

FY 2023 PLANNING BUDGET ITEMS PERTAINING TO MENTAL HEALTH (MH) PROGRAMS

A. Introduction

DBHIDS has implemented changes to better align our work processes. These changes affect your budget preparation, allocation, payment/ reimbursement, data reporting and internal and external monitoring. To date, these changes include:

1. State Cost Center Realignment
 - a. See the OMHSAS-12-02 Bulletin.
2. Electronic submission of the OMH Administrative (“claim”) Record.
 1. Documentation on the CCRI/837 submission process is found at:
https://dbhidsapps2.phila.gov/approot/rim_menu/rim_splash.html
3. Registration of County-funded service locations in PROMISe under the Electronic Performance Outcome Management System (EPOMS) category.
 - a. Unless otherwise noted, EPOMS must be in PROMISe for each provider service location approved to serve County base-funded mental health consumers.
4. Shift from Program Funding to Fee-for-Service for the following services
 - a. Outpatient (FY15)
 - b. Targeted Case Management (FY16)
 - c. Mobile Psychiatric Rehabilitation Services (FY17)
 - d. Certified Peer Specialist (FY17)
 - e. Administrative Management (FY17)
 - f. Residential Services (FY18)
 - g. Housing Support (FY18)
 - h. Family Based Services (FY19)
5. Supporting documentation associated with **administrative costs**-budget are no longer required to be submitted:
 - a. Expenditure Summary
 - b. Personnel Budget Schedule
 - c. Miscellaneous Item Detail and Budget Subsidiary Schedule
6. The “Administrative Cost Distribution Schedule” is still required.
7. Agencies must still complete administrative budgets. These should be maintained by the agencies and made accessible for review by DBHIDS, independent certified public auditors, and other governmental or private funding sources.

B. General MH Program Budget Instructions

1. For details regarding the FY 2023 planning allocation, please refer to the Planning Allocation Memorandum.
2. It is DBHIDS's expectation that agencies budget within Program Activity Code (PAC) allocations. Shifting funds between PACs cannot occur without prior approval of this Office. However, agencies can identify under-performing or obsolete programs and propose their elimination.

Any budget submission that **exceeds** the planning allocation **must** include an agency **contribution**. Any budget submission that exceeds the planning allocation and **does not include an agency contribution will be returned**. The agency will be requested to resubmit the budget within the planning allocation level of funding.

Please be advised DBHIDS has updated its financial database. Therefore, budget forms are not to be altered in anyway. Changes to the official DBHIDS forms will result in the forms/budgets being rejected.

3. Temporary service location codes or "9000" codes ensure Fee For Service (FFS) payments to providers not yet registered in the State PROMISE system. Temporary service codes impact reporting to the State for uninsured claims. Use of temporary services codes means providers will not have their service information reported to the State. Therefore, all temporary service codes must be replaced with service location codes registered with the State.

DBH is requiring providers to include the service code information on the budget Expenditure Summary and Residential Site Schedule. Providers are also required to review their Contract Services Files focusing on these temporary service codes.

Failure to register temporary service locations with the State will impact the approval of a Provider's FY '23 Contract Service File (CSF). Providers without an approved CSF will not be able to submit FFS claims data and therefore cannot receive payments for their County-funded FFS programs.

For further information on how to register these temporary service locations, please contact the Health Claims Quality Assurance (HCQA) unit at OMH.EDISupport@phila.gov

4. The Program Description Outcome (PDO) form continues to be a focal point within the budget submission. The form is composed of four (4) sections.

a. Section – I Program Description: Provide a concise and accurate program description for each program activity. The description should include the purpose and goals for each. This information will be referenced throughout the fiscal year to inform financial and programmatic decisions.

b. Section II – Contract Outcomes: Beginning FY23 DBH will collect program outcomes for all programs and services listed on the Initial Allocation Notice (IAN).

c. Section III – Budget Variance Section: Provide detail regarding Direct FTEs, UOS, and Capacity (Slots) for fiscal years 2022 and 2023.

d. Section IV – Sites: List all locations, including site name(s), address, phone number, and facility number. DBHIDS will be comparing PDO sites to PROMISE to ensure compliance to PROMISE enrollment.

Once the approved Contract Work Statement (CWS) has been issued, **any shifts or transfers between PACs will require a discussion.** All other budget variance controls are explained within the General Budget Instructions.

C. MH Program Reporting

Reporting Total and Direct FTEs, Capacity (Slots), and Units of Service (UOS)

1. Total and Direct FTEs must be reported on the Summary of Program Activities and the Program Description Outcome forms for all mental health programs, except for Client Contingency PACs.
2. Capacity (slots) must be reported on the Summary of Program Activities, Residential Site Schedule, and the Program Description Outcome forms for all mental health programs, except for Client Contingency PACs.
3. Units of service must be reported on the Summary of Program Activities and the Program Description Outcome forms for all mental health programs, except for Client Contingency PACs.
4. Please be advised, your budget information may include changes to the Cost Center Definitions and the reporting of Units of Service.
5. Payment for fee-for-service programs is based on adjudicated or “clean” claims, not quarterly expenses. Payment for these services also requires the submission of the OMH Administrative Record (837/5010 claim). These FFS PACs and the associated Provider Type, Specialty Code, CCRI Procedure Code, Modifiers and Unit of Measure are specified in the Contracted Services File sent to DBHIDS providers.
 - a. A Provider’s CWS may contain PACs that represent services that are both invoiced (paid via quarterly advances) or paid FFS (based on adjudicated claims).
6. DBHIDS uses a “modified” version of FFS claims payments, meaning provider allocations are considered a “draw down”. The draw down amount is capped at your annual allocation amount for that program/service. Total annual payments will not exceed the allocation amount. Payment for adjudicated claims that exceed annual allocations amounts may be considered on a case-by-case basis at the end of the Fiscal Year.
7. The Unit of Measure for a service is contained in the **Contracted Services File**. For other services that are not a part of the DBHIDS CCRI/837 Electronic Reporting use the following guidelines:

<u>ACTIVITIES</u>	<u>CWS UNITS</u>	<u>HCQA REPORTING UNITS</u>
Emergency	Quarter Hours	Quarter Hours*
Social Rehabilitation	Quarter Hours	Quarter Hours*
Children’s Psychosocial Rehabilitation	Quarter Hours	Quarter Hours*
Consumer-Driven Services	Quarter Hours	Quarter Hours*
Mental Health Crisis Intervention	Quarter Hours	Quarter Hours*

Community Employment/ Employment-Related Services	Quarter Hours	Quarter Hours*
Family Support Services	Quarter Hours	Quarter Hours*
Transitional and Community Integration	Quarter Hours	Quarter Hours*
Community Services	*Annual Reporting of events to PPM (formerly OPSFIS) only. No HCQA reporting at this time. See attachment for reporting format.	

* Service Units are reported to the MIS system in quarter hour units (0.75 hours = 3 units; 1.00 hour = 4 units; 2.00 hours = 8 units; 3.00 hours = 12 units).

D. Program-Specific MH Budget Instructions

1. Residential Programs and Housing Support Services

- a. Discussions continue regarding Residential Housing Transformation 2.0. Proposed changes may impact residential programs. However, for the purposes of FY 23 budget submission, prepare your budget submissions based on the current planning allocation.
- b. DBHIDS requires agencies to complete the Residential Site Schedule (RSS). **The RSS replaces the Expenditure Summary for residential programs.** There is no need for an agency to complete the Expenditure Summary for residential programs. All residential programs will continue to be paid FFS. We are asking agencies to continue to report the following:

1. Residential Revenue Projections

Based on the Residential Rent Policy, we are requesting information pertaining to the residential cost center as part of the FY 2022 Budget. The following requirements remain in place:

- a) To assess revenue projections for the Residential Cost Center, we are requiring all residential providers to show the actual methodology, calculating Room and Board income

$$\begin{aligned} \text{SSI } (\$591.40) \times 72\% &= \$425.80 \text{ per month} \\ \$425.80 \text{ (Per Month)} \times 12 \text{ (Months)} \times 8 \text{ (Beds)} &= \$40,876.00 \end{aligned}$$

- b) In addition to the calculation, please provide an explanation of what residents receive for the monthly charge. For example, if the charge is for Room and Board, please indicate what items are covered (i.e., rent, utilities, meals).
- c) Provide the actual per diem calculation for each PAC.
- d) Include a copy of the agency rent/room and board policy as an attachment to the PDO form.

2. **Case Management (Blended [Child and Adult], Community Treatment Team**

[ACT/CTT Fidelity], Family- Based and PARS.)

Note: OMHSAS issued a Bulletin (OMHSAS-13-01 – TCM Travel and Transportation Guidelines) which disallows the reimbursement for time spent transporting or escorting of a consumer. Effective 2/1/13, rate adjustments were made to address the average percentage of loss resulting from this change in policy. Changes are applicable to Targeted Case Management services only. This change does not apply to ACT/CTT and BHSI. These amended new quarterly rates will continue in FY 22.

- a. Adult and Child Targeted Case Management and ACT/CTT services continues to be an in-plan service authorized through and funded by Community Behavioral Health (CBH). Agencies will bill at a single, set rate for Medical Assistance (MA) eligible or non-MA eligible individuals. All services rendered to MA-eligible persons enrolled in Health Choices, services will be reimbursed at 100% of the approved rate by CBH MA. The county allocation for TCM only consists of funding for FFP - State Match share, zero liability individuals, etc.
- b. The PAC Expenditure Summary, Personnel Budget Schedule, Miscellaneous Item Detail and Budget Subsidiary Schedule are still required as part of the budget package for the TCM, ACT/CTT, and FB programs.
- c. TCM services have transitioned between DBHIDS and CBH. Activities continue with the TCM unit. For purposes of the FY23 budget submission, prepare TCM portion of your submission based on the current planning allocation.
- d. The TCM allocation cannot be reduced or transferred to any other program. Reviews of all programs will continue throughout FY 2023 and adjustments made as appropriate.

3. **Administrative Budget**

- a. Supporting documentation for the administrative budget is no longer required to be included in the Planning Budget submission.
- b. Please note that the “Administrative Cost Distribution Schedule” is still required to be included in the Planning Budget.

4. **Administrative Management – PAC #0100-2083 (Outpatient Support)**

- a. The billable functions and activities for Administrative Management services have been grouped into three (3) distinct categories:
 1. Pre-admission activities: which include screening and engagement, via telephone or walk-in. These activities must be 15 minutes in duration to submit a claim.
 2. Intake activities: defined as full intake with admission into an agency. A maximum of 2.25 hours has been established for adults and 2.75 for children.
 3. Post admission activities: defined as activities and services provided after admission.

- b. These services can be provided only to those individuals who are **uninsured** (this **excludes** CBH eligible individuals) **or underinsured** (this **includes** individuals that have Medicare as their only insurer).
- c. Providers are **NOT** permitted to bundle services that took place on separate days into a **single** billable day.
- d. Providers can **ONLY** bundle units that occurred within a single day. If the intake process took several days to complete; each day's units/services must be billed separately according to the day.
- e. Providers **CANNOT** submit claims for post-intake, Administrative Management services for individuals who are **CBH eligible**.

5. **Fee-For-Service (FFS) Programs**

Funds will only be available based on individualized billing services consistent with your OMH Contracted Services file (CSF). FFS Programs includes: Outpatient Services (**PAC# 0100-0600**), Case Management (**PAC# 0100-0400**), Residential Services (**PAC# 0100-1600**), Psychiatric Rehabilitation Services (**PAC# 0100-2433 and 0100-2400**), Peer Support (**PAC# 0100-2763**), Administrative Management Services (**PAC# 0100-2083**), Housing Support Services (**PAC# 0100-2253 or 2254**) and Family Based Services (**PAC# 0101-1725**) will be assessed via claims billing.