all ambulatory services, including:

- Mental Health and Substance Use Outpatient
- MH Partial Hospitalization
- Outpatient Substance Use Methadone Maintenance
- Clozapine Support Services
- Family Based Mental Health Services
- [Intensive Behavioral Health Services]
- [Multisystemic Therapy]
- [Community Residential Rehabilitation—Host Home]
- Peer Support Services
- [Mental Health Targeted Case Management]
- Substance Use Other Supplemental (Recovery Support Services)
- Mental Health General
- Psychiatric Outpatient Mobile Services.[252]

Beacon reported an average five percent change overall from 2018 to 2019.[253] Beacon also provided a comparison of the change from 2018-2019 and the change from 2018-2020. Representatives stated that a single year comparison does not reflect the dynamic nature of rate changes from year to year and county to county. Representatives also reminded Commission staff that measuring a percentage change is an incomplete picture of the change, as a provider initially receiving a higher rate may have a lower percentage rate change than a provider that received a significantly lower rate that was then adjusted to be similar to the first provider. The example provided by Beacon representatives was a rate change from $400 to $450 compared to a rate change of $100 to $300. The difference in starting points of rates would make the second percentage change look much more significant than the first, even though the first would still leave a provider with a higher rate.[254]

[252] Correspondence with PerformCare, March 22, 2023.
[253] Meeting with Beacon, March 17, 2023.
[254] Email Correspondence with Beacon, May 3, 2023.

Table 6

Beacon Percentage Rate Changes by Level of Care

Service Code	Modifier	Description	Avg % change 2018-19	Avg % change 2018-20
0126	--	Inpatient Substance Use Disorder Detox	2%	5%
0128	--	Inpatient Substance Use Disorder Rehab	1	1
90832	HF	Substance Use Disorder Individual Psychotherapy	4	6
90834	HF	Substance Use Disorder Individual Psychotherapy	1	3
90837	HF	Substance Use Disorder Individual Psychotherapy	12	12
90853	HF	Substance Use Disorder Individual Psychotherapy	0	6
99202	U7	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.	0	0
99204	U7	OV/OP Visit for Eval & Mgmt. of New Patient, Problem Moderate to High, face to face w/patient and/or family (Comprehensive Medical Exam & Eval)	0	0
99211	HF	Management of an established patient, that may not require the presence of a physician or other qualified care professional	0	1
99211	U7	Management of an established patient, that may not require the presence of a physician or other qualified care professional	0	0
99215	U7	Office or other outpatient visit for the evaluation and management of an established patient (Chemotherapy clinic visit for administration and evaluation of drugs other than methadone or drugs for opiate detox)	0	1
H0013	--	Alcohol and/or drug services; acute detoxification (residential addiction program outpatient) (*ASAM 3.7 WM*)	4	9
H2034	--	Alcohol and/or drug abuse halfway house services, per diem (*ASAM 3.7 WM*)	3	11
H0047	HA	Individual	0	0
H0047	U6	Substance Use Disorder Recovery Specialist	1	1
H0018	HF	Non Hospital Residential Rehabilitation	3	7
T2048	HF	Long Term Rehab 3.5	2	10

Source: Provided by Beacon Health Options.

Community Care Behavioral Health Organization provided changes in the amounts paid and units paid from 2018 to 2019. Unit costs do not represent rates, so the decrease in a unit cost means providers were billing a higher amount of lower cost codes in 2019 for MAT. Over the levels of care provided, rate increases ranged from 2.4 to 16 percent.[255]

Table 7

Community Care Behavioral Health Rate Changes

Level of Care	2018			2019			Year over Year		
	Amount Paid	Paid Units	Unit Cost	Amount Paid	Paid Units	Unit Cost	Amount Paid	Paid Units	Unit Cost
Ambulatory D&A	$49,271,924	2,496,228	$19.74	$52,190,122	2,629,230	$19.85	5.9%	5.3%	0.6%
Inpatient D&A	6,108,918	8,692	702.82	7,098,007	10,006	709.38	16.2	15.1	0.9
MAT	40,233,266	974,544	41.28	41,212,335	1,015,361	40.59	2.4	4.2	-1.7
SUD Residential Services (Health Choices)	137,226,152	694,277	197.65	147,094,358	736,623	199.69	7.2	6.1	1.0
Total	232,840,261	4,173,741	55.79	247,594,822	4,391,220	56.38	6.3	5.2	1.1

Source: Provided by Community Care Behavioral Health Organization.

[255] Email Correspondence with Matthew Hurford, President and Chief Executive Officer of Community Care Behavioral Health Organization, May 24, 2023.

Magellan reported an average increase of 10.44 percent for rates for Drug and Alcohol Treatment from 2018-2019 and a 6.15 percent increase from 2019-2020.[256] The rate change percentage broken down by level of care is as follows:

Table 8

Magellan Percentage Rate Changes by Level of Care
2017-2018, 2018-2019

Level of Care	2017-2018	2018-2019
Assessments	17.78%	3.00%
Halfway House	9.85	9.21
Inpatient Detox	3.75	5.00
Inpatient Rehab	4.43	5.00
IOP	3.00	10.00
NH Detox	10.09	5.07
NH Rehab	8.44	4.35
OP	4.00	10.04

Source: Provided by Magellan Behavioral Health of Pennsylvania

Community Behavioral Health provided a summary of their rate increases in 2018 and 2019 by description and level of care. Of Community Behavioral Health's 28,356 contracts as of October 20, 2019, 11,987 received increases in 2018 and 2019.[257]

Table 9

Community Behavioral Health Percentage Rate Changes by Level of Care
2018-2019

Description	Effective Date	Rate Increase	Count of Levels of Care	Count of Providers
Expanding Capacity for Withdrawal Management in Residential Drug and Alcohol Levels of Care and Crisis Response Centers #1	10/1/2018	When MAT designated = 5% if large provider; 10% if small provider	4	9 providers across 9 locations

[256] Meeting with Magellan, March 24, 2023.
[257] Data provided by Community Behavioral Health, May 2, 2023.

Table 9

Community Behavioral Health Percentage Rate Changes by Level of Care 2018-2019

Description	Effective Date	Rate Increase	Count of Levels of Care	Count of Providers
Expanding Capacity for Withdrawal Management in Residential Drug and Alcohol Levels of Care and Crisis Response Centers #3	10/1/2019	$989	1	2 providers across 2 locations
Diagnostic Laboratory Services in Outpatient Drug and Alcohol Clinics	9/17/2018	$10.60 to $11.63 per event; 9.72% rate increase	2	15 providers across 18 locations
Rate Increase for Board Certified Behavior Analyst (BCBA®) Providing Applied Behavior Analysis (ABA)	11/1/18 for $31.25; 1/1/2019 for $35.00	$31.25 to $35.00 per 15 minutes; 12.00% rate increase	1	17 providers across 19 locations
Outpatient Prescriber Rate Increase	1/1/2019	10%	MHOP LOCs - 11 NPOP LOCs - 20 DAOP LOCs - 6 **TOTAL LOCs = 37**	128 providers across 311 locations
Standard Rate Level of Care Rate Increase	5/1/2019	5%	AIP LOCs - 2 MHOP LOCs - 36 DAOP LOCs - 13 Family Based - 1 Case Mgmt - 3 MPRS - 1 **TOTAL LOCs = 56**	203 providers across 499 locations
Non-Standard Rate Level of Care Rate Increase Bulletin has 50 LOCs. Removed 10 and added 9 to yield 49 LOCs.	7/1/2019	5%	AIP LOCs - 4 IP D&A LOCs - 2 NH D&A LOCs - 3 MHOP LOCs - 14 BHRS LOCs - 6 RTF LOCs - 4 CS LOCs - 10 Other LOCs - 6 **TOTAL LOCs = 49**	49 providers across 92 locations
BHRS Standard and Non-Standard Level of Care Rate Increases	7/1/2019	5%	MHOP LOC - 1 BHRS LOCs - 22 **TOTAL LOCs = 23**	43 providers across 62 locations

Table 9

Community Behavioral Health Percentage Rate Changes by Level of Care 2018-2019

Description	Effective Date	Rate Increase	Count of Levels of Care	Count of Providers
Updates to PRTF and RTF Referral Process: Pre-Admission Interview Requirement	8/1/2018	$115.00 per event	1	9 providers across 17 locations
RTF Rate Increase	10/1/2018	Various	4	5 providers across 14 locations
Net Access Point	1/1/2019	$647.41 per event	1	1 provider across 1 location
Provider Initiated Rate Request	Various	Various	AIP LOCs - 5 NH D&A LOCs - 4 MHOP LOCs - 9 BHRS LOCs - 1 RTF LOCs - 3 Case Mgmt - 1 Other LOCs - 2 **TOTAL LOCs = 25**	23 providers across 64 locations

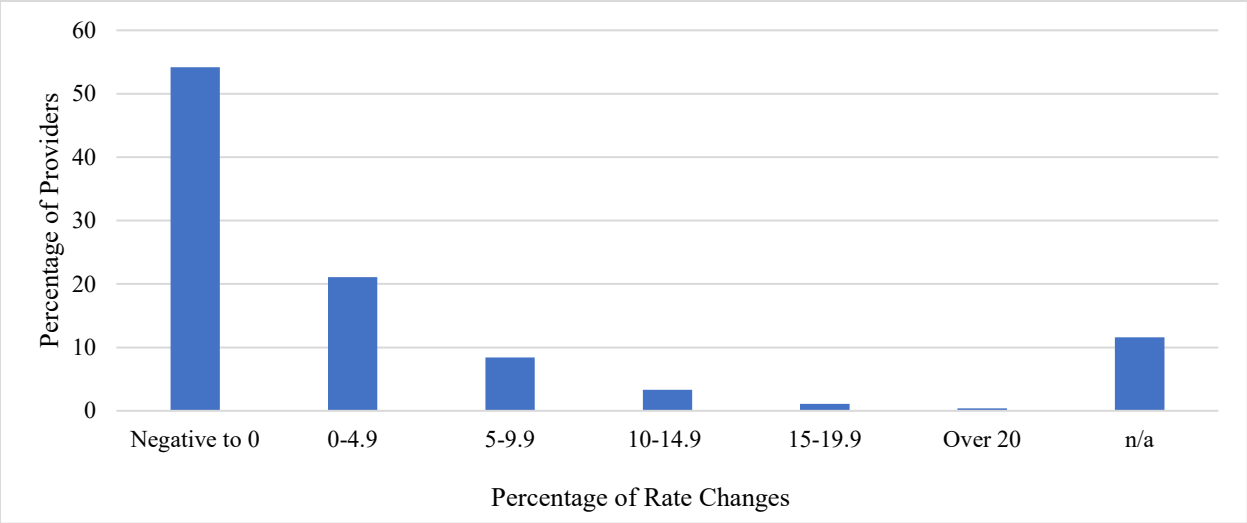
Source: Provided by Community Behavioral Health.

SCA Rate Changes

PACDAA posts the rates it approves for providers based on the XYZ Package on its website each year. This list is not representative of every rate offered by a BH-MCO, but as the BH-MCOs often use the XYZ rate, it is a helpful reference for the change of rates each year for the past four years. The website lists the name of each provider, the rate from the previous year where applicable, the target population, and the ASAM Level of Care provided. Using this information, Commission staff calculated the percentage change in rates each year by comparing the rate from the current year to the rate from the previous year where possible. As the number of providers is subject to change each year as facilities are opened and closed, calculating change for a single provider over multiple years is challenging. Therefore, Commission staff analyzed the percentage rate changes for each year separately.

Chart 3

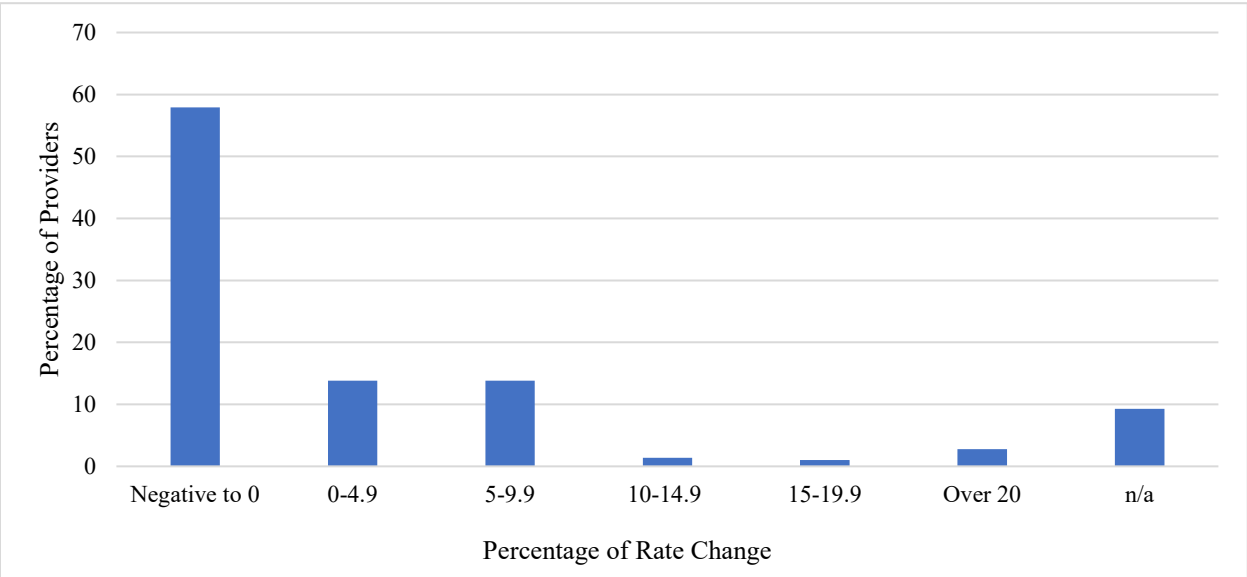
Percentage of XYZ Rate Changes
2018-2019



In 2018-2019, about 54 percent of providers had either no increase or a decrease in rates. About 21 percent of providers had an increase of less than five percent. About 12 percent were new providers and therefore had no change recorded. Around 13 percent experienced between five and 20 percent increases. One provider received an increase over 20 percent.

Chart 4

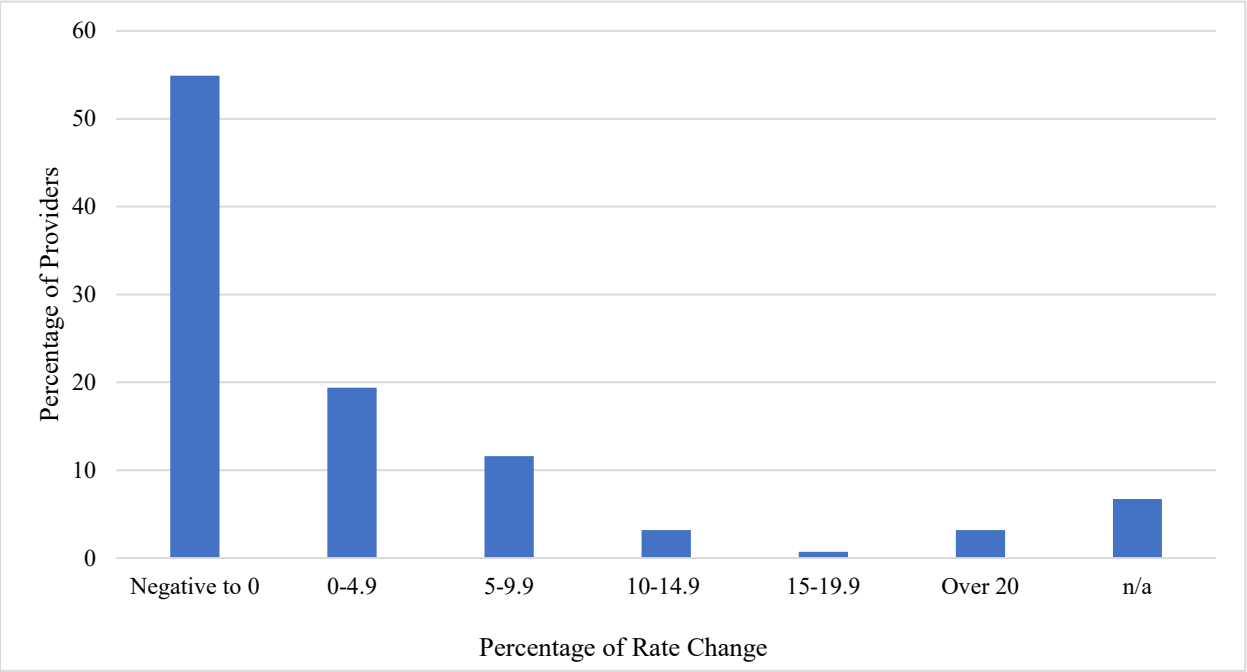
Percentage of XYZ Rate Changes
2019-2020



In 2019-2020, almost 58 percent of providers received a decrease or no increase in rates. Almost 14 percent received an increase under five percent and the same amount received an increase between five and 10 percent. Around nine percent of providers were new and had no change recorded. Around two and a half percent received an increase between 10 and 20 percent, and eight providers received changes of over 20 percent.

Chart 5

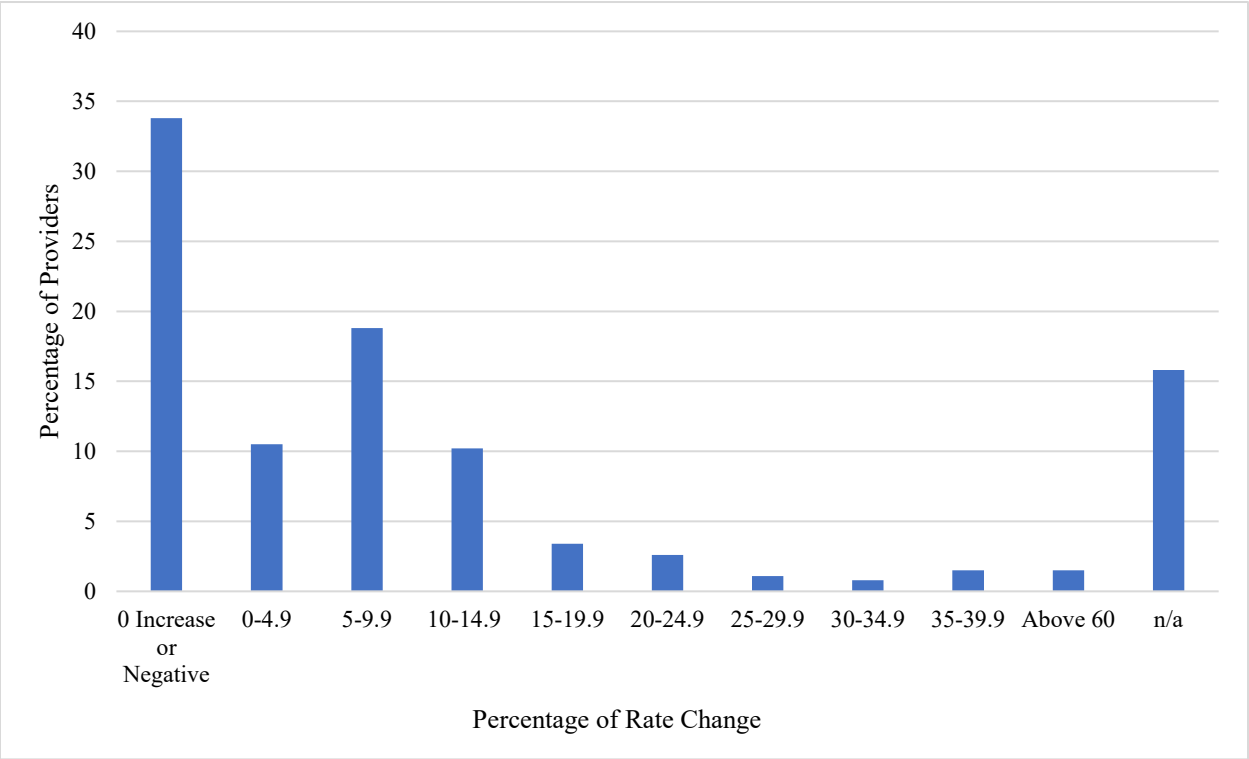
Percentage of XYZ Rate Changes
2020-2021



In 2020-2021, about 55 percent had no increase and almost 20 percent had an increase of less than five percent. Slightly over 15 percent had an increase between five and 20 percent, and nine providers had an increase of over 20 percent. Almost seven percent of providers were new and therefore had no change.

Chart 6

Percentage of XYZ Rate Changes
2021-2022



In 2021-2022, almost 34 percent of providers had no increase and around 10 percent had an increase of less than five percent. Around 19 percent had an increase of between five and ten percent. Around 14 percent had an increase between 10 and 20 percent and six percent had an increase between 20 and 40 percent. Four providers had increases above 60 percent and 42 providers were new and therefore did not have an increase.[258]

[258] Information from PACDAA's Website "Single County Authority Rate Setting," https://www.pacdaa.org/rate-setting.

RECOMMENDATIONS

Based on the research conducted and stakeholder feedback collected throughout this report, the Joint State Government Commission staff make the following recommendations:

Recommendation 1: *The Process for Developing Reimbursement Rates Should Be Made More Transparent.*

Because Pennsylvania leaves many decisions to counties regarding administration and policy, the managed care program opens itself to a tremendous amount of variety in administration, policy, and medical unit rates set. Though there is rationale for the various funding arrangements and choices, very little of this information is publicly available, leading to confusion for providers on where the capitation funding goes and how increases in state capitation affect providers. Many conversations with primary contractors and BH-MCOs highlighted common practices used in the different levels of the system that were not formalized or standardized, therefore the positive or negative feedback from a single primary contractor, BH-MCO, or provider could not be applied to the system. The Program Standards and Requirements for the HealthChoices Behavioral Health Program are designed to give primary contractors and BH-MCOs flexibility in determining reimbursement rates for services that reflect the unique needs of their population. However, some formalization or documentation of the factors taken into consideration when making these decisions would increase transparency and provider confidence in the system. A requirement for primary contractors to include this information could be written into the Program Standards and Requirements.

Recommendation 2: *Providers Should Be Properly Trained to Submit Financial Information.*

One common concern from the primary contractor/BH-MCO perspective was the request of a rate increase without sufficient cost data that would support the need for an increase. Though in some situations it appeared that an increase was not justified, one primary contractor stated that some smaller providers simply do not have the staff or resources to prepare the kind of information a BH-MCO would request. They recommended that primary contractors or BH-MCOs take on the responsibility of ensuring that providers are trained to submit complete and accurate financial information when requesting a rate increase.

Recommendation 3: *BH-MCOs Should Give Providers Explanations for Rate Increase Denials or Counteroffers.*

The Program Standards and Requirements for the HealthChoices Behavioral Health Program require providers to meet a plethora of quality and financial standards to qualify for the program. The standards and requirements are much looser in their requirements of primary contractors and BH-MCOs to be transparent with providers in their rate setting process. Currently, the requirement is only for primary contractors/BH-MCOs to have a rate setting process that includes the opportunity to request an increase, the information required to be submitted, and finance strategies like performance incentives that the primary contractor or BH-MCO may employ. Primary contractors and BH-MCOs are not required to justify to a provider their denial or counteroffer of a rate increase requested by a provider. Without clearly stated reasons for a denial or counteroffer, providers are uninformed as to the defect in their request and are not given adequate information to improve the next request or to appeal it. Though some BH-MCOs said they do provide an explanation, none offered a formal policy or a standard letter used to explain the financial analysis that led to their decision. When listening to provider and primary contractor/BH-MCO feedback about the rate negotiation process, Commission staff were often unable to corroborate claims on either side because of a lack of formal policy and documentation. A requirement to formalize more steps in the negotiation process could be added into the Program Standards and Requirements to increase transparency between providers and BH-MCOs.

Recommendation 4: *SCAs Should Give Providers Explanations for Rate Increase Denials or Counteroffers.*

Similarly, SCAs are not required to justify the denial of a rate increase after an XYZ Package is submitted until a formal appeal is filed. The SCA process is not officially linked with managed care, but anecdotally many BH-MCOs use the XYZ Package's cost-based rates with their providers when applicable. Therefore, if providers are unsatisfied with the XYZ rate they are offered, they will also be unsatisfied with the BH-MCO's rate. Similar to the BH-MCOs, some SCAs do provide explanations along with a denial or counteroffer, but with 47 SCAs in the state and no standardized requirement to do so, the experience of different providers can vary. An explanation is not required until a provider submits a formal appeal to the SCA, but without justification for the denial or counteroffer, it is challenging for providers to defend their original requested amount or properly revise it. A standardized policy for explanation of rate decisions from SCAs could increase transparency and reduce provider frustration.

Recommendation 5: *Funding Opportunities Should Focus on Sustainable Rate Increases instead of Inconsistent Lump Sums.*

Providers were thankful for lump sum payment incentives, as additional funding is always valued, however, they indicated that a value-based purchasing incentive or other incentives that granted a rate increase would be a more effective tool. Providers cannot budget throughout the year on a lump sum payment that they may or may not receive based on whether they meet a certain quality threshold. Incentives that would lead to a sustained rate increase in the following years would be preferred.

CONCLUSION

The capitation rates developed by DHS in collaboration with its actuary, Mercer, follow the federal actuarial standards that consider experiential data and trending based on industry reports. The effects of inflation including rising costs of living and workforce and salary demands are not specifically named as factors in the actuarial calculations, but much of this information would be incorporated in the previous year's financial reporting and experience data. Regional differences are considered in the calculations, as the capitation rates are developed by county or multi-county entity. The current workforce challenge is one area that providers indicated could be more robustly discussed in conversations about rising costs.

The amount of capitation funding used by BH-MCOs on SUD patients ranges from 15 to 29 percent, meaning that BH-MCO members utilize mental health treatment services more than SUD services. Utilization of SUD services has trended upward as more services have been covered. The percentage of capitation funding used on administrative or non-benefit expenses is capped by the federal standards at 15 percent, but hovers around 10 percent in Pennsylvania's BH-MCOs. BH-MCOs or primary contractors can maintain reinvestment funds to invest some funding into starting new services, but these reinvestment funds are capped at three percent annually.

BH-MCOs must file their rate increase request policies with DHS for approval. These plans outline the process by which a provider can request a rate increase, but do not outline a policy for how exactly requests must be analyzed and evaluated, nor how detailed responses to providers should be. All BH-MCOs cooperated with questions about the official policies and freely shared them, though the evaluation and analysis did not appear to be standardized or documented publicly.

Provider-level data on the increase in specific reimbursement rates from 2018 to 2019 was not available to Commission staff. Instead, Commission staff included some information that would not require any BH-MCOs to reveal proprietary information and would be easily comprehensible.

Some stakeholders questioned whether it was possible to trace the exact amounts of funding at each level of this process for SUD services as it would require a review of financial reports for 24 contractors and each of their contracts with BH-MCOs to attempt to parse out dollar amounts of spending for specific purposes. Nonetheless, Commission staff attempted to detail the process and stipulations primary contractors and BH-MCOs follow to distribute funds.

Pennsylvania's managed care system is built to support its decentralized structure: counties are given flexibility to create programs that best support their specific population's needs. Though accounting for regional differences in spending is a way to ensure that funding is being used responsibly, there are small elements of standardization that could alleviate some pressure on providers to understand many aspects of a complicated system.

APPENDICES

PRINTER'S NO. 1964

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE RESOLUTION

No. 352 Session of 2022

INTRODUCED BY BROOKS, OCTOBER 11, 2022

REFERRED TO HEALTH AND HUMAN SERVICES, OCTOBER 11, 2022

A RESOLUTION

Directing the Joint State Government Commission to study and issue a report on the specific data, calculations and mechanisms that the Department of Human Services utilizes to determine the amount of Medical Assistance capitation funding that is ultimately paid to drug and alcohol addiction treatment providers within this Commonwealth.

WHEREAS, This Commonwealth is among the top 10 states with the highest drug overdose death rate in this country, with approximately 42 deaths per 100,000 citizens recorded in the year 2020; and

WHEREAS, In 2021, at least 15 Pennsylvanians died each day due to a drug overdose; and

WHEREAS, The rate of drug overdose deaths and the need for drug and alcohol addiction treatment has increased in recent years due to the increased availability of fentanyl and xylazine; and

WHEREAS, The cost of providing drug and alcohol addiction treatment services has also increased due to workforce challenges exacerbated by the COVID-19 pandemic and heightened supply costs due to inflation; and

WHEREAS, The increased demand for addiction treatment services is directly impacting this Commonwealth's health care system, in which acute care hospitals are unable to find available settings to discharge patients or to transition patients to postacute care or treatment facilities; and

WHEREAS, The unprecedented demand for mental and behavioral health services post-COVID-19 pandemic has been echoed by increased rates of attempted and completed suicides among youth and young adults and individuals with substance use disorders; and

WHEREAS, This Commonwealth's reimbursement for drug and alcohol addiction treatment services is complex and includes:

(1) The Department of Drug and Alcohol Programs, which administers the Substance Abuse Prevention and Treatment Block Grant.

(2) The Department of Human Services, which pays for Medicaid-covered services.

(3) The 47 administrative entities called Single County Authorities, which utilize county and block grant funding to reimburse services for those not covered by Medicaid.

(4) The Behavioral HealthChoices managed care organizations that contract with a county to coordinate the delivery of Medicaid-covered services through a network of drug and alcohol addiction treatment providers; and

WHEREAS, Financing drug and alcohol addiction treatment and care coordination is complex, and it is unclear how funding allocated to these programs by the General Assembly is being directed toward reimbursing providers that support increasing access to care and making quality-based program improvements;

and

WHEREAS, Medicaid spending increases each year, requiring the Department of Human Services to make annual supplemental appropriation requests to cover program costs; and

WHEREAS, These drug and alcohol addiction treatment providers have not seen rate increases consistent with expanding demands; therefore be it

RESOLVED, That the Senate direct the Joint State Government Commission to study the specific data, calculations and mechanisms that the Department of Human Services utilizes to determine the amount of Medical Assistance capitation funding that is ultimately paid to drug and alcohol addiction treatment providers within this Commonwealth, including:

(1) explaining the allocation of funding distributed by the Department of Human Services to the county and from the county to the county's contracted Behavioral HealthChoices managed care organization;

(2) determining the process that the Department of Human Services utilizes to collect cost-reporting data from drug and alcohol addiction treatment providers and the extent to which the cost-reporting data and other information, including, but not limited to, the following, are used to determine reimbursement rates:

(i) increases in the general cost of living;

(ii) inflation;

(iii) capital depreciation and amortization costs;

(iv) workforce and salary demands;

(v) regional differences; and

(vi) other information that the commission finds relevant in the calculation that informs the Medicaid

capitation allocation;

(3) at a county level, confirming the information and data that informs the amount of county funding that is allocated to a county's Single County Authority; and

(4) at the managed care organization level, using data from fiscal year 2019 as a reference:

(i) determining the portion of the organization's capitation funding that was used to reimburse drug and alcohol addiction treatment providers for services provided;

(ii) reporting anonymized provider-level data on the percent change in provider reimbursement rates over the previous fiscal year; and

(iii) reporting on the policies and mechanisms of managed care organizations to afford providers a meaningful opportunity to negotiate reimbursement rates that account for increased demand for services and quality improvements;

and be it further

RESOLVED, That the Joint State Government Commission be authorized by the General Assembly to discuss proprietary information with the Department of Human Services' actuary in pursuit of this study; and be it further

RESOLVED, That the Joint State Government Commission issue a report of the findings, along with any statutory or regulatory recommendations, within seven months of the adoption of this resolution to the:

(1) Chair and minority chair of the Appropriations Committee of the Senate.

(2) Chair and minority chair of the Appropriations

Committee of the House of Representatives.

(3) Chair and minority chair of the Health and Human Services Committee of the Senate.

(4) Chair and minority chair of the Human Services Committee of the House of Representatives.

SCA - Provider
XYZ PACKAGE

UNIFORM RATE SETTING PACKET

FISCAL YEAR 2022-2023

Providers must use the forms and package currently posted on the PACDAA website. Earlier versions of these forms will not be accepted.

TIMELINE for 2022-2023

November 1st	Provider audits due to SCAs, unless otherwise specified in the DDAP/SCA Grant Agreement
By or before March 2nd	Providers submit the completed XYZ package to the SCA
By or before April 15th	SCAs respond to providers with the approved rates
Between April 15th – April 30th	Provider appeals are submitted to the SCA
April 30th – May 15th	Appeals that are unable to be resolved at the SCA level are submitted to DDAP
By or before June 1st	SCA posts rates to PACDAA's webpage

Provider appeals to the decision made for the Fiscal Year 2022-2023 rate request must be made in writing to the home SCA. Requests must include the information or facts that support the appeal.

No less than three SCAs, one of which must be the home SCA, must be involved in the rate setting review process. At a minimum, the SCA Administrator and Fiscal Officer from each SCA must participate in the review of the XYZ package submitted by providers. An SCA employee with a comprehensive understanding of the programmatic aspects of treatment must participate in the review. This SCA committee may ask to meet with the provider staff to clarify answers submitted in the rate setting package.

All rates must be entered onto the PACDAA website (www.pacdaa.org) Rate Setting Section by the home SCAs on or before **June 1, 2022.**

Program/Service:	
Agency:	
Address:	
Facility License #:	
Contract Contact Person:	
Phone Number:	
Email Address:	

FY 2022-2023 Rate Setting Appeal Process

Treatment Provider Appeal Process:

Appeal Action	Appeal Committee:
Level 1 Appeal: If a treatment provider is unsatisfied with the results of the negotiation process or the rate being offered by the Single County Authority (SCA), that provider may appeal in writing to the SCA for reconsideration.	- SCA - SCAs from surrounding areas
Level 2 Appeal: If a provider is dissatisfied with the results of the Level 1 appeal, that provider may appeal in writing to DDAP for reconsideration. All relevant documentation and correspondence (see below) must be included in the submission and can be sent to RA-DABAPS@pa.gov.	- DDAP Deputy Secretary - DDAP Special Assistant to the Secretary - DDAP Bureau Director, Quality Assurance and Administration - DDAP County Program Oversight (optional) - Input may be requested of SCAs or additional stakeholders as needed by DDAP

Single County Authority Appeal Process:

Appeal Action	Appeal Committee:
If an agreement cannot be reached between an SCA and a provider regarding a non-hospital inpatient rate, the SCA may make a written request for final determination from DDAP. All relevant documentation and correspondence (see below) must be included in the submission and can be sent to RA-DABAPS@pa.gov.	- DDAP Deputy Secretary - DDAP Special Assistant to the Secretary - DDAP Bureau Director, Quality Assurance and Administration - DDAP County Program Oversight (optional) - Input may be requested of SCAs or additional stakeholders as needed by DDAP

Documentation: Documentation for consideration of an appeal to a disputed rate must include all materials submitted to the SCA review committee, including the XYZ Packet. All correspondence between the SCA review committee and the provider, related to the Level 1 Appeal to the SCA appeal committee, must also be provided. Finally, providers may submit any additional materials, such as financial documents that will further substantiate their request for a rate different from that offered by the SCA review committee.

SCAs submitting an appeal to DDAP must provide justification for the non-acceptance of a rate or rates submitted by a provider.

FISCAL YEAR 2022-2023

RESIDENTIAL SERVICES REQUEST FOR INFORMATION CHECKLIST

In order to be considered for a per diem rate with the SCAs, please complete all referenced documents on this RFI Checklist and submit to the home SCA of this facility.

Section A - Eligibility Criteria Checklist

- ✓ Submit a copy of the current Department of Drug and Alcohol Programs (DDAP) or home state license. (If you do not yet have a current license, please request a letter confirming licensure from the Division of Drug and Alcohol Licensing.)
- ✓ If your program is licensed as a dually diagnosed facility, submit a copy of the current Department of Human Services (DHS) license.
- ✓ Submit a copy of the most recent year's independent audit report and management letter. If a program specific audit is not required, a financial statement is acceptable, signed by the facility director/CEO and the Chief Fiscal Officer attesting to its accuracy and have the statement notarized.
- ✓ Submit documentation of sixty (60) day cash operating capability (i.e., letter of credit, documentation of other revenue source).
- ✓ Submit a notarized statement indicating there is no evidence of civil or criminal violations against the management or any employee of the licensed facility during the previous two years, and adherence to one of the industry's recognized code of ethics (e.g. PCACB). If a notarized statement is not included with the eligibility checklist, please explain the nature of any confirmed ethical or criminal violations against any facility staff within the previous two years.
- ✓ Submit a program Organizational Chart
- ✓ Tax/Compensation Attestation Form (Attached)
- ✓ Submit Act 33 and Act 34 Compliance Certification (Attached) - Provide a certification that your agency, if treating adolescents, is in compliance with Act 33-1985 amending the Child Protective Services Law and Act 34.
- ✓ Complete Section B (Program Description General Information) attached.
- ✓ Complete Section C (Program Description Specific Information for **Each** service activity) attached.
- ✓ Complete Per Diem Rate Determination Process for **Each** Service Modality/Activity by completing and submitting the following forms for each Activity:
  1. Personnel Roster - HDA 313RS (Accompanying Excel Workbook)
  2. HDA 311RS – Page 1 (Revenues) & Page 2 (Expenses) (Accompanying Excel Workbook)
  3. Budget Narrative (Attached)
  4. Rate Request Form (Attached)

This is to certify that_____

has paid corporate, federal, and state income taxes (if applicable); paid the employers share of and has withheld the correct amount of income taxes, F.I.C.A. taxes, and unemployment compensation and workmen's compensation taxes or premiums from employees' salaries as required by law, and has remitted such amounts to the appropriate federal, state, and local level of government.

_____ _____

Date Signature

_____

Title

Act 33 and Act 34 Compliance Certification

This is to certify that _____

is aware of and is in compliance with the obligations of Act 33 of 1985 (Child Protective Services Law) and Act 34 (Pro Children's Act of 1994 for program serving minors).

_____ _____

Date Signature

_____

Title

Section B - Program Description General Information

Agency Name:
Activity:

Provide a brief description of provider's target population and program description

1. Please provide the demographics of your population served within the last six-month period, including **race**, **ethnicity**, **gender**, **age** and **pregnant women**.

   1.

2. Document staff composition as it compares to the population your program serves. Please break out clinical staff (including nurses and medical staff) from administrative staff.

   2.

3. Submit evidence, in the form of a statement to this fact, of persons in recovery representing your governing or advisory board. Describe the number and composition of your agency's governing or advisory board. (Persons in recovery representation is defined as an individual with a prior history of drug or alcohol dependency.)

   3.

4. Providers must verify experience in serving the Medical Assistance or MA clients. Show evidence of your experience by including socio-economic data, to include percentages of clients on Medical Assistance, SCA, or percentages of clients by income level.

   4.

5. To whom should communication regarding contract compliance be directed to (i.e. programmatic issues, monitoring reports, audit issues, etc.)?

   5.

6. Who is responsible for oversight and day to day decision making at the local level for the facility?

   6.

Section C - Program Description Specific Information

Agency Name: _____

Program Description

It is important that front line assessment personnel know as much about your program(s) as possible to ensure the best treatment match. Please complete the checklist below and attach narrative items A through Q for each unique service activity you offer at your facility(ies). Description should be brief and concise; thus your narrative is to be limited to one-third page. Do not use attachments unless specifically requested.

Example: You offer a clinically managed residential program for adults (3.5). There are no special tracks or target populations. You would only complete one checklist and one narrative. If you also offer a co-occurring program for this same population, you would complete an additional checklist and narrative to present this program.

NOTE: The development of a rate for treatment services may take into consideration other clinical activities that are not part of the therapeutic array of services, some of which may be required by regulation, such as aftercare planning as well as the management of non-treatment needs while an individual is in the treatment program. The rate may *not* include the provision of case management activities that are required in the DDAP Treatment Manual, such as screening, level of care assessment, and completion of reporting requirements for specialty grants.

Program Type: Only programs that have both a drug and alcohol license and a mental health license can be classified as dual diagnosed/Co-occurring.

- ☐ Medically Monitored Inpatient Withdrawal Management (3.7WM)

- ☐ ☐ Medically Monitored Intensive Inpatient Services - Adult (3.7) **
- ☐ ☐ Medically Monitored High-Intensity Inpatient Services – Adolescent (3.7) **
- ☐ ☐ ☐ Clinically Managed High-Intensity Residential Services – Adult (3.5)
- ☐ ☐ Clinically Managed Medium-Intensity Residential Services – Adolescent (3.5)

- ☐ ☐ Clinically Managed Low-Intensity Residential Services Adult or Adolescent (3.1)

Check the ☐ if the program treats women and their children *together*.
Check the ☐ if the program offers co-occurring services *(must be licensed by DHS)*

**** If 3.7 is being delivered on a separate unit, a separate XYZ package shall be completed.**

****If 3.7 and 3.5 are being provided on the same unit within the facility, the provider will follow instructions on page 16 to calculate an enhanced cost for 3.7 which will then be added to the rate established for the 3.5 LOC when 3.7 services are provided.**

Service Activity

A. Program philosophy/mission statement:

A. _____

B. Target population: If coed, please include male/female ratio. If you provide other culturally specific tracks, i.e. deaf/hard of hearing, ethnocentric, LGBTQI, older adults, etc., please list and attach schedule of weekly activities for each. Indicate ratio of target group to the rest of the population, and other information to illustrate what you are providing in this target track that is different from/supplemental to your mainstream program. Show specialized staffing provided under section J.

B. _____

C. Admission criteria and protocol: Include any factors which would prohibit your program from serving a particular need (i.e. level of staffing is not sufficient to address particular physical or mental health needs, etc).

C. _____

D. Specialty Services: Describe any specialty services, including evidence-based practices (EBPs) that your facility is equipped to provide and explain how you tailor services to meet individualized needs.

D. _____

E. Describe the client bio-psychosocial history process, to include:

1. How many days after admission does this process occur?

   1. _____

2. How is this process used in the development of the client's treatment plan?

   2. _____

F. Types of Treatment Activities: Please list the types of services provided by your facility (e.g. individual, group, life skills groups, family groups, education services, specialized groups, twelve step attendance, etc.) and explain how you tailor services to meet individual need.

F. _____

G. Please indicate the minimum frequency that each service is provided in the space furnished:

1. Per Week

Individual Counseling: _____
Group Counseling: _____
Life Skills Groups: _____
Addiction Education: _____
Specialized Groups (i.e., women's, cocaine...): _____
Twelve Step Attendance (specify on or off-site): _____

2. Per Course of Treatment

Academic Services (specify): _____
Physical Exam: _____
Psychiatric Exam: _____
Medication Checks: _____
Psychological Testing: _____
Vocational Testing: _____
Other Services (please specify): _____

If specialized services are provided for clients with a co-occurring mental illness, please submit evidence of approval from the Office of Mental Health and Substance Abuse Services, OMHSAS (see Section A Checklist) and indicate frequency of the following:

Counseling with psychiatrist: _____
Social Worker: _____
Psychologist: _____
Specialized Groups: _____
Other (Define): _____

H. Transportation: Is transportation provided as part of service package?

H. _____

1. If yes, please mark/highlight all that apply: (include any limitations)

☐ Pick up for Admission: _____
☐ To and from support services: _____
☐ Drop off at discharge: _____
☐ Other (please specify): _____

2. If transportation is already part of the service package, the cost of that service must be included in the per diem calculation. Please state if there are any limitations on transportation (e.g., number of miles).

2. _____

I. **Staffing:** Please define your counseling staff by position, and identify their daily schedule availability for day or night coverage. As requested earlier in this package, include a program Organizational Chart. (Insert additional rows as needed):

Staff Position	Daily Schedule

If your counselor to client ratio is different than below, please explain any variance from the staffing requirements.

- For facilities serving adult clients - one FTE counseling staff is required for every eight clients.
- For facilities serving adolescent clients - one FTE counseling staff is required for every six clients.
- For facilities providing withdrawal management services - one FTE counseling staff is required for every seven clients.

Explain: _____

Withdrawal Management Only - Please state whether or not you have a physician on-call available at all times:

Explain: _____

If you do not have 24-hour awake staff coverage please explain:

Explain: _____

Please state the turnover rate for the administrative and clinical staff, both separately and combined, during previous fiscal year (FY20/21) – note these are three separate rate calculations:

Administrative Turnover: _____
Clinical Turnover: _____
Combined Staff Turnover: _____

Justify in writing if the turnover is greater than 30 percent. Evidence of staffing stability as measured by a management and clinical turnover rate which does not exceed 30 percent during the past year.

Explain:

Please identify any position that remained vacant in FY 2020-2021 for more than 60 days and explain why the delay occurred. Also, please identify positions that remained vacant for more than 60 days in the current fiscal year (2021-22).

Explain:

J. Provide your policy and procedure for the initial privileging/credentialing of clinical staff (for each type of clinical position). Also include your policy/procedure for re privileging/ credentialing during the period of a staff member's employment. Include evidence of any required competence in treating clients from multiple cultures and relate this back to item B., Target Population.

J.

K. Please identify any evidenced-based treatment protocols (as defined by SAMHSA) or promising practices, e.g. Motivational Interviewing, Motivational Enhancement Treatment (MET), Motivational Enhancement for Dual Diagnosed Consumers, Naltrexone or other medication agents or antagonists, methadone (protocol for withdrawal management and/or continuing clients on methadone while in their level of care); Suboxone/buprenorphine, clinicians and supervisors certified in Cognitive Behavioral Therapy, Stages of Change, Contingency Management, etc.

K.

L. If your facility is providing withdrawal management, please attach your withdrawal management protocol(s).

L.

M. Describe how you measure outcomes for your program and attach any reports for the prior year on your outcome measures.

M.

N. Please include a copy of any client grievance, complaint and/or appeal process distributed to clients in your facility. Also include a copy of your internal policy and procedure(s) addressing the issue of addressing client grievances or complaints.

N.

O. In fiscal year 2021-22, identify the percent of clients that completed the program as compared to the total number of clients admitted to the program?

O. _____

P. Please identify the target populations you intend to serve by filling in the below grid.

Facility #	Type of Service	Adult	Adolescent	Co-occurring	Male	Female	Pregnant Female	IDU	Rate Requested

Q.) Women with Children Programs only:

- Please provide prevention programming/services for children. Include age groups per activity and frequency of occurrence.

- Please describe mother's role, if any, in children's prevention services.

R. **Medication Assisted Treatment (MAT):** The following pertains to MAT practices within your facility.

1) How do you ensure that individuals on MAT are not excluded from admission to treatment within your facility?

2) How do you make available all forms of FDA approved medications for MAT within your facility?

3) How do you ensure coordination of care for clients on MAT when the prescriber is not your facility?

4) How do you educate individuals within your facility about MAT options?

RATE DEVELOPMENT INSTRUCTIONS

All providers must submit the enclosed Budget and supporting forms (Personnel Roster and Budget Narrative), as well as a Rate Request form, in order to establish a reimbursement rate for FY 2022-2023. This process has been standardized and will be used by all Single County Authorities (SCAs). The SCA in which the facility is physically located is considered the home SCA.

1. Personnel Roster

Providers must submit a Personnel Roster (HDA 313RS), which lists staff as Administrative or Client Oriented. For staff who provide both functions, salaries should be pro-rated across both categories. (See Administration definition under #2 below.) Please ensure prorated salary is based on total annual salary.

The sub-totals for Administrative and Client Oriented Salaries must equal HDA 311RS categories 111 and 121, respectively.

Rosters are to include all staff employed in the facility regardless of activity, and are to list Name, Position, and Salary to be paid in FY 2022-2023.

Staff engaged in Marketing functions, regardless of title, must be shown on the Administrative section of the Roster.

If vacant positions are listed on the Personnel Roster and included in the budget, a written justification and hiring schedule must be attached. It is expected that all vacant positions are filled within 60 days of being vacant.

2. Budget - Projected Revenues and Expenses

Providers must submit a Total Facility-based Budget, with an itemization of projected expenses and revenues. Additionally, expenses must be broken out for each activity provided at that facility. Budgets must be prepared using the budget category definitions from the modified DDAP Uniform Chart of Accounts (enclosed).

Use additional copies as needed to show all activities.

NOTE: You must show budget detail for all activities, regardless of whether you will be requesting an SCA rate for that activity. For example, a facility which provides both non-hospital residential and outpatient under the same facility number must display expenses and revenue for both activities, although they will only be requesting an SCA rate for non-hospital residential.

Page One of HDA 311RS
Providers must show all Revenue and Income applicable to all facility operations. Revenue and Income must at least equal total facility expense as shown on Page Two of HDA 311RS unless the facility experienced a budget deficit in the fiscal year.

Page Two of HDA 311RS
There is a cap of twenty percent (20%) on the amount of allowable administrative cost for the purposes of rate development. Therefore, you will note in completing the HDA 311RS what costs are to be allocated as either administrative or client oriented by category for each activity, as instructed below.

Administration is defined as those costs not incurred in the direct or indirect provision of treatment services.

Most of the personnel costs for CEOs, executive directors, secretaries, administrative assistants, clerks, receptionists, accountants, fiscal assistants are administrative in nature. If identifying some of these position costs as client oriented, identify how you allocated the cost.

Justify in writing any line item in column J that increased more than 10% over column G.
Justification **MUST** be detailed and specific; e.g. insurance cost increased by X% over X period of time.

Definition of Administration

Administration is defined as general managerial functions or activities which are supportive to, but not an intrinsic part of the provision of direct services. Administrative functions or activities include: executive supervision, personnel management, accounting, auditing, legal services, purchasing, billing, community board activities, activities associated with management information systems (does not include maintenance of individual client case records), and clerical activities which are supportive to these administrative functions or activities.

Clerical activities which provide direct support to the program activity are to be reported as direct costs of the program activity. Room and board, including maintenance, are direct costs for residential programs. For the purpose of rate setting, clinical and program supervision associated with direct client care is to be considered a direct program expense. Staff time associated with such supervision should be allocated among, and reported within, program activities as a direct program expense. The method of allocation is discretionary, as long as it is verifiable and results in an equitable distribution among program activities. Using this definition, budget categories from the HDA Form 311 RS have been classified as follows: (Refer back to budget categories starting on page 2).

Submit one form, including a personnel roster and a budget narrative, for each activity for which a rate is to be established. The form will contain fiscal information for three years: the previous Actual Year, the Current Year, and the Budget Year. Information for each of the three years must be designated as Administration or Client Related. Three years are required in order to allow for comparability between actual, current, and budgeted costs.

For the current fiscal year, provide information that is projected based upon data/numbers you have so far year-to-date. Since the current fiscal year is not completed, some of this information is projections.

NOTE: Revenue and Income figures on page one should relate to the Total Facility Budget Expense Column on page two for each fiscal year.

3. Budget Narrative

Complete the enclosed Budget Narrative form, describing the costs included in each category. For those marked with an asterisk (*), the allocation method must be described.

4. Rate Request Form

To calculate your requested rate, use the following procedures:

a. Complete a separate Rate Request Form for each activity for which you are requesting a rate.

b. Total the Client oriented column for that activity divided by *.80* determines the Total Allowable Budget for that Activity. This cannot exceed the total actual budget.

c. To determine Bed Days, use the formula shown on the form.
Number of beds used for each drug and alcohol activity should equal the number of licensed beds for the facility.
Note: a minimum utilization rate of 85 percent is to be used.

d. To arrive at your requested rate, divide the lesser of the Total Budget or the Total Allowable Budget by Bed Days calculation.

3.5 and 3.7 services provided on the same unit within the facility:
If 3.5 and 3.7 services are provided on the same unit within the facility, the provider will in addition to the package required for the 3.5 LOC complete and submit the following specific to the 3.7 LOC:

1) **Section B – Program Description Specific Information for 3.7 LOC**
2) **Personnel Roster specific to the additional salaries to provide the 3.7LOC not already captured in the 3.5 package.**
3) **Form HDA 311RS Budget (Revenue & Expenses) to capture Revenue and Expenditures for the 3.7 LOC not already captured on the 3.5 package.**
4) **Budget Narrative to justify additional expenses for the 3.7LOC not already captured in the 3.5 package.**
5) **Rate Determination Form for the additional expenses for the 3.7 LOC which will calculate a rate enhancement added onto the determined 3.5 LOC rate when 3.7 services are provided. Under this circumstance, the provider shall estimate the number of bed days expected to be delivered for 3.7 to align with the expected costs captured in items #2,3, and 4 above.**

Note: If the increase in the requested per diem rate exceeds the current Consumer Price Index (CPI), please explain in one page or less what expenses rose to justify the increase. Identify major changes, purchases and enhancements in detail that contributed to the increase.

BUDGET NARRATIVE

Provider Name: _____
Facility Name: _____
Activity: _____

List all activities for which SCA funding is being requested:

For each budget category on the HDA 311RS, please complete a description of the costs included.

In addition, if the category is marked with an (*), you must show the methodology for allocating the costs in this category between Administrative and Client Oriented for each activity. One example could be: rent is pro-rated between Administrative and Client Oriented based on square footage used by administrative staff. It is then allocated across the activities based on the number of beds devoted to each activity.

Again, the costs included in each category must conform with the Uniform Chart of Accounts, as included in this packet.

111 Administrative Salaries: Description not necessary. Described on personnel roster.

112 Administrative Benefits: State the percentage used and list all benefits included.

121 Client Oriented Services Salaries: If any non-clinical staff is listed on the personnel roster as client oriented, please describe why. This includes CEOs, Executive Directors, secretaries, clerical, receptionists, fiscal, etc. (NOTE: Any staff engaged in marketing functions, whether called Outreach or Community Relations personnel, may not be included in this category.)

122 Client Oriented Services Benefits: State percentage used and list all benefits included.

131 *Staff Development:

301 Meeting and Conference Expense:

302 Consultant Expense:

303 Miscellaneous Personnel Expense:

304 *Occupancy Expense:

305 *Insurance:

306 *Communications:

307 *Office Supplies:

308 *Minor Equipment and Furniture:

309 Medical Supplies and Drugs (not including medications used for MAT in the form of Buprenorphine, Vivitrol, or Methadone which would be paid for separate from the daily FFS rate):

310 Food and Clothing:

311 Program Supplies:

312 *Staff Travel:

313 Client Transport:

314 Purchased Client Oriented Services: (Psychological consultants should be shown here.)

315 *Equipment Maintenance Expense:

316 *Equipment Leases:

317 Motor Vehicle Maintenance Expense:

318 Motor Vehicle Leases:

319 *Other Operating Expense:

Please explain if any costs are placed in Client Oriented.

320 Indirect Cost:

Administrative costs to a parent corporation or central office should be included here as administrative. Provide a detailed itemization of this cost.

320 *Indirect Cost: Depreciation

UNIFORM CHART OF ACCOUNTS

DEFINITIONS FOR MAJOR AND MINOR OBJECTS

The Uniform Chart of Account represents the list of major and minor objects that will be utilized for reporting purposes. DDAP suggest that the Single County Authorities (SCA) and Contracted Providers use the Uniform Chart of Accounts as a basis for their accounting journals and ledgers. Those SCAs and Contracted Providers who choose not to set up their books according to the Uniforms Chart of Accounts must maintain, on file, a documented reference sheet used to crosswalk their books onto the required reports.

PERSONNEL SERVICES

MAJOR OBJECT 100 - PERSONNEL SERVICES

This major object is used to report salaries and wages, payments toward various benefits, and training received by the employees of the D&A Program. Employees working for two or more programs should have their salaries and benefits pro-rated between the programs.

The minor objects are defined below:

111 - ADMINISTRATIVE SALARIES

This category should include all wage and salary costs of part-time and full-time employees who render their services within the administrative section.

Administration is defined as general managerial functions or activities which are supportive to, but not an intrinsic part of the provision of direct services. Administrative functions or activities include: executive supervision, personnel management, accounting, auditing, legal services, purchasing, billing, community board activities, activities associated with management information systems (does not include maintenance of individual client case records), and clerical activities which are supportive to these administrative functions or activities.

112 - ADMINISTRATIVE BENEFITS

This category should include only the employer's share of benefit costs incurred on behalf of all part-time and full-time employees who render their services within the administrative section. Included under Administrative Benefits are such items as social security contributions, retirement, employee health, life and other insurance plans, and worker's compensation.

121 – CLIENT-ORIENTED SERVICE SALARIES

This category should include the salaries and wages of all part-time and full-time employees who perform client-oriented services or client support services, and includes Case Management (screening, assessment and intensive case management) salaries and wages as well. Clerical activities that provide direct support to the program activity are to be reported as direct costs of the program activity. Clinical and program supervision associated with direct client care is to be considered a direct program expense. Staff time associated with such supervision should be allocated among, and reported within, program activities as a direct program expense.

122 - CLIENT-ORIENTED SERVICE BENEFITS

This category should include the employer's cost of benefits incurred on behalf of all part-time and full-time employees who perform client-oriented services or client support services. Included under Client-Oriented Service Benefits are items such as social security contributions, retirement, employee health, life and other insurance plans, and worker's compensation.

131 – STAFF DEVELOPMENT

This category covers development and training both within the facility and outside the facility. Expenses incurred for in-house development might consist of meetings or seminars held at the facility, books, videos, other training tools or equipment. Examples of training or development received outside the facility might be special courses, conferences, and training sessions by an outside agency. Only those staff development and training activities (administrative, technical, clerical) that are essential for the continuation or improvement of the program are eligible for State participation. Any activities in question should be cleared through the SCA or DDAP.

This category does not include travel by staff to these developmental activities; such costs would be recorded under minor object 312 - STAFF TRAVEL.

OPERATING EXPENSES

MAJOR OBJECT 300 – OPERATING EXPENSES

This major object includes the cost of supplies, commodities, services, travel, or manufactured articles that are used in current operations. This major object also includes minor equipment and furniture, as well as other articles not meeting the criteria set forth in Major Object 400, Fixed Assets.

Any expenses entered in the following minor objects must be substantiated by invoices, canceled checks, contracts or other means of documentation that are readily available for review at the SCA and DDAP's option. Any expenses identified as client oriented must be justifiable.

The minor objects are defined below:

301 - MEETING and CONFERENCE EXPENSES

Charge to this category total meeting costs incurred by the provider, excluding travel and advertising. This would include the cost of meetings related to conducting the business of the provider, as well as sponsoring of conferences and training events by the provider. Examples may include room rental, equipment rental, and food services.

302 -CONSULTANT EXPENSES

Charge to this category the cost incurred for all consultants hired on a limited term basis for administrative services. Include the total cost of consultants or other specialized and professional administrative services subcontracted or purchased, such as attorneys, auditors, accountants, management analysts and research analysts. Travel and lodging expenses incurred by the consultant are eligible under this category and are reimbursed by State standards as explained in Minor Object 312 - Staff Travel.

303 -MISCELLANEOUS PERSONNEL EXPENSES

Charge to this category the cost of administrative personnel that are hired on a temporary basis and do not appear on the Roster of Personnel. Examples may include replacements for any leaves of absence and student interns. If temporary staff is approved for travel, the expense should be charged under Minor Object 312 - Staff Travel.

304 -OCCUPANCY EXPENSES

All direct costs for the following expenses may be charged to this category.

1. Rent for an office or other space occupied by the facility. D&A rental will be pro-rated when offices or space is in buildings rented for additional purposes other than D&A functions. An agency must be able to demonstrate, upon request from the SCA or DDAP, that the cost of space per square foot is based on a fair market value for the surrounding area.

2. Utilities include heating fuel, sewage, water, gas, electricity, etc.

3. Housekeeping Services and Supplies include all supplies used in the performance of general housekeeping and grounds care services, or the cost of contracting out those services.

4. Building Repairs and Maintenance include minor building repairs, maintenance, repairs and maintenance to heating, ventilation and air-conditioning units. Repairs are defined as work done to maintain the existing structures and equipment.

5. Minor Renovations are considered to be the adaptation of available space and do not include construction cost for additional space. Minor renovations are those at a cost of less than $10,000.

6. Insurance includes building, content, fire and liability insurance costs.

305 - INSURANCE

Charge to this category any insurance not covered under Minor Object 304 - Occupancy Expenses and Minor Object 317 - Motor Vehicle Maintenance Expense. Examples include professional liability, directors' and officers' insurance, and fidelity bonds.

306 - COMMUNICATIONS

Charge to this category the costs of telephone service (including installation), postage, advertising, marketing, pagers, cell phones, web sites, internet services, printing, duplicating and parcel service.

307 - OFFICE SUPPLIES

Charge to this category the cost of all expendable items that are normally consumed within one year and used in the day-to-day operations of an office. Some examples are pens, pencils, paper, calendars and tape.

308 - MINOR EQUIPMENT AND FURNITURE

Charge to this category items with a useful life of more than one year and a unit cost of less than $5,000. Examples may include fax machines, copiers, computers and computer-related equipment, software, tables, desks and chairs.

309 - MEDICAL SUPPLIES AND DRUGS

Charge to this category the cost of medical supplies and drugs used in the treatment of clients, with the exclusion of medications used for MAT in the form of Buprenorphine, Vivitrol, or Methadone which would be paid for separate from the daily FFS rate.

310 - FOOD AND CLOTHING

Charge to this category the cost of necessary food and clothing used by D&A clients. Also, charge all costs associated with specialized or professional food preparation and food delivery services.

311 - PROGRAM SUPPLIES

Charge to this category the cost of supplies purchased for activities related to rehabilitation or recreational purposes. Also included are supplies used in client training and education services. Some examples are books, periodicals, games, videos, tapes, creative supplies and drug testing kits.

312 - STAFF TRAVEL

Charge to this category the cost of business-related staff travel. Include allowances for meals, lodging, and other related expenses.

313 - CLIENT TRANSPORT

Charges to this category include actual miles traveled, parking, tolls, meals and expenses incurred or fees paid to an outside agency for the transportation of D&A clients. Accurate and up-to-date records must be maintained.

314 - PURCHASED CLIENT-ORIENTED SERVICES

Charge to this category the cost incurred from the purchase of client-oriented services, such as medical care, laboratory services, psychiatric services and interpreter services. Psychological consultants should be shown here.

315 - EQUIPMENT MAINTENANCE EXPENSE

Charge to this category the cost of maintenance agreements and repairs to all types of office or medical equipment.

316 - EQUIPMENT RENTALS AND LEASES

Charge to this category the cost of all equipment rentals and leases. An example of such a cost would be rented urinalysis equipment.

317 - MOTOR VEHICLE MAINTENANCE EXPENSE

Charge to this category the cost of maintenance to motor vehicles used in the performance of official D&A Program activities (e.g., repairs, insurance, inspection, tires, gas, oil and lubrication).

318 - MOTOR VEHICLE LEASES

Charge to this category the cost of motor vehicle leases.

319 - OTHER OPERATING EXPENSES

Charge to this category operating costs that cannot properly be recorded in the other minor expense objects. All costs in this category should be documented and held to a minimum.

320 - INDIRECT COSTS

Charge to this category costs for supportive activities that are necessary to maintain the direct effort involved in providing the services. A copy of the provider's indirect cost plan must be maintained on file for review by the SCA or DDAP. Administrative costs to a parent corporation or central office should be included here as administrative.

320 – INDIRECT COSTS – DEPRECIATION

In recent years, the DDAP Rate-Setting Committee determined that depreciation would be allowed as an expense for rate setting purposes. Accordingly, depreciation can be charged here. Providers claiming depreciation on Fixed Assets must include as backup with the submission of the package a copy of their depreciation schedule(s) which need to correlate to the amounts claimed on Form 311.

PROVIDER REVENUE AND INCOME

MAJOR OBJECT 500 – PROVIDER REVENUE AND INCOME

This major object is used to report all income received by the contracted service providers directly from Federal, State, and Local governments, as well as from client and private sources. Funding source, for reporting purposes, shall be defined as the agency from which the checks were received.

The minor objects are defined below:

501 – Provider Revenues

Provider revenue is comprised of direct federal revenues received by the contract provider, revenues received from other government or private entities as well as revenues received from other SCAs for the provision of treatment services or related ancillary services. The contract provider must identify the source(s) of these funds.

502 – Provider Charitable Income

Income received from unspecified sources such as donations (i.e. funds donated to the contract provider as a general contribution where the donor determines how the funds will be spent) from private firms, unions, charitable organizations and individuals. Identify the source(s) of all provider income.

503 – Provider Interest Income

The contract provider must enter any interest income earned in the space provided.

504 – Client Fees

Income received from clients who have a full or partial payment for services received.

505 – Private Health Insurance

Income received for insurance carriers, e.g. Blue Cross/Blue Shield, employer of union health plans and private purchase health insurance.

506 – Medical Assistance (include Health Choices Revenue)

Income received from the DHS for substance use and gambling disorder services provided to MA-eligible recipients.

507 – Other Third-Party Fees

Income received as payment for client services from a source such as employers (where insurance coverage is not applicable), client family member, food stamps, etc. (when the payment by such sources is agreed to by the client and does not violate confidentiality requirements).

508 – Miscellaneous

Use this code to indicate funding of a special nature or circumstance that cannot be categorized using the definitions and examples cited above.

FY 2022-2023

RATE REQUEST FORM

Please fully complete this form separately for each activity for which an SCA rate is requested.

Provider Name:
Facility Name:
Activity:

TOTAL ALLOWABLE BUDGET
Total Client Oriented Costs per Activity divided by .80 = Total Allowable Budget
(HDA 311RS, page 2) (Cannot exceed total actual budget)
_____ /.80 = _____

BED DAYS
_____ Beds x 365 days per year x 85% utilization = _____ bed days per activity. Bed capacity should equal the total number of licensed beds for this activity.

RATE REQUEST FORMULA
The Lesser of the Total Budget or the Total Allowable Budget as calculated above divided by the Bed Days per activity calculated above = $Rate/Day

_____ = $_____/Day Round down if under $0.49

Or round up if $0.50 or above.
Example: $79.48=$79.00
$98.50=$99.00

RATE REQUESTED OF SCA $_____/Day
_____% increase (decrease) compared to FY 2021-22 approved state-wide rate
If there are any other contracts with your program at a lower rate, please indicate that rate:
$_____/day.

In fiscal year 2020-21 how many total bed days, for all sources of funding did this facility provide?
_____/days.

CERTIFICATION STATEMENT

I certify that I am the Executive Officer of said organization and that to the best of my knowledge the expenses listed on this form are in accordance with the fiscal guidelines, as required by the County; and that the organization understands that any and all payments made as a result of the approval of this budget are made in reliance by the SCA upon the statement herein made. *I certify that the rate requested in this package does not exceed the rate received from non-public payers.*

_____
Signature CEO Title Date

_____
Signature Chief Fiscal Officer Title Date

FY 2022-23 FORMS HDA 311RS

RATE SETTING BUDGET				
Facility Name:		Facility ID#:		
Street Address:		Contract Year 7/1/2022 - 6/30/2023		
City/State:	Zip Code:	Activity:		
SECTION I - CUMULATIVE REVENUE & INCOME PART A - Cumulative Revenue & Income Receipts Applicable to Eligible Expenses		Actual for Year 2020/21	Current Year 2021/22	Budget Year 2022/23
SOURCES:				
501	Provider Revenues			
502	Provider Charitable Income			
503	Provider Interest Income			
504	Client Fees			
505	Private Health Insurance			
506	Medical Assistance Fee For Service (HealthChoices)			
507	Other Third Party Fees			
508	Other Income (identify)_____			
	Totals	-	-	-
		Identify your program facility:	a. Unrestricted Assets or Cash $	
			b. Restricted Assets or Cash $	
CERTIFICATION STATEMENT *I certify that I am the Executive Officer of said organization, and this statement of income and expenses for the period shown is true and correct to the best of my knowledge and belief; that the expenses and income shown on these forms have been reconciled with the related balances of the books of this organization; that the expenses are in accordance with fiscal guidelines, directives, and provisions of the contract/agreement, as required by the Single County Authority; and that the organization understands that any and all payments made hereunder are made in reliance by the Single County Authority upon the statement herein made.*				
Prepared By		Telephone No.		
FACILITY DIRECTOR/ADMINISTRATOR		Date		

Facility Name:	Actual for Year 2020/2021 (Audited)			Current Year 2021/2022 Projected			Budget Year 2022/2023			Proposed increase
Activity:	Admin	Client Oriented	Total	Admin	Client Oriented	Total	Admin	Client Oriented	Total	(Decrease) Column J
Personnel Services (100)										compared to Column G
111 - Administrative Salaries			$ -			$ -			$ -	#DIV/0!
112 - Administrative Benefits			$ -			$ -			$ -	#DIV/0!
121 - Client-Oriented Services Salaries			$ -			$ -			$ -	#DIV/0!
122 - Client-Oriented Services Benefits			$ -			$ -			$ -	#DIV/0!
131 - Staff Development			$ -			$ -			$ -	#DIV/0!
Sub-total: Personnel Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	#DIV/0!
Operating Expenses (300)										
301 - Meeting and Conference Expenses			$ -			$ -			$ -	#DIV/0!
302 - Consultant Expenses			$ -			$ -			$ -	#DIV/0!
303 - Miscellaneous Personnel Expenses			$ -			$ -			$ -	#DIV/0!
304 - Occupancy Expenses			$ -			$ -			$ -	#DIV/0!
305 - Insurance			$ -			$ -			$ -	#DIV/0!
306 - Communications			$ -			$ -			$ -	#DIV/0!
307 - Office Supplies			$ -			$ -			$ -	#DIV/0!
308 - Minor Equipment and Furniture			$ -			$ -			$ -	#DIV/0!
309 - Medical Supplies and Drugs			$ -			$ -			$ -	#DIV/0!
310 - Food and Clothing			$ -			$ -			$ -	#DIV/0!
311 - Program Supplies			$ -			$ -			$ -	#DIV/0!
312 - Staff Travel			$ -			$ -			$ -	#DIV/0!
313 - Client Transport			$ -			$ -			$ -	#DIV/0!
314 - Purchased Client-Oriented Services			$ -			$ -			$ -	#DIV/0!
315 - Equipment Maintenance Expense			$ -			$ -			$ -	#DIV/0!
316 - Equipment Leases			$ -			$ -			$ -	#DIV/0!
317 - Motor Vehicle Maintenance Expense			$ -			$ -			$ -	#DIV/0!
318 - Motor Vehicle Leases			$ -			$ -			$ -	#DIV/0!
319 - Other Operating Expenses			$ -			$ -			$ -	#DIV/0!
320 - Indirect Costs			$ -			$ -			$ -	#DIV/0!
320 - Indirect Costs - Depreciation			$ -			$ -			$ -	#DIV/0!
Sub-total: Operating Expenses	$ -	$ -	$ -			$ -			$ -	#DIV/0!
Column Totals	$ -	$ -	$ -			$ -			$ -	#DIV/0!

FY 2022-2023
ROSTER OF PERSONNEL
Project Budget

Facility Name: **Facility ID#:**
Activity:

Name and Title and Credentials (e.g. CAC, B.S., M.S., MSW, etc.)	Total Annual Salary From all sources	Administrative		Client Oriented	
		Hrs Per Wk	Salary	Hrs Per Wk	Salary
Column Totals	-		-		-
		Total Project Salaries			-

Prepared By:__ Telephone:_Date:

GLOSSARY

Abbreviation	Denoting
ACH	Automated Clearing House
ACT	Assertive Community Treatment
AHCI	Allegheny HealthChoices, Inc.
AIP	Acute Inpatient Psychiatry
ASAM	American Society of Addiction Medicine
ASO	Administrative Services Only
BH	Behavioral Health
BHARP	Behavioral Health Alliance of Rural Pennsylvania
BH-MCO	Behavioral HealthChoices Managed Care Organization
BHO	Beacon Health Options
BHoCC	Behavioral Health of Cambria County
BHRS	Behavioral Health Rehabilitation Services
BHSSBC	Behavioral Health Services of Somerset & Bedford Counties
BLS	Bureau of Labor Statistics
CABHC	Capital Area Behavioral Health Collaborative
CBH	Community Behavioral Health
CBO	Community Based Organization
CCBHO	Community Care Behavioral Health Organization
CFRs	Code of Federal Regulations
CMS	U.S. Centers for Medicare and Medicaid Services
CY	Calendar Year
DAOP	Inpatient, Drug and Alcohol
DBHIDS	Depart. of Community Behavioral Health and Intellectual Disability Services
DDAP	Department of Drug and Alcohol Programs
DHS	Pennsylvania Department of Human Services
FCBHA	Fayette County Behavioral Health Administration
FFP	Federal Financial Participation
FFS	Fee for Service
FQHC	Federally Qualified Health Clinics
FTE	Full-Time Equivalent
HSC	Human Services Code
IBHS	Intensive Behavioral Health Services
IHCP	Indian Health Care Provider
IOP	Intensive Outpatient
IPMH	Inpatient Mental Health
IP D&A	Inpatient Drug and Alcohol

Abbreviation	Denoting
LOC	Level of Care
MBH	Magellan Behavioral Health (MBH)
MCO	Managed Care Organization
MH	Mental Health
MHOP	Mental Health Outpatient
MLR	Medical Loss Ratio
NAIC	National Association of Insurance Commissioners
NH	Non-Hospital
NH D&A	Non-Hospital Drug and Alcohol
OMAP	Office of Medical Assistance Programs
OMHSAS	Office of Mental Health and Substance Abuse Services
OP	Outpatient
PHP	Partial Hospitalization
PIHP	Prepaid Inpatient Health Plan
PAHP	Prepaid Ambulatory Health Plan
PCCMs	Primary Care Case Management programs
PCPC	Pennsylvania Client Placement Criteria
PM/PM	Per Member/Per Month
PPS	Prospective Payment System
NBHCC	Northeast Behavioral Health Care Consortium
NWBHP	Northwest Behavioral Health Partnership, Inc.
OMHSAS	– Office of Mental Health and Substance Abuse
RHC	Rural Health Clinic
RTF	Residential Treatment Facility
SCA	Single County Authority
SDOH	Social Determinants of Health
SU	Substance Use
SWBH	Southwest Behavioral Health Management, Inc
TCM	Transitional Care Management
WM	Withdrawal Management
VBP	Value Based Purchasing