

FY 2025 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)
 - i. Assertive Community Treatment Team/ Community Treatment Team
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 2025 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.
3. Permission must be obtained from DBHIDS prior to the movement of funds between line items. Provider must submit a budget narrative in a Word document to support the modification.

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.

4. The Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) has created a centralized mechanism for the submission of funding requests to the County. This process provides a centralized inventory of funding requests from providers. If/when funding becomes available, requests with all required materials are reviewed and prioritized by the Behavioral Health Division and approved by the Commissioner.

Use the [DBHIDS County Funding Request Form](#) to submit proposals for increased funding and/or new funding requests.* The form includes rate requests, new program or concept requests, program expansion or modification requests, and reinvestment requests.

*** Submission of request does not guarantee that funding will be approved or allocated.**

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

5. In FY23 the HC unit at DBHIDS implemented several State-mandated changes to the FFS claims billing system. These changes impact both telehealth and anonymous claims submissions. A detailed description of these changes are outlined below:

Telehealth Billing

As of July 25, 2022, one of the changes to FY23 Contracted Services Files is the additional place of services 02, 10, and FQ modifier which refers to Telehealth services.

The 02 Place of Service (POS) can be used when services are provided other than in the member's home.

The 10 Place of Service (POS) can be used when the services are provided in the member's home.

The FQ modifier is for audio only services.

Anonymous Billing

As of October 14, 2022, the list below are the **ONLY** services that OMH/HCQA will allow for anonymous clients. The services below do not pertain to all agencies.

Service Name	Procedure Code/Modifier (if applicable)	Acceptable Service
Crisis Intervention Service	(H 2011)	<i>nature of the service/presenting circumstance</i>
Crisis Intervention Service	(H 2011 U7 HT)	<i>Mobile crisis/ Team delivered</i>
Emergency Services	(H 0046 ET)	<i>nature of the service/presenting circumstance</i>
Community Mental Health Services – Other (Adults) not otherwise specified	(H 0046 HW)	<i>services with emergency capacity to the homeless</i>
Community Mental Health Services – Other (Children) not otherwise specified	(H 0046 HK)	<i>assessment, counseling, consultation or referrals related to the Student Assistance Programs that are not reportable elsewhere</i>
Social Rehabilitation Services	(H 0046)	<i>Drop-in Centers</i>
Administrative Management	(T 1016 HX)	<i>ensure the intake into the county mental health system (to include Base Service Unit and CASSP outreach)</i>
Transitional and Community Integration – Services to Adults	(H 2017 HW)	<i>homeless outreach services (can include homeless)</i>
Behavioral Health hotline services	(H 0030)	<i>nature of the service/presenting circumstance</i>

New Anonymous Format

OMH has a new anonymous format that all providers **MUST** use when submitting anonymous claims for services from the chart listed above.

The New Anonymous Format:

ID Number	First Name	Last Name
9906192597	ADULTFEMALE	OMHSAS
9906192589	ADULTMALE	OMHSAS
9906192605	CHILDMALE	OMHSAS
9906192613	CHILDFEMALE	OMHSAS

For questions, please contact OMH.EDISupport@phila.gov.

- 6. 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 FY25 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

- 7. The Program Description Outcome (PDO) form continues to an important part of the 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 FY24 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 2024 and 2025.

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.	

8. 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**) and **0101-0425**, Residential Services (**PAC# 0100-1600XX**), 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**) and Assertive Community Treatment/ Community Treatment Team (PAC#23XX) will be assessed via claims billing.

* 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 25 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 FY25 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.

SSI (\$591.40) X 72% = \$425.80 per month
\$425.80 (Per Month) X 12 (Months) X 8 (Beds) = \$40,876.00

- 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 24.

- a. Adult and Child Targeted Case Management and ACT/CTT services is 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.

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**.