



Report on the City of Philadelphia HealthChoices Behavioral Health Program

**Department of Behavioral Health and Intellectual disAbility Services
and
Community Behavioral Health**



**City Controller
Rebecca Rhynhart**
July 2021



CITY OF PHILADELPHIA

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REBECCA RHYNHART
City Controller

Thursday, July 29, 2021

Dr. Jill Bowen
Commissioner
Department of Behavioral Health and Intellectual disAbility Services
1101 Market Street, Suite 700
Philadelphia, PA 19107

Dear Commissioner Bowen,

The Office of the City Controller conducted a performance audit of the HealthChoices Behavioral Healthcare Program (HealthChoices) administered by Community Behavioral Health (CBH) under the oversight of the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). The audit was conducted pursuant to Section 6-400(c) of the Home Rule Charter. The objectives of this audit were to determine if DBHIDS was properly and effectively using public financial resources in administering the HealthChoices Program and supporting individuals in need of mental health and addiction treatment services. To assist with the audit, the Controller's Office engaged Mercadien, P.C., Certified Public Accountants (Mercadien, P.C.) as subject matter experts to provide consulting services and conduct a second phase of the engagement.

Our report primarily focused on the documentation used to support claims submitted by third party providers under contract with CBH, as well as internal controls and processes in place at DBHIDS and CBH during the audit period of July 1, 2016 through June 30, 2017. The results of our work, which was performed in accordance with *Government Auditing Standards* for the performance audit and *American Institute of Certified Public Accountants Statements on Standards for Consulting Services* for the Mercadien, P.C. engagement, are detailed in the attached report.

During the audit period, we found issues with documentation, the reimbursement process, procurement, and a lack of oversight and accountability in CBH's administration of HealthChoices and DBHIDS' oversight of CBH. Specifically, auditors identified numerous discrepancies in the

clinical documentation used to support Medicaid-related claims, demonstrate the quality of care provided, and show patient progress. Of 284 transactions selected for testing across 27 providers, the audit identified 149 instances of non-compliance with documentation requirements. The engagement also identified several instances in which CBH incorrectly requested and received reimbursements from DBHIDS. This includes \$6.4 million in duplicate expenses submitted by CBH to DBHIDS for reimbursement and \$1.5 million in reimbursement requests related to voided transactions. While most of these funds were returned to the City of Philadelphia, as of March 2020, nearly \$1.1 million remained outstanding and DBHIDS has not provided a corrective action plan to fix this. We also found several instances in which CBH violated the procurement criteria to which it is subject under the Philadelphia Code. Given the limited scope of the testing period and the significance of the issues identified, it is possible that many of CBH's other procurements over the years may have been inappropriate.

Additionally, we found the payment structure for the Community Integrated Recovery Centers (CIRC) program was not cost effective. During the audit period, CBH paid CIRC providers \$10.4 million for services that were based on program capacity estimates rather than the actual number of patients served. While we did not review other years, it is likely that CBH has paid providers millions of dollars annually for services not rendered to actual patients since the program's inception in 2007.

Our audit also found that CBH submitted and was reimbursed for nearly \$200,000 in expenses related to its 20th anniversary celebration and various health and wellness programming for CBH employees. This included anniversary related gifts, awards, and a paid day off for staff, as well as wellness incentives like personal trainers, in-house massages, fitness trackers, and exercise equipment, none of which would be considered program-related expenses. While your official response states that these costs were appropriate, I would like to emphasize that they are not necessary for the administration of the HealthChoices Program and come at the expense of Philadelphians in need of the essential services CBH provides. Additionally, it does not appear that DBHIDS performed any review of CBH administrative expenses for appropriateness, demonstrating a lack of oversight and accountability.

Throughout your response, you did not adequately address our specific findings and observations. I urge you to take these findings and observations seriously and fully implement our recommendations to improve CBH's administration of the HealthChoices Program, as well as DBHIDS's oversight of CBH's operations. As Philadelphia struggles to combat the opioid and gun violence crises, the need for high quality behavioral health supports for our residents has never been greater. Addressing the issues identified in our report is critical to the effective administration of these essential services.

Our specific findings, observations, and recommendations were shared with your staff during our exit conference. We included management's written response as part of the report, as well as our comments on management's response. While we were made aware of changes in certain areas since the audit period, these changes were not reviewed by the Controller's Office or Mercadien, P.C. as part of the engagement.

We would like to express our thanks to the management and staff of both DBHIDS and CBH for their assistance during the audit.

Sincerely,

A handwritten signature in black ink, appearing to read 'Rebecca Rhynhart'. The signature is stylized with a large 'R' and a long horizontal stroke.

Rebecca Rhynhart
City Controller

CC: Honorable James F. Kenney, Mayor
Honorable Darrell L. Clarke, President, City Council
and Honorable Members of City Council
Dr. Faith Dyson-Washington, CEO, CBH



CITY OF PHILADELPHIA

HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM JULY 2016 TO JUNE 2017

EXECUTIVE SUMMARY

Across Philadelphia, the opioid crisis has wreaked havoc on neighborhoods – since 2017, more than 1,000 Philadelphians have died from drug overdoses annually, with more than 80 percent of those deaths occurring as a result of opioid overdoses. At the same time, Philadelphia has experienced a dramatic increase in shootings and four years of increasing homicides. In 2020, Philadelphia had its second highest homicide rate since 1990 and through July of 2021, there has already been a 33 percent increase in homicides over last year. The trauma of this violence has left communities bereft and afraid. These crises demonstrate the need for high quality behavioral health supports for Philadelphians who desperately need them.

The Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) offers behavioral health care, including mental health and addiction treatment and services, and intellectual disability supports to vulnerable Philadelphians. Despite an annual budget of more than \$1.3 billion for the HealthChoices Behavioral Healthcare Program (HealthChoices) and average annual expenses of nearly \$1 billion, DBHIDS has yet to undergo a rigorous performance audit. As such and pursuant to Section 6-400(c) of the Philadelphia Home Rule Charter, the Office of the City Controller initiated an audit of the HealthChoices Program, administered by Community Behavioral Health (CBH) under the oversight of DBHIDS, for fiscal year 2017 to determine whether CBH and DBHIDS were properly and effectively using public financial resources in the administration of HealthChoices to support vulnerable Philadelphians.

Under a contract with DBHIDS, CBH serves as the Managed Care Organization for HealthChoices, the Commonwealth of Pennsylvania’s program for delivering mental health and/or drug and alcohol services to medical assistance recipients, in Philadelphia county. DBHIDS disperses Medicaid funds from the Commonwealth of Pennsylvania for the program to CBH. CBH contracts with third party healthcare providers and reimburses them for services provided to patients through local programs. While CBH is responsible for monitoring and oversight of its service providers, as well as administrative support services, DBHIDS serves as the oversight function for CBH. Despite the multi-layered monitoring and oversight structure for HealthChoices, the engagement identified many compliance and internal control deficiencies, shortcomings in monitoring and oversight efforts, and an overall lack of accountability.

To assist with our audit, the Controller’s Office engaged Mercadien, P.C., Certified Public Accountants (“Mercadien, P.C.” or “MPC”) as subject matter experts to provide consulting services and conduct Phase II of the engagement. The results of their separate engagement are detailed in the Consulting Report section of this document.

KEY PHASE I FINDINGS

Providers are required to maintain key clinical documentation to support Medicaid-related claims, demonstrate the quality of care provided, and show patient progress. Testing identified 149 instances of non-compliance with documentation requirements across 27 providers sampled. The inability to provide required clinical documentation calls into question whether CBH should have reimbursed providers for these claims, as well as the validity of the services provided and the quality of care administered. Moreover, auditors' review of CBH provider profiles, which summarize CBH's monitoring of providers, found that CBH was well aware of providers' claims-related deficiencies in the past, including insufficient or missing documentation, incomplete treatment plans, billings for non-billable services, conflicting information in supporting documentation, re-use of progress notes and late entries in progress notes. Importantly, the monitoring units identified considerable claims-related deficiencies and/or high error rates even though the testing samples were small and the results of the testing were not extrapolated. Despite knowing that certain providers had a history of documentation issues, CBH did not appear to undertake additional scrutiny of those providers. It does not appear that DBHIDS performed any review of CBH's monitoring efforts.

Since 2007, CBH has run the Community Integrated Recovery Centers (CIRC) program. Thirteen providers administer services under the CIRC program. These providers were permitted to set individual treatment options and rates, and were paid a fixed monthly payment for a contracted number of patients to be served. Providers were paid the full payment regardless of whether the provider reached full service capacity. During the audit period, CBH distributed approximately \$33 million in varying amounts to CIRC program providers. On average, CIRC program providers reached 65 percent of their patient capacity during the audit period. Only one of the 13 CIRC providers exceeded capacity. In total, CBH paid CIRC program providers \$10.4 million for services that were not actually provided to patients from July 2016 through June 2017. While auditors did not review other years, it is likely that CBH has paid providers millions of dollars annually for services not rendered to actual patients since the program's inception. Auditors noted no formal monitoring program for CIRC providers or formal intervention by CBH or DBHIDS to reduce budgeted capacity to a realistic level.

Other findings include:

- CBH submitted expenses totaling approximately \$200,000 for reimbursement to DBHIDS, including \$149,000 for costs related to CBH's 20th anniversary celebration and more than \$54,000 in various health and wellness programming for CBH employees. These expenses were submitted as administrative costs despite not being related to the administration of HealthChoices. It does not appear that DBHIDS performed any review of CBH administrative expenses for appropriateness; and
- The quality of services provided may not be accurately depicted as part of the performance bonus structure for the Pay-for-Performance program, a state initiative aimed at improving the quality, efficiency, and overall value of managed health care providers. There appears to be a lack of transparency and communication by CBH to providers regarding the Pay-for-Performance program, which has led to confusion among providers.

KEY PHASE II OBSERVATIONS

CBH is responsible for credentialing and recredentialing providers, a vital process to ensure patients receive high quality care by qualified professionals and staff. Per the CBH Provider Manual, facility

organizations/agencies are solely responsible for ensuring that the staff they employ, or contract with, meet all educational and experiential requirements for the positions held and possess all the appropriate certifications and clearances. The engagement found that CBH's credentialing process for HealthChoices providers in a facility organization/agency needs strengthening.

The engagement identified several instances in which CBH incorrectly requested and received reimbursements from DBHIDS. From February 2014 through June 2018, CBH submitted duplicate expenses totaling more than \$6.4 million to DBHIDS for reimbursement. The amount in question was eventually returned to the City. However, neither CBH nor DBHIDS performed a reconciliation of reimbursements for HealthChoices and non-HealthChoices reimbursements to identify over reimbursements in a timely manner. From July 2014 through December 2017, CBH submitted reimbursement requests related to voided transactions totaling nearly \$1.5 million. As of March 2020, nearly \$1.1 million was still not returned to the City. The lack of adequate internal controls over the invoice review process could create the potential for fraud or waste to occur undetected. Lastly, CBH submitted inaccurate requests for reimbursement for payroll and payroll related expenses from the City for six of 26 pay periods during the testing period. Despite payroll being a relatively consistent and standard expense, the overpayment, totaling almost \$1.5 million, was not identified in a timely manner. The amounts in question were returned to the City almost a year later. No review occurred by CBH or DBHIDS to timely identify the inaccurate requests prior to the reimbursements being made. CBH does not have adequate controls in place to prevent inaccurate requests from being made or erroneous under or overpayments from being identified. Without a consistently followed review process in place by both CBH and DBHIDS or a formal reconciliation process, it is possible that additional erroneous payroll requests occurred outside of the engagement scope.

During the course of the engagement, testing identified several instances in which CBH's administrative procurements violated parts of the Philadelphia Code to which they were subject, and/or CBH failed to follow its own internal procurement protocols. Specifically, CBH entered into sole source contracts for professional services, including one contract that was awarded to a then-current CBH employee for consulting services. CBH also entered into three separate administrative contracts utilizing old RFPs to procure services without issuing a new RFP. Two of the three contracts were expired and had no renewal provisions, and one contract had a renewal for which the new services were not applicable. Despite these shortcomings, CBH awarded these contracts as renewals. Additionally, the engagement found no evidence that DBHIDS provided adequate oversight for any of these procurements. These examples call into question whether these procurements were transparent and represent the best value, that is, an efficient use of public resources. Given the limited scope of the testing period, the wide-ranging examples of non-compliance with procurement standards, and DBHIDS's lack of oversight over CBH's procurements, it is possible that many of CBH's other procurements over the years were inappropriate.

CBH issued 41 advances totaling more than \$6.5 million to 13 providers during the testing period. The engagement found 16 instances in which those advances were not in compliance with CBH's policy governing advances/loans to providers, including six instances in which the stated reason for the advance did not conform to the policy requirement relating to a contracting or billing system issue. While most of the providers who received advances repaid them, two of the 13 providers defaulted on the repayment of the advances they received totaling \$236,574 and \$3,835,000, respectively. One of these providers closed prior to repaying the advances and one entered into bankruptcy proceedings. CBH ultimately wrote the advances/loans off as "bad

debts.” As such, it is unlikely that the City will be able to recoup these funds. Weaknesses in internal controls, like CBH improperly documenting approvals or allowing non-authorized individuals to approve advances, could lead to fraud or waste going undetected. DBHIDS’s lack of oversight of CBH’s operations could also contribute to fraud, waste or abuse going undetected.

CBH allows providers to apply for rate increases on an ad-hoc basis. The policy for requesting a rate increase details required documentation standards, including the reason for the rate increase request. The engagement found that CBH did not consistently follow the guidelines established in its policies and procedures and did not have sufficient processes in place for documentation retention. It does not appear that DBHIDS provides any review or oversight over CBH’s rate increase process.

RECOMMENDATIONS

To improve CBH’s administration of the HealthChoices Program and ensure the proper and efficient use of public resources, it is recommended that CBH implement considerably stronger internal controls regarding provider monitoring and compliance with its own and City policies, as well as DBHIDS’s oversight of CBH’s operations, which are detailed in the following reports.

**CITY OF PHILADELPHIA
HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM**

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OFFICE OF THE CITY CONTROLLER



AUDITORS' REPORT

**CITY OF PHILADELPHIA
HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM**

JULY 2016 TO JUNE 2017

**DEPARTMENT OF BEHAVIORAL HEALTH
AND INTELLECTUAL DISABILITY SERVICES
AND
COMMUNITY BEHAVIORAL HEALTH**

OFFICE OF THE CITY CONTROLLER
Auditors' Report – Introduction

PURPOSE OF THE AUDIT

The Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) is responsible for providing mental health, intellectual disability, and addiction treatment services to vulnerable Philadelphians. Over the last two decades, DBHIDS's responsibilities have grown considerably, however, its escalating budgets and the relative success of its efforts have not received comparable increasing scrutiny. With an annual budget of more than \$1 billion, and the need for additional community behavioral health support due to the gun violence and opioid crises, the Office of the City Controller wanted to determine whether DBHIDS is properly and effectively supporting individuals most in need of the services they provide. Accordingly, we initiated this audit pursuant to Section 6-400(c) of the Home Rule Charter, which authorizes the city controller to perform audits of the financial affairs of every city department, board, or agency, as well as to conduct special audits when, in the controller's judgment, it appears necessary.

BACKGROUND

The Commonwealth of Pennsylvania, Department of Human Services ("Commonwealth" or "PA DHS") approved the City of Philadelphia ("City") to manage a Mandatory Medical Assistance Behavioral Health Managed Care Program, called the HealthChoices Behavioral Health Program ("HealthChoices"), for eligible persons residing in Philadelphia County. Introduced in 1997, HealthChoices is managed at the state level through the Office of Mental Health and Substance Abuse Services (OMHSAS), with medical assistance recipients receiving access to mental health and/or drug and alcohol services through local programs that are overseen by DBHIDS and administered by a Managed Care Organization (MCO). Philadelphia's MCO for the County's HealthChoices Program is Community Behavioral Health (CBH).

Creation of DBHIDS and CBH

DBHIDS was established in 2003 by Executive Order No. 3-03 as the Office of Behavioral Health and Mental Retardation Services (OBH/MRS). OBH/MRS was charged with overseeing and coordinating the City's behavioral health system and the mental disability services, both directly and through contracts with local healthcare providers. It also absorbed the duties of the Coordinating Office for Drug and Alcohol Abuse Programs, which was previously a part of the Managing Director's Office. In 2012, the OBH/MRS became the Office of Behavioral Health and *Intellectual disAbility Services*, and soon thereafter, was renamed the *Department of Behavioral Health and Intellectual disAbility Services*.

CBH is a non-profit corporation created by the Department of Public Health. Currently, under a contract with DBHIDS, CBH is engaged to act as the City's MCO for the HealthChoices Program and to deliver medically necessary services to covered members in the least restrictive and most appropriate manner. CBH's mission is to integrate medical assistance and program funding streams, while managing mental health and substance abuse services. Specifically, CBH is charged with:

- Planning and coordinating the delivery of services to medical assistance recipients, working closely with DBHIDS to ensure a full and appropriate range of behavioral health treatment modalities and supportive services;
- Contracting with third parties to provide mental health and substance abuse services; and

- Monitoring and evaluating services and requiring accountability from its contracted, Medicaid enrolled and licensed, service providers.

DBHIDS has also contracted with CBH to provide administrative support services related to certain grants and information systems. The majority of CBH's Board of Directors is comprised of City employees and includes the Health Commissioner, Director of the Office of Homeless Services, and the City's Department of Human Services Commissioner.

Funding for the HealthChoices Program comes from the federally-funded Medicaid program administered at the state level by the PA DHS. DBHIDS receives monthly "capitation payments" from the Commonwealth that are based on the number of enrolled Medicaid recipients in Philadelphia by Medicaid eligibility type. CBH receives this funding from DBHIDS. CBH is a component unit of the City and its financial activities are included in the City's Comprehensive Annual Financial Report.

***Behavioral Healthcare
Providers***

During fiscal year 2017, CBH reimbursed approximately 270 healthcare providers, including 175 in the City's network of providers, that offer mental health services, drug and alcohol treatment, and intellectual disability services. Almost half of the in-network agencies¹ were already under contract with the City to provide these services when CBH officially started functioning as the MCO in 1997.

These providers offer 19 levels of care (or programs) that include mental health outpatient services, drug and alcohol outpatient programs, and intensive outpatient care. Providers also oversee residential treatment facilities, behavioral health rehabilitation services, inpatient drug and alcohol services, medication-assisted treatment, long-term structured residences, and community support services. Provider agencies vary in size and structure, with some offering just one level of care at one location to others managing a variety of programs spread across multiple facilities. A customized rate schedule (also known as "Schedule A") is included in the provider agreement and indicates all approved services or levels of care along with authorized billing codes, rates, and any relevant pricing and/or information modifiers.

***Billings, Claims, and
Reimbursements: Providers to
CBH and CBH to DBHIDS***

The process for billings, claims, and reimbursements should work in the following manner. Once a client starts receiving services, the provider submits a bill to CBH based on the nature of the treatment and Schedule A charges. Almost all claims submitted by providers are done so electronically, with Schedule A rates included in the programming, as protection against improper billings. Providers are required to enter the recipient (patient) identification number, date(s) of service, Schedule A coding, and other relevant information into the claims processing system. If all the required information is entered correctly, payment will be made by CBH to the provider. If identification numbers or other data is incorrect or inconsistent with information in the system, the payment claim will likely be rejected and returned to the provider for correction. If the provider requests reimbursement for an amount greater than allowed by CBH, the system will only pay the provider up to the amounts authorized by Schedule A. CBH will then request weekly reimbursements from DBHIDS via the Weekly City Invoice for all payments made to their providers during that same period.

¹ Eighty-three of the 175 in-network providers.

During fiscal 2017, DBHIDS reimbursed CBH \$766.5 million for program services directly performed by contracted mental health and addiction treatment providers. Over that same period, DBHIDS reimbursed CBH \$157.9 million for payroll costs and other operating expenses specifically incurred by CBH acting as the City's behavioral health MCO. This also includes the MCO assessment levied by the Commonwealth.

Monitoring and Oversight

CBH relies on three units, Compliance, NIAC² Credentialing (NIAC), and Quality Management, to deliver what CBH defines as a "multi-disciplinary, cross-departmental approach" to oversight and monitoring. The units were

created to perform the following functions:

- Compliance Unit – Reviews and monitors providers' adherence to applicable federal and state regulations governing the Medicaid program as well as CBH policies and procedures, including program operation and billings.
- NIAC Unit – Reviews staffing qualifications, facility standards, written policies, clinical recordkeeping, and required business documents before providers enter the CBH network and thereafter when re-credentialing is required.
- Quality Management Unit – Assesses significant reported incidents and quality of care concerns, addresses patient complaints and grievances, conducts provider site visits, facilitates meetings with providers and monitors Quality Improvement Plans, when required.

The Compliance Unit is comprised of 17 staffers, many of whom have medical certifications that allow them a better understanding of the information in the patient files they review. It utilizes multiple types of reviews to monitor providers, including self-audits or self-evaluations, probe audits, and site visits. Additionally, the Compliance Unit performs targeted reviews of providers or specific claims when requested by either of the other two monitoring units.

The NIAC Unit is responsible for conducting recredentialing reviews of facilities. They ensure provider adherence to relevant regulatory requirements and provide monitoring oversight for providers related to the implementation of recovery and resiliency standards set forth within Network Inclusion Criteria (NIC)³ Standards for Excellence; this is inclusive of staff qualifications, facility standards, written policies, clinical recordkeeping, required business documents, and recovery-oriented practices as part of the recredentialing process. They examine licensing and board certification for the professional staff, written policies regarding the clinical services offered and any incident reports prepared for the site. They will also engage in discussions with staff members and individuals receiving services, with the primary goal to determine whether the provider achieves an acceptable level of care or a provisional or warning status. Acceptable levels of care are graded at Basic, Sufficient, and Excellent with a one, two, or three-year credentialing status, respectively, which means that a follow-up review should occur within the assigned time frame. Providers receiving a Warning Status are placed on a six-month probationary term, and Provisional status indicates that the provider does not meet minimal NIAC approval standards.

² Network Improvement and Accountability Collaborative

³ Establishes a set of core capabilities that a provider must demonstrate to be approved for network recognition and maintained within the DBHIDS network of care.

Providers receiving either a Warning or Provisional Status will be given mandatory technical assistance to help raise their NIAC recognition levels. The NIAC Unit, which is comprised of DBHIDS and CBH employees, will offer recommendations for improvement that must be addressed by the provider's Performance Improvement Plan. NIAC site visits can take from one to several days to complete, depending on the number of provider locations and the extent of program services offered. The NIAC Unit's recommendations for recredentialing status is presented to the CBH Board of Directors.

The final unit sharing monitoring responsibilities with the Compliance and NIAC Units is CBH's Quality Management Unit. Comprised of medically trained personnel, this unit is primarily concerned with matters of clinical importance that have been reported to CBH⁴ and involve patient safety and/or the quality of care. If the Quality Management Unit determines that the matter is significant and must be addressed immediately, they will perform a site visit to investigate the specifics of the incident. This may involve reviewing files for several patients if the matter involves a specific caregiver or reviewing all services to a specific patient if the concern involves the quality of treatment. Quality Management may close admissions to a provider until the matter is resolved and/or will require the provider to prepare a Quality Improvement Plan, which will remain in effect until the provider can show that they have addressed the problem(s).

⁴ Incidents reported to CBH may come from hotline complaints, concerns reported by patients receiving care, the providers themselves, or from another monitoring unit.

OFFICE OF THE CITY CONTROLLER
Auditors' Report – Findings and Recommendations

REQUIRED CLINICAL DOCUMENTATION MISSING FROM PATIENT FILES

To assist DBHIDS in meeting its mission, CBH created performance manuals to ensure that providers administer mental health services and substance abuse treatment in accordance with Medicaid regulations and quality care standards. These manuals give providers specific guidance regarding clinical documentation, performance standards, credentialing, and operational directives. They also outline CBH's reimbursement requirements, including clinical documentation showing into which program(s) a patient is placed and what services a patient receives. These required documents, which include treatment plans and progress notes, are also important to demonstrate patient progress and the quality of care.

We focused our review on the controls established by DBHIDS and CBH to ensure that reimbursements to providers were adequately supported and only made when services were rendered in accordance with contract requirements and CBH regulations. We did not evaluate the quality of the medical services rendered.

Using a random sample of 27 providers⁵, we haphazardly selected 284 transactions from the Weekly City Invoices submitted to CBH for the fiscal year July 1, 2016 to June 30, 2017. We asked the providers to produce the documents described below, when applicable to the required treatment, to substantiate delivery of the services and validate billing for the transactions selected.

- The Encounter Form – evidences a patient's participation in, or receipt of, specific services or treatments. This form also serves as a time record for the employee that is used for billing purposes. Encounter forms are not required at sites where patients receive residential services. When our sample included residential services, we looked for evidence showing the patient was present on the sampled day. An encounter form may also be replaced by a sign-in-sheet or a progress note.
- Progress Notes – documents a patient's improvement or clinical regression while receiving treatment. The notes can be used to validate a clinician's time or help other program staff to intelligently participate in the treatment process. Notes that only report attendance, are not considered useful for clinical purposes.
- A Treatment Plan – documents how the care of the patient will be performed and how long the individual should be receiving care. The plan should include a diagnosis, treatment method, planned intervention, and the name of the clinician responsible for ensuring the plan is carried out properly. The patient and responsible clinician must sign this document.
- A Comprehensive Biopsychosocial Evaluation (CBE) / Comprehensive Biopsychosocial Re-evaluations (CBR) or Pennsylvania Client Placement Criteria (PCPC) Form – assesses a patient's intellectual and emotional functioning. This information is obtained through interviews and clinical record reviews and is used to help create or amend a patient's treatment plan for mental health services. A PCPC is a

⁵ Approximately 10 percent of provider agencies receiving reimbursements from CBH during fiscal year 2017.

modified⁶ version of assessment criteria created by the American Society of Addiction Medicine (ASAM) and is used to evaluate the needs of patients receiving drug and/or alcohol treatment services. A CBE/CBR or PCPC must be on file for each patient.

Additionally, while not required to support reimbursement for the services in the specific claims we tested, we also requested the following documentation required by Medicaid regulations:

- The Release of Information (ROI) Form – indicates the patient’s consent to release personal and medical information to any organization or individual listed on the document in accordance with HIPAA requirements. This form includes a provider’s right to bill CBH for the services rendered.
- The Intake Form – contains personal identification and relevant medical information gathered from a patient upon first contact with the provider. Information on the Intake Form is used to place patients in programs and contributes to the creation of the Treatment Plan.

Condition: As a result of testing for the seven key clinical documents described above, we identified the following instances of non-compliance with CBH and/or the PA DHS documentation requirements. Specifically, of the 284 transactions we tested, we noted that:

- 31 Encounter Forms (10.8%) were not located within patient files.
- 26 Progress Notes (9.2%) were not located within patient files.
- 16 Treatment Plans (5.6%) were not located within patient files.
- 30 Comprehensive Biopsychosocial Evaluation (CBE) Forms, Reevaluation (CBR) Forms, or Pennsylvania Client Placement Criteria (PCPC) Forms (10.6%) were not located within patient files.
- 28 ROI Forms (9.9%) were not located within patient files.
- 18 Intake Forms (6.3%) were not located within patient files.

Refer to **Table I** below for more information.

⁶ Pennsylvania makes evaluations in a similar manner as specified in the ASAM criteria but since some recommended services are not available in Pennsylvania, the OMHSAS modified the form for the type of services the Commonwealth can provide.

Table I: Missing or Unavailable Documentation

Provider	Encounter Form	Progress Notes	Treatment Plan	CBE/CBR Evaluation	PCPC Form	ROI Form	Intake Form	Total Per Provider
1		2		1			1	4
2						2	2	4
3		1	2			4	1	8
4						1		1
5	5	5	1	1				12
6		1				1		2
7		2						2
8	5	1						6
9		2	2		3	1		8
10						1		1
11				6		1		7
12		4		2				6
13		2	10	8		10	10	40
14	9			1				10
15	2	5	1		1	2	1	12
16	10			1		1		12
17		1		3	3	3	3	13
18						1		1
# Exceptions	31	26	16	23	7	28	18	149
# Providers	5	11	5	8	3	12	6	

Source: Prepared by the Office of the City Controller.

Criteria: Providers are required to follow the directives CBH outlined in its Treatment Planning Guide and other comprehensive manuals. These manuals reflect PA DHS' guidelines.

Cause: While it appears that CBH's manuals are comprehensive and informative, providers do not always follow the directives outlined in the manuals to ensure that quality standards are met, while protecting the confidential nature of patient services and ensuring the validity of program expenditures.

Effect: Providers were not in compliance with CBH and PA DHS documentation requirements. CBH reimburses providers with the expectation that this clinical documentation is always maintained in patient files and available to substantiate the payment claim for services rendered. The inability to provide required clinical documentation calls into question the validity of these claims, as well as the validity of the services provided, and the quality of care administered. Since our sample was not statistically selected or projectable, we did not compare our results to what

the federal government would deem an acceptable error rate. However, the number of exceptions across a small and impartial sample raises concerns that missing documentation could be more widespread across all providers.

Recommendations: To ensure clinical documentation is maintained as required, and available to substantiate the payment claims for services, we recommend that providers:

- Comply with all PA DHS and CBH documentation requirements. [201520.01]
- Institute the necessary controls to ensure critical information is accurate and complete to support encounters/claims. [201520.02]

Additionally, we recommend that CBH more closely and regularly monitor providers to ensure reimbursements are appropriate and supported by required documentation that demonstrates compliance with quality of care standards. This would help make providers more mindful of their responsibility to adhere to program requirements. [201520.03]

PROVIDER PROFILES IDENTIFIED DOCUMENTATION ISSUES SIMILAR TO AUDIT RESULTS

CBH maintains an overview snapshot or “profile” for each provider in its network. These profiles offer relevant information as it relates to provider operations, such as the types of programs offered, what locations they oversee, the number of clients enrolled in the programs, expenditures related to those programs, awards, and/or loans given to the providers. The profiles also include the summarized results of CBH’s monitoring reviews, which cover matters involving credentialing, compliance, quality of care, recordkeeping, adequacy of clinical documentation, and billing procedures at the provider locations.

Condition: CBH’s provider profiles identified significant claims-related deficiencies, including insufficient or missing documentation, incomplete treatment plans, billings for non-billable services, conflicting information in supporting documentation, reuse of progress notes, and late entries in progress notes. See **Table II** below.

Table II: CBH Profiles Compared to Results of Audit Testing												
	Insufficient or Missing Documentation		Claims Without a Valid Treatment Plan		Non-Billable Activities		Conflicting Information		Reuse of Content		Late Note Entries	
Provider	Per CBH Profiles	Per Auditor	Per CBH Profiles	Per Auditor	Per CBH Profiles	Per Auditor	Per CBH Profiles	Per Auditor	Per CBH Profiles	Per Auditor	Per CBH Profiles	Per Auditor
1		X	X									
2		X					X					
3							X					
4	X		X		X		X		X		X	
5	X	X		X			X				X	
6	X	X	X		X		X		X			
7	X	X	X	X	X		X		X			X
8		X				X						
9	X	X				X	X					
10	X	X						X				
11	X	X		X		X	X	X		X	X	
12	X						X		X		X	
13		X	X		X							
14	X	X			X		X					
15												
16	X	X	X		X		X				X	
17	X		X		X		X				X	
18	X						X		X			
19	X	X	X	X		X	X					
20	X						X				X	
21	X	X					X					
22	X		X		X		X					
23		X		X		X		X		X		
24	X				X		X		X			
25	X	X				X						
26	X	X							X			
27		X	X								X	
Total	19	18	10	5	9	6	18	3	7	2	8	1

Source: Prepared by the Office of the City Controller using Provider Profile Reports obtained from CBH and audit testing results.

Specifically, the claims-related deficiencies that CBH identified include:

Insufficient or Missing Documentation

In profiles for 19 of the 27 providers we selected for testing, CBH noted concerns regarding the absence or lack of adequate documentation to support billing for services. Concerns ranged from a few missing documents at one site, to another site's frequent inability to present adequate data showing that services were delivered to properly enrolled patients on the date and times specified. During one evaluation, CBH stated that the content of the provider's progress note did not give a clear picture of what was occurring during the patient's session, stating that it lacked interventions, and did not support the duration of time billed. For another, the profile stated that "documentation continued to be vague, generic, and without rationale why a behavioral specialist consultant continued to implement the same interventions despite lack of progress." Finally, another spoke of the lack of coordination between the psychiatrist and therapist and the lack of formal risk assessments and safety planning for patients.

Incomplete Treatment Plans

CBH cited ten of the 27 providers in our sample for lacking valid treatment plans. For one provider, CBH noted that “a couple of recovery plans did not contain contact goals (the goal section was blank) but the client initialed and signed the blank sheets” and several other recovery plans were unsigned. Another provider was cited for completing a treatment plan with “an improper correction to the date of the plan which invalidated the plan and impacted fifteen dates of service.”

Billings for Non-Billable Services

CBH cited nine of the 27 providers in our sample as submitting charges for activities that were unallowable. Comments included “billing for days in which there was no attending psychiatrist in place” and “multiple group notes had non-billable activities” resulting from (progress) notes not having start and end times. CBH also observed that one provider billed for dates before the actual start of treatment.

Conflicting Information Within Supporting Documentation

CBH cited 18 of the 27 facilities we tested for having documentation in patient files that did not agree with the treatment plan or other required information in the patient file. During one compliance audit, CBH noted that “medication consent forms were not clear around what symptoms were being treated as different diagnoses are listed in different notes.” In another provider’s review, notes in a client’s chart were found to have a different name for a foster parent than the name noted in the treatment plan. Other conditions cited in the profiles include payment for participation in group sessions that were not attended by some of the clients, and hours in session with a client that were not in agreement with units charged for reimbursement.

Re-Use of Progress Note Content

CBH’s profiles indicate that seven of the 27 sites we tested were found to have instances of what appeared to be re-use of progress note content. In one provider’s profile, CBH stated that the progress notes “lacked unique content” and each session was similar to the previous one. Another provider was cited twice for duplicating notes, once in January 2016 and again in May 2017. CBH also identified that multiple individuals at one of the provider facilities reused content of progress notes within and across patient charts.

Late Entries into Progress Notes

CBH’s compliance reviews found that eight of the 27 providers had instances of progress notes entered later than required by CBH policy.

We then compared CBH’s noted deficiencies in its most recent provider profiles with our own observations and found similar claims-related deficiencies, including:

Insufficient or Missing Documentation

Like CBH, we identified the absence or lack of adequate documentation to support billing for services at 18 of 27 providers tested during our review. Our observations included one provider that disposed of patient sign-in-sheets (i.e., encounter forms for that location) after six months, violating both CBH and the Commonwealth’s record retention policy requiring the storage of paper medical records for seven years.

Incomplete Treatment Plans

Our auditors observed that five of the 27 providers had incomplete treatment plans for patients, including missing plans, missing clinician and/or patient signatures, and untimely treatment plans.

Billings for Non-Billable Services

Our auditors also identified six providers billing for non-billable services, including one provider that billed CBH for services administered to individuals living in Delaware County. Reimbursement for Delaware County residents should be sought from Delaware County's MCO. The provider stated that it believed it was permitted to treat and request reimbursement for non-city residents through Philadelphia's program.

Conflicting Information in Supporting Documentation

We noted similar instances of conflicting information at three locations, including one provider that billed for services rendered to a patient in March 2017, however, the patient's file showed services were rendered between June and August 2017.

Criteria: As patients are enrolled in a program or receive treatment, records documenting these actions should be prepared and inserted into the patient's case folder. Effective treatment plans are crucial to providing a strategy for effective patient care and successful outcomes. Additionally,

- CBH policies require that treatment plans must be developed, updated, and signed by all appropriate persons (including the patient) for each level of care.
- Treatment progress notes, signed and dated by the person making the entry, should be prepared for each service rendered.
- CBH policies, as well as medical best practices, specifically state that documentation must be original and accurately describe the individual's treatment experience for the billed service. This covers the clinician's preparation of progress notes as evidence of patient improvement or remission. Providers are instructed to ensure that their clinicians and other medical staff prepare specific and detailed records supporting the treatment or services they provide.
- Per CBH policy, progress notes must be completed, signed, and entered into the clinical record before the service is billed or within seven days of the date of service, whichever comes first.

Cause: During discussions with our auditors, high-ranking DBHIDS and CBH officials stated that it was their goal to "not lose providers." They contended that it is extremely difficult to relocate patients when providers do not meet quality of care standards. According to CBH, it works to raise providers to higher performance levels through a combination of technical assistance, monitoring reviews, performance incentives, and other support services. However, it appears that many of the deficiencies or similar deficiencies are noted repeatedly for the same providers based on our review of CBH's provider profiles. While CBH recoups reimbursements for unsupported claims and requires corrective action plans for providers with repeated deficiencies, the consequences may not be significant

enough to improve practices or ensure a provider follows documentation requirements. It does not appear that DBHIDS reviews the results of CBH's monitoring efforts to provide meaningful oversight.

Effect: Providers were not in compliance with CBH policies, as appropriate and required documentation was often insufficient to support HealthChoices claims selected for testing. As such, CBH may have inappropriately reimbursed providers for these transactions. The lack of documentation or inability to produce required documentation does not support that the care stated was actually provided to patients, which could potentially call into question the provision of care or the quality of care provided.

In addition to unsupported claims being disallowed, it is possible that a federal oversight agency, such as the U.S. Department of Health and Human Services, Office of the Inspectors General, could perform an audit utilizing a statistically valid sample of claims. The audit findings could then be extrapolated over the entire population of claims, which could result in a significant federal recovery for disallowed claims or have a negative impact on future capitation funding for the City.

Recommendations: Per CBH policies, a provider that is cited for documentation issues will face a number of escalating consequences, including developing and implementing a corrective action plan. To ensure that providers remain in compliance with CBH policies and prevent the risk of oversight agencies disallowing claims, we recommend that CBH:

- Establish procedures for following up with a provider regarding the creation and implementation of a corrective action plan. [201520.04]
- Review the corrective action plan developed by the provider and ensure through regular monitoring, that it is being followed and supporting documentation is kept as required. [201520.05]
- Review and consistently enforce disciplinary mechanisms and escalating consequences, relating to providers with repeated deficiencies in recordkeeping. [201520.06]

Additionally, we recommend that DBHIDS, which has the oversight responsibility for the HealthChoices Program, ensure that CBH takes effective action with respect to providers with significant repeat findings. [201520.07]

COMPLIANCE UNIT OVERSIGHT INSUFFICIENT TO ADDRESS DOCUMENTATION CONCERNS

CBH's Compliance Unit, comprised of 17 employees, is responsible for providers' adherence to federal and state regulatory requirements, as well as to CBH policies and procedures. The Compliance Unit utilizes multiple types of reviews to monitor providers, including (1) probe audits, which evaluate specific levels of care across the provider network; (2) self-audits or self-evaluations, which require the provider to review their own operations and report their findings back to CBH; and (3) site visits, which are more targeted reviews conducted by teams of two or three Compliance Unit employees. The Compliance Unit also examines claims, or the activities performed by specific

individuals, whenever complaints or allegations are made against the provider, when requested by either of the other two monitoring units, or when findings from self-audits warrant further review or indicate the need to return funding.

Condition: Our review of CBH's monitoring efforts indicates that compliance monitoring is insufficient to identify and rectify systemic issues at the provider level. The depth and frequency of site visits are inadequate to ensure recordkeeping requirements are identified and corrected in a timely manner for the 19 levels of care offered at 700 locations by 270 providers across the city.

Criteria: Providers are required to follow the directives CBH outlined in its Treatment Planning Guide and other comprehensive manuals. The Compliance Unit performs monitoring reviews to verify providers adhere to program operation and billing requirements.

Cause: The frequency and depth of CBH site visits and testing samples are not sufficient to ensure that concerns regarding recordkeeping requirements were timely identified and corrected. The claims testing samples are typically small and, if CBH identifies a documentation issue at a provider, they do not expand the sample to determine if the problem is more widespread within the program, across other programs, or at the provider's other locations. While CBH may recoup payments for unsupported claims identified, the testing conducted is not robust enough to identify further incidents of non-compliance. Additionally, as the same or similar conditions are noted from monitoring visit to monitoring visit, as detailed in the previous finding, it appears that enforcement and/or disciplinary efforts may not be improving recordkeeping concerns. It does not appear that DBHIDS management reviews the results of CBH's monitoring efforts to provide meaningful oversight.

Effect: Providers are not in compliance with documentation requirements in CBH policies. As such, CBH may have inappropriately reimbursed providers that were unable to provide proper and required documentation. CBH's monitoring efforts are insufficient to identify and correct systemic issues at a provider or across providers, which could result in unsupported claims being paid to providers.

Recommendations: Ensuring that provider billings are monitored frequently and thoroughly will help to address the problems associated with inadequate and insufficient documentation, and thereby increase levels of performance among the providers. Therefore, we recommend that CBH management:

- Determine a more efficient and effective method of monitoring providers, including reviewing the use of self-audits and probe-type audits. While permitted by the federal government, self-audits are not as thorough as the compliance reviews conducted by CBH and should not be used as a replacement for them. Additionally, while probe-type audits that focus on specific programs are also recommended by the federal oversight agencies, they severely limit the number of provider locations that would be reviewed each year. It also reduces the likelihood that deficiencies across the other 18 major programs would be timely identified. [201520.08]
- Require the Compliance Unit to increase testing sample sizes, especially if a deficiency is identified at a provider. Expanding testing sample sizes would help CBH understand the full breadth and depth of deficiencies at a specific provider and potentially identify other unsupported claims that should be disallowed. [201520.09]

- Re-evaluate staffing levels of the Compliance Unit. Given the small staffing size of the Compliance Unit and the number of locations, providers, and programs they must review, the unit size is inadequate to meet current monitoring needs and will be more so if monitoring reviews occur with more frequency and greater depth. [201520.10]
- Consider creating a separate team within the Compliance Unit that performs daily desk reviews of provider reimbursement requests. Personnel assigned to this task would select a statistical sample of daily activity and request the electronic submission of records to support these expenditures. Currently, CBH, DBHIDS, and the network provider agencies utilize a secured portal that allows them to safely transmit files that contain Protected Health Information (PHI). The results of these daily desk reviews would then be tracked and forwarded periodically to the teams that perform the in-depth compliance reviews so that they can be included in the results that are communicated to the provider. [201520.11]

Additionally, as the oversight body for CBH, DBHIDS should review CBH's monitoring protocols to ensure they are adequately designed and implemented. DBHIDS should also develop a review procedure, documented in writing, for spot-checking CBH's monitoring efforts. [201520.12]

CBH MONITORING/OVERSIGHT LACKED COORDINATED EFFORT

Along with the Compliance Unit, CBH uses the NIAC and Quality Management Units to monitor and oversee operations and quality of care by providers. CBH stated that these three units work together toward a common cause, raising providers to a higher level of performance, as findings and concerns noted by one unit may impact the need or frequency of another unit's intervention.

Condition: We analyzed the monitoring reviews by Compliance, NIAC, and Quality Management Units for each provider to determine the timing of site reviews, which locations were visited, and what programs were selected. Overall, our findings indicate that large gaps of time, sometimes years, occurred between site visits by individual monitoring units, as well as between all the monitoring units. We also noted inconsistencies in monitoring efforts and recommendations. For example, Compliance Unit audits showed providers with high error rates in how they document and carry out mental health and addiction treatment responsibilities, however, some of these providers received higher NIAC re-credentialing ratings, which increases the time between NIAC reviews. Quality Management cites a provider for a history of clinical concerns, yet service billings are not subject to more frequent and intense compliance audits. NIAC issues a "basic" one-year rating to a provider based on weaknesses assessed through a review of clinical records, but there is no evidence that the Quality Management Unit followed-up to determine the cause of the problem.

Criteria: CBH policies and procedures denote that the Compliance Unit, NIAC Unit, and Quality Management Unit are employed to use a "multi-disciplinary, cross-departmental approach" to provider oversight and monitoring to ensure the quality of care for patients and the appropriateness of reimbursements for services rendered to patients.

Cause: There appears to be a lack of coordination between the Compliance, NIAC, and Quality Management Units. Monitoring and oversight work conducted by the units appear to be disjointed and siloed.

Effect: In contradiction to CBH's manuals, the Compliance, NIAC, and Quality Management Units do not adequately coordinate efforts to ensure the quality of patient care, the completeness or accuracy of documentation supporting patient services, or the appropriateness of credentialing decisions. The disjointed efforts of these units may not result in a timely response by providers to the units' findings or appropriate consequences, if warranted. Additionally, the units may not achieve their intended purpose of raising providers to a higher level of performance.

Recommendations: To ensure a more cohesive effort to raise providers to a higher level of performance, CBH must determine the root causes of the deficiencies identified during the various monitoring reviews. Therefore, we recommend that the Compliance Unit work in conjunction with the NIAC Unit to address credentialing, training, and/or other needs of the provider staff. [201520.13] We also recommend that the Compliance Unit review underlying documentation for other billing transactions impacted by identified deficiencies relating to staff credentialing or training. [201520.14]

Furthermore, to ensure compliance oversight, credentialing and quality of care efforts are effectively coordinated, CBH should also better utilize its ability to share provider data/information/findings between their monitoring units. This would include:

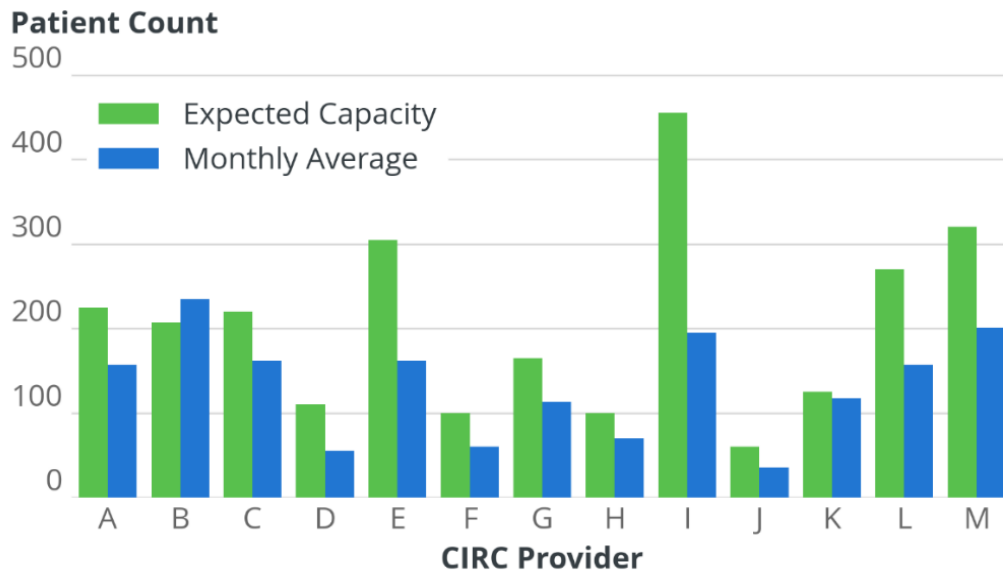
- Establishing procedures for determining a comprehensive site visit schedule and how an individual unit's finding may affect the efforts of the other units. [201520.15]
- Developing a comprehensive schedule for monitoring of all providers by all three monitoring and oversight entities. [201520.16]

CIRC PROGRAM PAYMENT STRUCTURE NOT COST EFFECTIVE

The Community Integrated Recovery Centers (CIRC) program provides individualized psychiatric or substance abuse treatment to patients in a group-based setting. Thirteen providers administer services under the CIRC program. These providers were permitted to set individual treatment options and rates and were paid a fixed payment for contracted capacity. As long as the units of service submitted via claims were within 5% of the prior twelve-month average, providers received full payment regardless of whether they reached their service capacity. During the audit period, CBH distributed approximately \$33 million in varying amounts to CIRC program providers.

Condition: During the period under review, most providers did not meet or come close to meeting their established capacity under the CIRC program. On average, CIRC program providers reached about 65% capacity. Only one provider exceeded capacity. The agreed-upon available slots (expected capacity) compared to actual patients served, appear in **Figure I** below. We noted no formal monitoring program for CIRC providers or formal intervention to increase capacity by CBH.

Figure 1: Anticipated Patient Capacity vs. Average Enrolled Patient Count for CIRC Providers



Source: Prepared by the Office of the City Controller using Table III, columns D and E.

Criteria: CBH contracts with each CIRC provider based on the actual cost of providing the service during a trial period that ran ten years prior, from April 1, 2007 through October 31, 2007. This alternative payment arrangement (APA) is approved by the State. Each provider is assigned a unit rate based on the contracted units of service to be delivered.

Cause: While CBH was in compliance with the funding structure for the program, CBH did not set adequate capacity standards for providers. CBH informed our auditors that they have negotiated lower payments with providers if patient counts fell significantly below the average. However, only slight decreases were made in payments processed between fiscal years 2016 and 2017. CBH did not have a comprehensive monitoring program for the CIRC program to adjust rates or increase providers' actual capacity. It does not appear that DBHIDS provided any oversight over CBH's administration of the CIRC program.

Effect: CBH paid CIRC program providers \$10.4 million for services that were not provided to patients from July 2016 through June 2017. See **Table III** below. While we did not review other years, it is possible that in prior years, CBH paid providers millions of dollars each year for services not rendered to actual patients.

Table III: CIRC Funding Distribution and Patient Counts

Provider	Monthly Payments (A)	Number of Payments (FY17 services) (B)	Total Payment Amount for FY17 (C) = A x B	Agreed Upon Monthly Program Capacity (D)	Avg. Monthly Patient Count (FY17 Actual) * (E)	Excess Payment for Not Meeting Capacity Expectations ** (F)
A	\$ 304,158	12	\$ 3,649,896	225	157	\$ 1,105,783
B	\$ 374,098	12	\$ 4,489,176	207	235	\$ -
C	\$ 187,769	10	\$ 1,877,690	220	162	\$ 219,348
D	\$ 131,340	12	\$ 1,576,080	110	55	\$ 782,070
E	\$ 325,923	12	\$ 3,911,076	305	162	\$ 1,840,129
F	\$ 139,019	12	\$ 1,668,228	100	60	\$ 668,681
G	\$ 94,737	12	\$ 1,136,844	165	113	\$ 359,426
H	\$ 160,350	12	\$ 1,924,200	100	69	\$ 586,881
I	\$ 235,626	12	\$ 2,827,512	455	195	\$ 1,615,721
J	\$ 82,349	12	\$ 988,188	60	35	\$ 413,117
K	\$ 181,026	12	\$ 2,172,312	125	117	\$ 147,717
L	\$ 261,688	11	\$ 2,878,568	270	157	\$ 1,049,660
M	\$ 358,418	12	\$ 4,301,016	320	200	\$ 1,606,161
Total			\$ 33,400,786	2,662	1,717	\$ 10,394,694

Source: Prepared by the Office of the City Controller using payment vouchers prepared during fiscal year 2017 by DBHIDS.
 * Calculated by totaling the actual monthly patient counts and dividing the sum by twelve months.
 ** Calculated by multiplying the monthly cost per slot by the difference between the annual capacity total and the annual patient count.

DBHIDS and CBH must submit a Cost-Effectiveness Demonstration Certification Form to the PA DHS annually. While the State approved the continued use of the fixed-rate funding structure for calendar year 2017, it reduced the subsequent year funding by 5% as a result of its review of the cost-effectiveness analysis.

Recommendations: To help ensure that CIRC providers are only compensated for services delivered as specified in their contractual agreements, CBH should move from a fixed payment model to a new value-based purchasing system. [201520.17] CBH should also develop and implement a monitoring program for CIRC providers that sets reasonable capacity standards and works with providers to ensure more Philadelphians receive services. [201520.18]

We further recommend that DBHIDS develop an oversight mechanism for CBH's administration of the CIRC program. [201520.19]

Note: Upon discussion of this finding with DBHIDS and CBH officials, we were informed that the payment structure for this program changed in fiscal year 2019. Therefore, we recommend that DBHIDS and CBH monitor the CIRC program to determine if the proposed changes to the program's payment structure more accurately reflect the actual services rendered.

CBH REIMBURSED FOR ADMINISTRATIVE COSTS NOT NECESSARY FOR OPERATION OF HEALTHCHOICES PROGRAM

CBH is the MCO for the HealthChoices Program. The relationship between the City and CBH is contractual. The contract states that the City will not reimburse ineligible administrative or program costs.

Condition: During our analysis of the Weekly City Invoices, we found that CBH submitted administrative costs for reimbursement from DBHIDS that did not appear to be related to its responsibility as the MCO administering the HealthChoices Program. The costs are as follows:

- \$149,000 in celebratory expenses commemorating CBH's 20th Anniversary as the City's MCO. These expenses included a day off for all employees (at a cost of approximately \$125,000), breakfast and dinner buffets costing \$11,000, promotional gift items, such as lanyards, tote bags, and journals costing \$8,300, engraved commemorative gifts/awards totaling \$2,800 and use of a photo booth costing \$925. These expenses were incurred over a two-day period.
- \$54,200 in various health and wellness programs for CBH employees, including \$29,000 for a fitness and health program, \$13,000 for personal trainers, dance instructors, and exercise equipment used during in-house yoga and Zumba classes and personal training sessions, \$3,600 for a 12-week Weight Watchers program, \$3,600 to rent FitBits and Garmin fitness trackers, \$3,300 on healthy snacks at CBH headquarters, and \$1,900 for a day of in-house massages.

Criteria: The contract between the City and CBH, as well as the Financial Reporting requirements of the HealthChoices Behavioral Health Program.

Cause: The contract does not define ineligible costs. Administrative budgets attached to the contract on an annual basis do not show sufficient detail to identify any potential ineligible costs. DBHIDS does not review the expenses submitted by CBH for appropriateness.

Effect: More than \$200,000 in questionable operating costs were reimbursed by the City as program-related administrative costs. If these costs were included in the financial reports required by HealthChoices, then administrative costs were overstated. Without a formal process for reviewing expenses submitted by CBH, DBHIDS may be reimbursing CBH for costs not related to the administration of the HealthChoices Program.

Recommendations: We recommend that CBH management refrain from incurring expenses that do not appear necessary to its mission as the City's MCO. This includes celebratory expenses and extravagant expenses for the direct benefit of CBH employees. [201520.20] We also recommend that the City revise the language in the contract between DBHIDS and CBH to better define ineligible costs that are not considered to be program-related. [201520.21]

Furthermore, DBHIDS should:

- Remove from the database for rate-setting purposes, those expenditures included in the financial reports submitted to the Commonwealth that are not directly related to the operation of the HealthChoices program; [201520.22] and
- Develop and implement a process for reviewing CBH administrative expenses to ensure the expenses are HealthChoices related. [201520.23]

PAY-FOR-PERFORMANCE INCENTIVE PROGRAM LACKED TRANSPARENCY WITH PROVIDERS

Pay-for-Performance (P4P) is a state-mandated incentive program aimed at improving the quality, efficiency, and overall value of managed care. Service providers that achieve a higher level of quality receive an incentive bonus in addition to their standard payment for services. The P4P bonus is based on a percentage of a provider's total medical expenses multiplied by a weighted score that is based on the provider's ability to meet certain national and state recognized standards of service quality, as well as CBH's own service expectations.

Condition: Based on discussions with providers during site visits, there is confusion and a lack of transparency among network providers caused by the complexity of the incentive formula for the P4P program. The P4P incentives appear to conflict with the results of monitoring evaluations performed by the Compliance Unit and Quality Management Unit and are more driven by the electronic information in the claims payment system. The following inconsistencies were noted:

- Despite being cited by the CBH Compliance Unit in May 2016 and May 2017 for the six clinical record deficiencies we noted in **Table II**, site #4 received the highest bonus in both years (\$565,193 and \$511,703, respectively). The awards were largely based on performance in the Behavioral Health Residential Services (BHRS) Program, which was among the programs cited for recordkeeping irregularities.
- One provider (site #6), cited for five clinical recordkeeping deficiencies within the BHRS program (based on targeted compliance reviews in April 2016 and April 2017), received a \$237,427 P4P bonus in 2017 for that level of care. Additionally, the Compliance and NIAC Units both stated concerns about high use of contracted (temporary) staffing delivering those services. This was the second-highest bonus payment for that program during 2017.
- Another provider (site #24), whose profile showed several clinical record deficiencies, received no bonus during 2016 and a calculated P4P bonus of \$4,440 during 2017, which was increased to \$10,000. In 2017, DBHIDS and CBH agreed to increase the bonus of the lower scoring providers to a \$10,000 minimum. We found 21 other sites that benefitted as well. Furthermore, nine of these increased bonuses were based on a calculated P4P award of less than \$1,000. Consequently, what should have been a minimum distribution of \$63,435 was increased to \$220,000.

Criteria: The P4P program, a state initiative aimed at improving the quality, efficiency, and overall value of managed health care, provides for financial incentives based on the methodology outlined in the HealthChoices Behavioral Health “Program Standards and Requirements,” Amendment dated January 1, 2016, Appendix E.

Effect: CBH acknowledged that information supporting service expenses are largely based on information in the claim system, with little or no human review of the documentation behind the transactions. Therefore, the data upon which the performance bonus is calculated may not present a completely accurate depiction of the quality of service.

Recommendation: We believe that there needs to be greater transparency of the P4P measures and outcomes to avoid the appearance of impropriety. We recommend that the scoring matrix used to calculate the P4P financial incentive, specifically incorporate clearly defined factors measuring the weight assigned to compliance audit findings, NIAC deficiencies, and quality management actions. [201520.24] The scoring matrix should also be regularly discussed with providers as part of CBH’s plan to help providers meet each program’s targeted performance standards. [201520.25]

OFFICE OF THE CITY CONTROLLER
Auditors' Report –Objective, Scope, and Methodology

AUDIT OBJECTIVES

The objectives of the audit were to determine whether DBHIDS was properly and effectively using public financial resources in administering the HealthChoices Program and supporting individuals in need of mental health and addiction treatment services. We performed procedures to determine that reimbursement payments made by DBHIDS to CBH were supported by adequate documentation.

AUDIT SCOPE

The period covered in the audit scope was July 1, 2016 through June 30, 2017. The audit included an assessment of compliance with specified provisions of the HealthChoices Program and the contractual relationship between DBHIDS and CBH, as well as determining whether internal policies and procedures within DBHIDS and CBH are designed to ensure effective and efficient administrative oversight of the program and that they are operating as intended.

The audit experienced delays, including rescheduled site visits and withholding certain documentation from auditors or providing heavily redacted documentation, due to CBH's concerns over the disclosure of protected health information. During the audit, Controller's Office staff received training from the City's HIPAA Privacy Unit to address CBH's concerns, better understand the sensitive and confidential nature of PHI, and ensure the proper safeguarding of information obtained for audit purposes. Despite the training, not all supporting information was made available for review.

Additionally, while the Compliance and NIAC Units shared their monitoring reports with us, the Quality Management Unit only provided us with summaries reflecting the status of the provider (i.e. admission closures, when quality improvement plans were in effect, etc.). Once again citing PHI in the reports, they did not offer details on when they conducted site visits or how many records they reviewed.

AUDIT METHODOLOGY

To efficiently plan and evaluate the operating performance of the program, we developed an audit plan and performed testing to assess our objectives. Some of our procedures included: inspection of the contract terms between DBHIDS and CBH; HealthChoices Program Standards and Requirements; CBH Manuals; and CBH Policies and Procedures. We performed inquiries and on-site observations at CBH and on-site reviews at various healthcare provider agencies. As a result of these procedures, we identified findings and developed recommendations to address the deficiencies noted.

To determine compliance with the HealthChoices Program requirements, testing was performed in accordance with specified sections of the above noted documents. We gathered information from a variety of sources using various methodologies, including those listed below.

We also engaged the services of an accounting and consulting firm to act as a subject matter expert, to assist us in understanding the documentation requirements for mental health and addiction treatment services and the payment of Medicaid-based claims.

To satisfy our audit objectives, we performed the following audit procedures:

Performed inquiries of key DBHIDS and CBH management and staff to gain an overview of their operations and the oversight that DBHIDS and CBH provide related to the HealthChoices Program. These inquiries included gaining an overall understanding of DBHIDS and CBH's relationship, daily operations, and oversight from management.

Corroborated our understanding of the policies and procedures in place by walking-through specific operations and processes.

Obtained an understanding of the design, operation, and effectiveness of internal controls where significant within the context of the audit objectives. We then identified the key controls that have an impact on compliance. These key controls were then tested through transaction testing as well as other procedures.

Performed an assessment of applicable DBHIDS and CBH documents, including the CBH operations manual, HealthChoices Program Standards and Requirements, and the fully executed agreement between DBHIDS and CBH. Inquiries were conducted with DBHIDS and CBH key management to gain an understanding of the relevant policies and procedures in place regarding DBHIDS, CBH, and the program as a whole.

Reviewed the organizational chart to determine how the hierarchy of DBHIDS and CBH was structured toward meeting their required oversight responsibilities of the HealthChoices Program.

Interviewed DBHIDS and CBH staff regarding their job responsibilities related to the administration, oversight, and implementation of the rules and regulations pertinent to the HealthChoices Program.

Reviewed the Weekly City Invoices submitted by CBH to DBHIDS during fiscal year 2017. Each CBH invoice contained a listing of weekly payment amounts made to providers, as well as total expenditures incurred by CBH for its administration of the program. These weekly invoices intermittently covered the majority of the approximately 270 healthcare providers and totaled on average \$14.7 million per week and \$766.5 million for the fiscal year. We selected 10% of the total providers (27 locations) to test the validity of sample reimbursements. While the invoices CBH submitted to DBHIDS only showed the total amounts paid to each of the providers, the supporting invoices from the providers to CBH (also known as the "835 Reports") contained thousands of transactions and much greater detail, including patient identification numbers, fee-for-service payment charges and units of service (i.e., the amount of time patients were seen). Since the invoices DBHIDS received from CBH did not contain the same level of detail contained in the 835 Reports, we used the 835 Reports for selecting our sample transactions.

Inquired about the nature of the P4P program and reviewed how incentive awards were calculated.

Requested and reviewed information about the CIRC program to determine how payment for these services was calculated. Computed overpayment during fiscal year 2017 using expected and actual capacity data obtained from management.

Selected a separate sample of administrative expenditures incurred by CBH during the audit period of July 1, 2016 through June 30, 2017. We reviewed invoices and other supporting documentation for the expenditures to determine if the expenditures were reasonable and necessary to its mission as the City's MCO for the HealthChoices Program.

Inquired of CBH and DBHIDS management regarding the oversight of the healthcare providers. We reviewed CBH manuals, as well as any applicable policies and procedures. We interviewed personnel from CBH's three monitoring units to determine how they carried out their duties and to obtain a better understanding of their responsibilities. To determine the regularity of their provider site visits, we requested and reviewed all compliance audits and monitoring reviews conducted from July 1, 2016 to the end of April 2019. We analyzed the reports to determine when, and how often, unit personnel visited provider locations to physically review documentation supporting services charged to the HealthChoices Program.

Performance Audit Standards

In the execution of the performance audit, we performed the engagement in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States of America. Those standards require that we plan and perform the audit to obtain sufficient, appropriate audit evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. Accordingly, we performed testing of records and source documentation as well as other auditing procedures determined necessary in the circumstances. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**CONSULTING REPORT ON
CITY OF PHILADELPHIA
HEALTHCHOICES
BEHAVIORAL HEALTH PROGRAM
JULY 2016 TO JUNE 2017**

Prepared by



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Rebecca Rhynhart, City Controller
City of Philadelphia – Office of the Controller
1230 Municipal Services Building
1401 John F. Kennedy Boulevard
Philadelphia, PA 19102-1679

Dear Controller Rhynhart,

We have concluded our engagement to provide consulting services with respect to the Philadelphia HealthChoices Behavioral Health Program (“HealthChoices”), managed by the City’s Department of Behavioral Health and Intellectual disAbility Services (“DBHIDS”) and Community Behavioral Health (“CBH”) functioning as the Managed Care Organization. This engagement was agreed to by the City of Philadelphia – Office of the Controller (the Controller’s Office) and was performed solely to assist the Controller’s Office with its performance audit of HealthChoices for the period July 2016 to June 2017.

We were retained as subject matter experts to provide consulting services and our procedures were performed in accordance with the American Institute of Certified Public Accountants (“AICPA”) Statements on Standards for Consulting Services. Our consulting services did not constitute an audit conducted in accordance with generally accepted auditing standards, an examination of internal controls, or other attestation or review services in accordance with standards established by the AICPA, the Public Company Accounting Oversight Board, or other regulatory body. The sufficiency of the procedures is solely the responsibility of the management of the Controller’s Office. Consequently, we make no representations regarding the sufficiency of the scope and procedures described in the following pages either for the purpose for which this report has been requested or for any other purpose.

Our engagement consisted of limited consulting procedures, including discussions with senior management of DBHIDS and CBH, inspection of various policies and procedures, process walkthroughs and testing of controls related to the processes reviewed. We were not engaged to, and did not perform an audit, the objective of which would be the expression of an opinion on the specified elements, accounts, or items. Accordingly, we do not express such an opinion. Had we performed additional procedures; other matters might have come to our attention that would have been reported to you. Our analyses, observations, and recommendations are based upon

information provided to us as of the date of this report. It is possible that if additional information is forthcoming, our analysis and observations could be materially different.

This report is intended solely for the information and use of the Controller's Office and is not intended to be and should not be used by anyone other than the Controller's Office.

The engagement background, procedures performed, as well as the related observations and recommendations are described in the following sections of the report.

Mercadien, P.C.
Certified Public Accountants

July 14, 2021

The Controller's Office engaged Mercadien, P.C., CPAs ("Mercadien, P.C.") in December 2019 to assist the Controller's Office with its on-going performance audit of HealthChoices. We were retained as subject matter experts to provide consulting services.

The Controller's Office commenced their performance audit in February 2018 and primarily focused on documentation to support claims submitted by third party providers under contract with CBH functioning as the Managed Care Organization ("MCO"). These claims were processed and paid by CBH.

We conducted this engagement in accordance with Statements on Standards for Consulting Services issued by the AICPA. The scope of the engagement was limited to internal controls and processes designed and in place during the period ended June 30, 2017. These processes were designed by DBHIDS and CBH as part of oversight and management of HealthChoices. Our procedures during the months of January 2020 through March 2020 were limited to testing those processes and associated controls.

ENGAGEMENT BACKGROUND

The Commonwealth of Pennsylvania, Department of Human Services (Commonwealth or PA DHS) approved the City of Philadelphia to manage a Mandatory Medical Assistance Behavioral Health Managed Care Program for eligible persons residing in Philadelphia County called the HealthChoices Behavioral Health Program. The City began administering HealthChoices in 1997. HealthChoices is managed at the state level through the Office of Mental Health and Substance Abuse Services (OMHSAS), with medical assistance recipients receiving access to mental health and/or drug and alcohol services through local programs at the county level that are administered by Managed Care Organizations. Philadelphia's Managed Care Organization for the HealthChoices program is CBH.

CBH is a non-profit corporation created by the Department of Public Health. CBH is contracted by the City to act as the City's Managed Care Organization for the HealthChoices Behavioral Health Program, which officially implemented the managed care system in early 1997. CBH's mission was to integrate medical assistance and program funding streams, while managing mental health and substance abuse services. Currently, DBHIDS contracts with CBH to deliver medically necessary services to covered members in the least restrictive and most appropriate manner. CBH, with oversight from DBHIDS, utilizes Requests for Proposals ("RFP"), Requests

for Qualifications (“RFQ”), Request for Applications (“RFA”) or Requests for Information (“RFI”) to acquire new services or add providers to the City’s network for providing mental health and drug and alcohol treatment services. According to the City Law Department, CBH is not required to RFP for providers if a contract is awarded on a renewal basis or if the contract is with a nonprofit, effectively exempting the majority of its provider agreements from continually undergoing a formal procurement process.

The City has also contracted with CBH to provide administrative support services related to certain grants and information systems. CBH is a component unit of the City. CBH receives all of its funding from the City. The majority of CBH’s Board of Directors is comprised of City employees and includes the Health Commissioner, Director of the Office of Homeless Services, and the Department of Human Services Commissioner. Its financial activities are included in the City’s Comprehensive Annual Financial Report.

OBSERVATIONS AND RECOMMENDATIONS

CBH Credentialing Oversight

Observation 1

CBH’s Credentialing Oversight for Facility/Organization Providers Needs Strengthening

Under the HealthChoices Program, providers can be individual practitioners, practitioners in a group practice, a Federally Qualified Health Center (“FQHC”) or facility organizations/agencies. CBH is responsible for credentialing and recredentialing providers of all types. Credentialing is a vital process to ensure patients receive high quality care by qualified professionals and staff.

The CBH Provider Manual, Chapter 2 “Credentialing” details the requirements for the credentialing and recredentialing process for all provider types, including individual practitioners, practitioners in group practices, FQHCs and provider organizations or facilities.

While reviewing the credentialing process for HealthChoices Program providers, we noted there is a distinct difference in the processes for individual practitioners and practitioners in a group practice, as opposed to facility organizations/agencies. CBH utilizes the services of a National

Committee for Quality Assurance (“NCQA”) certified Credentials Verification Organization (“CVO”) to collect and complete primary source verification on credentials for individual practitioners and group practice members for both initial credentialing and recredentialing. Initial reviews for facilities are conducted solely by CBH staff. Recredentialing reviews for facilities are conducted by the NIAC unit.

Per the CBH Provider Manual, facility organizations/agencies are solely responsible for ensuring that the staff they employ, or contract with, meet all educational and experiential requirements for the positions held and possess all the appropriate certifications and clearances, as staff employed by a facility are not considered individual practitioners. While facility organizations/agencies are required to submit staff rosters to CBH annually, CBH does not independently verify the credentials of staff at a facility organization/agency. Individual practitioners and practitioners in a group practice are credentialed and recredentialed directly by CBH. It should be noted that facility organizations/agencies receive a significantly greater portion of HealthChoices medical payments than individual practitioners or practitioners in a group practice.

We believe the process for individual practitioners and practitioners in a group practice to be adequate, however we found that the credentialing process for HealthChoices providers in a facility organization/agency may not provide sufficient oversight to ensure qualified individuals are delivering necessary behavioral health and addiction treatment services.

As such, unqualified individuals may be delivering services to patients thereby calling into question the quality of care provided and the appropriateness of reimbursements for services rendered. This concern was also expressed by the United States Attorney’s Office for the Eastern District of Pennsylvania (“USAPAE”). If unqualified individuals are delivering services to patients, it may open the provider, CBH and/or DBHIDS to liability. According to CBH’s acting CEO, facility organizations/agencies often experience rapid turnover, which results in staff rosters submitted to CBH becoming outdated and inaccurate. These inaccurate rosters are therefore not a useful tool for any type of monitoring effort conducted by CBH or DBHIDS.

Recommendations

CBH should ensure that each facility/organization provider has an effective process to credential its practitioners. Practitioners who provide services to CBH members should meet CBH's credentialing requirements for individual practitioners. If the organization cannot demonstrate that it performs the required verification of credentials, the individual practitioners within the organization should not render services until they are credentialed by CBH.

CBH could strengthen the oversight for facilities by increasing the frequency of roster submission from annually to biannually. Additionally, facilities should submit copies of appropriate documentation to support education, experience and certifications for all staff hired since their last submission. CBH should implement an internal review process for staff at the facility/organization level whenever there are concerns about the organization's credentialing process.

CBH Reimbursement Process

Observation 2

Review Process Failed to Identify Duplicate Reimbursements in a Timely Manner

CBH functions as both a Managed Care Organization for HealthChoices payments and an Administrative Services Organization for non-HealthChoices payments under contracts with the City. As such, CBH is reimbursed via two separate and distinct processes for each of these functions. The separation of these processes is an important internal control.

DBHIDS and CBH have policies and procedures designed to address the reimbursement process from DBHIDS to CBH. The DBHIDS policy entitled "Reimbursement Process between CBH and DBHIDS" references "Other Non-HealthChoices Program Reimbursements" policy maintained by CBH. CBH's policy is entitled "Non-HealthChoices." CBH additionally maintains a "General Accounting Policy and Procedure for Cash Accounts, Non-HealthChoices Account."

However, reimbursement requests for HealthChoices did not properly exclude the payments that were issued for non-HealthChoices purposes. The reimbursement request process was not sufficiently designed to identify and exclude non-HealthChoices expenditures from the reimbursement request. CBH maintained only one bank account so that payments for both HealthChoices and non-HealthChoices payments were reflected on the same check register but lacked an adequate process to track disbursements. Neither CBH nor DBHIDS performed a reconciliation of reimbursements for HealthChoices and non-HealthChoices reimbursements to identify over reimbursements in a timely manner.

CBH and DBHIDS's review processes failed to identify duplicative invoices prior to reimbursement and failed to identify in a timely manner the over reimbursement after it was paid. From February 2014 through June 2018, CBH submitted several duplicative invoices for the same costs through both the Managed Care Organization process and the Administrative Services Organization process. As a result, the City inappropriately over reimbursed CBH for \$6,407,697 in HealthChoices payments. This included \$2,612,057 that occurred during the testing period of July 2016 through June 2017. Additionally, other previous over reimbursements prior to February 2014, may not have been identified and returned to the City. A lack of adequate internal controls in the reimbursement process may create the potential for fraud or abuse to occur undetected. The amount in question was returned to the City via a credit reflected on the reimbursement request for the period August 16 through August 22, 2018.

Recommendation

CBH should strengthen the written procedures around the process for non-HealthChoices reimbursements to ensure that adequate internal controls are in place to prevent duplicative invoices and over reimbursement. CBH should develop a comprehensive written reconciliation process that includes a monthly reconciliation of both HealthChoices and non-HealthChoices payments to the reimbursements received by the City. The new comprehensive process should be implemented immediately. DBHIDS should review its reimbursement process for shortcomings and update its policy to ensure controls are in place to prevent or identify duplicative invoices or over reimbursements to CBH.

Note: CBH notified us that it had opened a separate bank account for the purposes of non-HealthChoices payments in December 2018. We did not verify the account. We continue to recommend CBH develop a comprehensive written policy in this instance.

Observation 3

CBH Inaccurately Reimbursed for Voided Transactions

As the MCO for HealthChoices, CBH submits a weekly invoice to the City through DBHIDS for reimbursement for services provided under the HealthChoices Program. If a transaction that was previously reimbursed by the City is voided by CBH, that voided transaction must be reduced from a future reimbursement request. Similarly, if a transaction is voided and reissued, the value of the transaction should only be reimbursed once.

CBH maintains Finance Policies and Procedure, entitled “Procedures for Weekly City Invoice, Steps to get Provider and Operating Amounts,” which details how to identify amounts from the check register to be reimbursed and also covers how to address voided transactions.

However, CBH’s process used to produce the Weekly City Invoice did not consistently identify the scenarios regarding void and replacement transactions. CBH also did not perform a reconciliation of the total cash payments they made and those included in the reimbursement request.

As a result, CBH submitted reimbursement requests to the City that included reissued transactions (both checks and EFTs) without an offsetting reduction for the original voided transaction. Additionally, some voided transactions that were not reissued were not reduced from a subsequent reimbursement request.

Consequently, CBH was over reimbursed by the City for \$369,784 in HealthChoices administrative/operating reimbursement and \$1,065,355 in provider reimbursement for the period of July 2014 through December 2017. This included \$213,924 in HealthChoices operating reimbursement and \$1,065,355 in provider reimbursement that occurred during the testing period of July 2016 through June 2017. The operating over reimbursement amounts were returned to the City via credits reflected on the reimbursement request for September 21, 2017 and August

27, 2018. The provider over reimbursement of \$1,065,355 was not returned. Additionally, other inaccuracies in the Weekly City Invoice may have occurred prior to July 2014 and not been detected, due to the lack of adequate internal controls, reconciliation, and oversight. The lack of adequate internal controls over the invoice review process could create the potential for fraud or waste to occur undetected.

Recommendation

CBH should develop more detailed procedures for the production of the Weekly City Invoice. These procedures should be incorporated in a written policy that also includes a procedure for a regular formal reconciliation between the HealthChoices cash payments and the amounts included in the weekly reimbursement request. DBHIDS should ensure that the Weekly City Invoice is accurate prior to reimbursing CBH. CBH should reimburse the City the remaining \$1,065,355 owed as of March 2020.

Note: Over the course of our engagement, CBH subsequently developed more detailed procedures to be used in the production of the Weekly City Invoice, however these new procedures were not formally written into policy.

Observation 4

CBH Inaccurately Reimbursed for Payroll Related Expenses

CBH requests reimbursement for payroll and payroll related expenses from the City on a bi-weekly basis. The bi-weekly payroll reimbursement request appears on the Weekly City Invoice every other week. Payroll should be relatively consistent and a standardized expense. However, CBH submitted inaccurate requests for reimbursement for payroll and payroll related expenses from the City for six of 26 pay periods during the testing period.

CBH maintains Finance Policies and Procedure, entitled "Procedures for Weekly City Invoice, Steps to get Payroll and 403B Amounts," which details specifically where in the payroll statistical summary to obtain the total liability amount and 403B amounts. These represent the cash outlay associated with the payroll.

Despite this, we found that CBH did not consistently follow its own policies and procedures for payroll and payroll expense reimbursement. The appropriate supporting documentation (the statistical summary extract provided by ADP) was not utilized for six of 26 payroll reimbursement requests. No review occurred by CBH or DBHIDS to identify the inaccurate requests prior to the reimbursements being made. CBH did not have adequate internal controls in place to prevent inaccurate requests from being made or erroneous under or overpayments from being identified in a timely manner. There was no formal documented reconciliation process in place for the Weekly City Invoice.

As a result, CBH was over reimbursed \$1,480,883 for payroll and payroll related expenses during the testing period of July 2016 through June 2017. The amounts in question were returned to the City via credits reflected on the reimbursement request for March 1, 2018. Without review protocols in place by both CBH and DBHIDS or a formal reconciliation process, it is possible that additional erroneous payroll requests occurred outside of the testing scope. The lack of adequate internal controls in place could increase the potential for fraud or abuse to occur undetected.

Recommendation

CBH should develop more detailed procedures for the preparation of the Weekly City Invoice. These more detailed procedures should be documented in writing as part of a comprehensive updated Finance Policies and Procedures. DBHIDS should review CBH's reimbursement requests, including payroll requests, for anomalies. Additionally, CBH should develop a process for and conduct a formal reconciliation between the HealthChoices cash payments and the amounts included in the weekly reimbursement request. The reconciliation should be performed at least monthly. DBHIDS must review CBH's monthly reconciliations to ensure the accuracy of payments made.

CBH Procurement Process

Observation 5

CBH Did Not Follow Philadelphia Code for Awarding Sole Source Contracts

CBH is not a City department or agency and therefore has some flexibility in developing its own processes and policies for procurement of goods and services. However, CBH is defined as a “City-Related Agency” under Chapter 17-1400 of the Philadelphia Code, Non-Competitively Bid Contracts, and is subject to certain criteria related to procurement and contracting under the Philadelphia Code.

Specifically, under its contract with DBHIDS, CBH is required to abide by the requirements of Chapter 17-1400 in its award of subcontracts. Philadelphia Code, subsection 17-1406(2) excludes professional services contracts from being awarded on a sole source basis. The interpretation of this provision was confirmed by the City Law Department.

Sole source procurement is when a contract is entered into without a competitive process, based on a justification that only one known source exists or only one known supplier can fulfill the requirements for the procurement. Testing found that CBH entered into several administrative professional services contracts on a sole source basis. For example, CBH awarded a \$125,000 contract for consulting services to a then-current CBH employee effective January 1, 2017. The employee was on CBH’s payroll through the pay period ending January 6, 2017. In another instance, CBH awarded a contract to a vendor who provided the clinical dashboard software to perform CIO level services. It does not appear that DBHIDS reviewed the award of these contracts in any way.

As detailed, CBH improperly awarded professional services contracts on a sole source basis under Philadelphia Code, subsection 17-1406(2). CBH also lacks a comprehensive formal procurement process for professional services that complies with the sections of the Philadelphia Code to which it is subject.

By entering into sole source contracts for professional services, CBH violated the procurement requirements under the Philadelphia Code. Sole source contracts for professional services are not the result of competitive procurements and do not ensure that taxpayers receive the best value for their money. Awarding sole source contracts for professional services does not ensure transparency, standardization, and confidentiality as intended by the CBH procurement process protocol.

Recommendation

CBH should only award sole source contracts as allowed under Philadelphia Code, subsection 17-1406(2). CBH should not continue to award professional services contracts on a sole source basis. CBH should revise its procurement process and policy to ensure it is comprehensive and inclusive of Philadelphia Code requirements to which it is subject. These changes should be documented in writing and controls should be established to ensure that the process and policy is followed. DBHIDS should play a more active oversight role in ensuring CBH is compliant with procurement requirements as outlined in its own policy and those of which they are subject to under the Philadelphia Code.

Observation 6

CBH Did Not Follow Philadelphia Code for Contract Renewals

As noted previously, CBH is not a City department or agency and therefore has some flexibility in developing its own processes and policies for procurement of goods and services. However, CBH is defined as a “City-Related Agency” under the Philadelphia Code and is subject to certain criteria related to procurement and contracting under the Philadelphia Code, including requirements for renewing contracts.

For the purposes of Chapter 17-1400 of the Philadelphia Code, Non-Competitively Bid Contracts, CBH is considered a “City-Related Agency.” Under its contract with DBHIDS, CBH is required to abide by the requirements of Chapter 17-1400 in its award of subcontracts. Philadelphia Code, subsection 17-1406(12) sets forth the only instances under which a contract may be renewed. The interpretation of this provision was confirmed by the City Law Department.

During the period under review, CBH entered into three separate administrative contracts without conducting a new procurement process. Instead, CBH utilized old RFPs issued in November 2010, March 2013, and July 2014, respectively, to procure services. Despite none of the contracts originally awarded under those RFPs having relevant renewal provisions and two of those contracts being expired, CBH awarded these contracts in the testing period as renewals.

CBH awarded each of these contracts based on prior services rendered, claiming that those services were similar in nature to the current required services. CBH did not follow procurement requirements under the Philadelphia Code for contract renewals for these contracts. None of the contracts included relevant options to renew or met any of the allowable exceptions stated in Philadelphia Code, subsection 17-1406(12). CBH has an internal process for procurement called the Procurement Process Protocol, and we were advised that although the process is explicitly written for clinical procurements, it is also used for administrative procurements. The written Procurement Process Protocol does not incorporate the Philadelphia Code requirements to which CBH is subject.

CBH violated Philadelphia Code requirements for contract renewals. None of the contracts were awarded using a new procurement process. Renewing expired contracts for new services or otherwise awarding new contracts under old RFPs rather than initiating a new procurement process limits competition and therefore does not ensure that CBH obtained the best value for the procurement. Awarding contracts as renewals outside of the allowable renewal circumstances does not ensure transparency, standardization and confidentiality as intended by the CBH procurement process protocol.

Recommendation

CBH should only award renewals in the limited circumstances provided in Philadelphia Code, subsection 17-1406(12). CBH should not award contracts as renewals in which the original contracts do not contain relevant, operable renewal clauses. CBH should issue a new RFP to award new contracts such as these examples. CBH should revise its procurement process and policy to ensure it is comprehensive and inclusive of Philadelphia Code requirements to which it is subject. These changes should be documented in writing and controls should be established to ensure that the process and policy is followed. DBHIDS should play a more active oversight

role in ensuring CBH is compliant with procurement requirements as outlined in its own policy and those of which they are subject to under the Philadelphia Code.

Observation 7

CBH Did Not Comply with Its Own Procurement Protocol

As a result of testing five vendors that underwent the formal procurement process, the following instances of non-compliance with the CBH procurement protocol were noted:

- The documentation provided for four of the procurements did not provide any evidence of final approval by the CBH CEO and the DBHIDS Commissioner.
- The documentation provided for one of the procurements did not provide any evidence of review group approval in the form of score sheets.

CBH utilizes a formal Procurement Process Protocol that defines processing timelines and responsibilities. CBH failed to document that it followed its own Procurement Process Protocol. Despite overseeing CBH's operations, it does not appear that DBHIDS reviewed CBH's procurement process or ensured said process is followed.

The inability to provide supporting documentation to verify that required steps were taken gives the appearance that CBH did not follow its own procurement rules. The appearance of an incomplete procurement process does not ensure transparency, standardization and confidentiality as intended by the CBH procurement process protocol.

Recommendations

CBH should review its Procurement Process Protocol and develop and implement a comprehensive procurement process, including developing an internal process or checklist to ensure that the completion of all steps in the procurement process are properly documented and maintained. DBHIDS should take a more active oversight role in ensuring that CBH follows its own policies and procedures.

Observation 8

DBHIDS Did Not Provide Adequate Oversight of CBH Procurement

DBHIDS serves as the oversight function for CBH, but did not provide adequate oversight over CBH's procurement processes for multiple contracts. This includes the examples referenced in Observations 5, 6, and 7.

The contract between DBHIDS and CBH is subject to the requirements of Philadelphia Code Chapter 17-1400. Specifically, CBH is a "City-Related Agency" under Philadelphia Code, Chapter 17-1400, Non-Competitively Bid Contracts. Philadelphia Code, section 17-1408 states that each agreement between the City and a City-Related Agency shall contain a provision detailing how the City-Related Agency is to carry out its duties under this section, including, but not limited to, specifying who at the City-Related Agency is responsible for carrying out the duties that Chapter 17-1400 assigns to City officers and employees.

Philadelphia Code, section 17-1408 further states that contracts between the City and City-Related Agencies should clearly define the roles and responsibilities of all parties. However, the language in the contract between DBHIDS and CBH does not clearly detail how CBH is to carry out its duties under Chapter 17-1400, much less who is responsible for carrying out the duties that this Chapter assigns to City officers and employees. The contract does not clearly define the separation of duties and responsibilities for CBH and DBHIDS.

The ambiguous or undefined roles and responsibilities in the contract between DBHIDS and CBH is confusing and leads to unilateral decision-making by CBH and insufficient oversight of CBH by DBHIDS. DBHIDS has failed to provide proper or sufficient oversight of CBH's procurement processes. As a result, CBH has entered into various contracts that violate Philadelphia Code, Chapter 17-1400.

Recommendations

The contract between DBHIDS and CBH should be reviewed. The contract should be revised to clearly define the duties, roles, and responsibilities of CBH and DBHIDS's management, as well

as all other parties involved. DBHIDS should provide necessary and proper oversight to ensure that CBH follows all Philadelphia Code requirements that applies to them regarding procurement.

Observation 9

Contractors Performed Services/Were Paid Prior to Signed Contract with CBH

Internal controls are mechanisms, rules or procedures implemented by an entity to ensure the integrity of financial information, prevent fraud, and promote accountability. Internal controls serve as an important check on different processes, including procurement and contracting.

CBH entered into three professional services contracts with outside contractors in which the contractor provided services, billed for services, or was paid for services prior to the contract being signed by both parties and/or the contract's effective date. Details for the contracts are as follows:

One contract for consulting services was effective January 1, 2017. The contractor billed and was paid for services provided in January and February, prior to the contract approval date of February 27, 2017. The contractor was paid a total of \$22,800 for services provided prior to the signed date of the contract.

Another contract with an outside non-profit contractor to provide a trauma education program was to be delivered no later than August 31, 2016. This contract was effective August 18, 2016. The contractor billed for and was paid for services provided from May 9, 2016 through August 16, 2016, which was prior to both the contract effective date and the approval date. This contract was not signed or approved by both parties until September 6, 2016. The contractor was paid a total of \$52,750 for services provided prior to the effective and signed dates of the contract.

The third contract was with an outside contractor to provide consulting services to be delivered during the period January 31, 2016 to July 31, 2016. However, this contract was not signed and approved by both parties until August 16, 2016. The contractor billed for services on June 12, 2016 and was paid for those services August 18, 2016. The contractor performed and billed for the services totaling \$6,826 prior to the signed date of the contract.

Strong internal control would dictate that a contract be fully executed (signed by both parties) prior to the initiation of and payment for services. CBH lacks a detailed policy and procedure that addresses the contracting process particularly for contracts which were not a result of the formal Procurement Process Protocol.

Contractors provided, billed, and/or were paid for services prior to contracts being signed and approved by both parties. Without strong internal controls or sufficient oversight, there is a potential for fraud, mismanagement, or waste to occur undetected and for contractual disputes to arise.

Recommendations

Procurement and contractual processes should be complete prior to the payment of any funds. CBH should develop and implement a comprehensive procurement process that includes rigorous internal controls to protect against fraud and promote accountability. DBHIDS should provide better oversight of CBH contracting activities.

Provider Loans/Advances

Observation 10

CBH Did Not Comply with Its Own Policies and Procedures for Provider Advances/Loans

As the Managed Care Organization for the HealthChoices Program, CBH contracts with providers to render behavioral health and addiction treatment services to residents of Philadelphia County. CBH has a process for temporarily advancing funds to providers if the provider is unable to submit claims for services rendered due to a contracting or billing system issue. The process outlines repayment responsibilities and requirements. This process is maintained in the CBH General Accounting Policies and Procedures – Advances, dated 07/01/12.

As a result of testing the temporary advance process for 41 requests totaling \$6,510,883 across 13 providers, we identified the following 16 instances of non-compliance with the CBH Policies and Procedures:

- Six instances, totaling \$4,067,259, in which the stated reason for the advance did not conform to the policy requirement relating to a contracting or billing system issue.
- One instance for \$26,822 in which the date of approval by the CBH CEO could not be determined.
- Three instances, totaling \$1,070,284, in which the approval for the advance was not documented.
- Six instances, totaling \$128,000, in which the CBH CEO was not the individual who approved the advance. In these instances, the advances were approved by either CBH's Chief Operating Officer or Chief Financial Officer.

CBH did not consistently follow the guidelines established in its policies and procedures for the temporary advancement of funds to providers. CBH did not properly document the approval of temporary advances. DBHIDS's lax oversight of CBH did not identify these issues of non-compliance with CBH's own policies and procedures.

While most of the providers who received advances repaid them, two of the 13 providers defaulted on the repayment of the advances totaling \$236,574 and \$3,835,000, respectively. One of these providers closed prior to repaying the advances and one entered into bankruptcy. CBH ultimately wrote the advances/loans off as "bad debts." As such, it is unlikely that the City will be able to recoup these funds. Weaknesses in internal controls, like improperly documenting approvals or allowing non-authorized individuals to approve advances, could lead to fraud or waste occurring undetected. DBHIDS's lack of oversight could also contribute to fraud, waste or abuse occurring undetected.

Recommendations

CBH should adhere to its own process for temporary advances, only approving an advance if it meets the criteria as set forth in the policy (a provider's inability to submit claims for services rendered, as the result of a contracting or billing system issue). CBH should also adhere to its policy in terms of who is permitted to approve temporary advances. CBH should also strengthen its process for temporary advances outlined in its policies and procedures to include the development of a process for documenting all advance requests and approvals, for maintaining all supporting documentation, and for considering legal options for recovering unpaid advances. In its oversight role, DBHIDS should ensure that CBH complies with its own policies and

procedures and that CBH has strong internal controls in place to protect against fraud, waste, and abuse.

Observation 11

CBH Did Not Comply with Its Own Policies and Procedures for Provider Rate Increases

CBH has a process by which providers can request rate increases for the various levels of care that they deliver to clients. The process outlines required documentation standards for the rate increase, including the reason for the rate increase request, and its subsequent approval or denial by CBH. This process is maintained in CBH Philadelphia HealthChoices Behavioral Health Program Policy and Procedure for Provider Rate Setting, dated 07/01/12. Required documentation should be maintained for recordkeeping purposes.

We requested a listing of all rate increase requests for our testing period. We then tested CBH's rate increase request process for 11 of the approximately 33 requests for a rate increase across 9 providers, identifying the following 32 instances of non-compliance with the CBH policy and procedure:

- Two instances in which the reason for the request could not be determined.
- One instance in which the date of the request could not be determined.
- One instance in which the effective date of the increase was before the date of the request.
- Nine instances in which the rate increase was not supported by a rate increase request letter.
- Nine instances in which the rate increase was not supported by approval or denial by the CBH Finance Committee.
- Ten instances in which the rate increase was not supported by written notification of approval by the Finance Committee to the provider.

CBH did not consistently follow the guidelines established in its policy and procedure and did not have sufficient processes in place for documentation retention. It does not appear that DBHIDS provides any review or oversight over CBH's rate increase process.

As a result of the missing documentation, it cannot be determined whether the process by which these providers obtained the rate increases was transparent and/or complied with the requirements of the policy and procedure. Improper documentation or poor record retention is a weakness in internal control. Weaknesses in internal controls could increase the potential for fraud, waste, or mismanagement to occur undetected.

Recommendations

CBH should follow the guidelines established in its policy and procedure for provider rate increase requests. CBH should develop processes to ensure that documentation is maintained to support the guidelines established in the policy and procedure. DBHIDS should strengthen its review and oversight processes.

CONSULTING PROCEDURES PERFORMED

Inquiries with Key DBHIDS and CBH Management and Staff

To understand the entities and their environment to plan our procedures, we performed inquiries of key DBHIDS and CBH management and staff to gain an overview of their operations and the oversight that DBHIDS and CBH provides related to the HealthChoices Program. These inquiries included gaining an overall understanding of DBHIDS and CBH's relationship, daily operations, and oversight from management.

Observations and Walkthroughs

To corroborate our understanding of the policies and procedures in place, we "walked-through" specific operations and processes.

Internal Control

We obtained an understanding of the design, operation, and effectiveness of internal controls where significant within the context of our objectives. Once an understanding of the design of internal controls was obtained through inspection of policies, procedures, and inquiries with management, we documented accordingly. We then identified the key internal controls that have

an impact on compliance. These key controls were then tested through transaction testing as well as other procedures. As a result of these procedures, we concluded whether CBH has controls in place that are designed and operating effectively to ensure compliance with policies and procedures.

Governance and Relationship between DBHIDS and CBH

Procedures performed under Governance and Relationship between DBHIDS and CBH involved an assessment of applicable DBHIDS and CBH documents including bylaws, employee handbooks, CBH operations manual, board policies and procedures, board meeting minutes, HealthChoices Program Standards and Requirements and the fully executed agreement between DBHIDS and CBH. Inquiries were conducted with DBHIDS and CBH key management to gain an understanding of the relevant policies and procedures in place regarding DBHIDS, CBH and the Program as a whole.

Organizational Structure

Procedures performed under Organizational Structure involved a review of the organizational chart to determine how the hierarchy of DBHIDS and CBH was structured toward meeting their required oversight responsibilities of the Program.

Roles and Responsibilities

Procedures performed under Roles and Responsibilities included interviews with DBHIDS and CBH staff regarding their job responsibilities related to the administration oversight and implementation of the rules and regulations pertinent to the Program.

Sample Selection and Testing Procedures

The areas tested during our engagement correspond directly to the relevant compliance elements related to the administration of the HealthChoices Program and the effectiveness and efficiency of that administration. A summary of these areas included:

- HealthChoices Financial Reporting
- CBH Compliance Monitoring and Oversight
- CBH Budget Process
- Provider Agency Advances and Loans Process
- Provider Agency Request for Rate Increases Process
- CBH Reimbursement from DBHIDS
- CBH Procurement Process

Procedures

HealthChoices Financial Reporting

We inquired of CBH management regarding the process for preparing and submitting the required reports to the State oversight agency. We reviewed examples of quarterly reports and the HealthChoices Program annual audit which is the basis for the annual report. We reviewed the Financial Reporting Requirements for the HealthChoices Behavioral Health Program in the Program Standards and Requirements, as well as the CBH Procedure for completing the Quarterly State Reports.

CBH Budget Process

We inquired of CBH management regarding the process for preparing the annual budget for the entire HealthChoices Behavioral Health Program. We were provided and reviewed the CBH Policy and Procedure for Annual Budget. We requested and reviewed the administrative budgets for CBH fiscal years 2016 and 2017. Additionally, CBH provided the four quarterly variance analysis reports comparing budgeted to actual detail for 2017.

Provider Agency Advances and Loans Process

We inquired of CBH management regarding the process and reviewed the Policies and Procedures for Advances (the, “Policy”). A list of all advances and loans made during the testing period was requested and provided by CBH. From this list a sample of 41 items was chosen to test for compliance with the Policy and to determine whether the internal controls were in place

and operating effectively. From the Policy we identified the key internal controls for ensuring that all requests are transparent and uniformly treated. The key internal controls identified were as follows:

- Written request for an advance with a justification that conforms to the Policy.
- Written approval by the CEO.
- Payment date subsequent to approval by CEO.

We additionally traced the payment of the advance/loan to the check register and verified whether the advance/loan was repaid and that there was no duplicative reimbursement request to DBHIDS.

Provider Agency Request for Rate Increases Process

We inquired of CBH management regarding the process and reviewed the Policies and Procedures for Provider Rate Setting (the, "Policy"). Rate increases can be provider initiated, anticipated per the contract, State assigned such as for Federally Qualified Health Centers, Nonstandard Rate Rebasing which is a rate increase across the board for nonstandard rates, and across the board standard rate increases. A list of all rate increases during CBH Fiscal Year 2017 was provided. There were 34 rate increases that were provider initiated. We selected 11 provider-initiated rate increases to test for compliance with the Policy and to determine whether the internal controls were in place and operating effectively.

From the Policy we identified the key internal controls for ensuring that all requests are transparent and uniformly treated. The key internal controls identified were as follows:

- Letter requesting rate increase must be submitted to the CEO.
- Letter must provide justification including financial data and expected clinical outcomes.
- Rate increases for new programs and services are forwarded to the Clinical Review Committee for review and approval.
- Approved rate increases for existing programs are forwarded to the Finance Committee.

- Finance committee will either approve or deny the request.
- Provider will receive written notification as to whether the request has been approved or denied.

The purpose of the Rate Increases testing was to verify whether rate increase requests were properly initiated and approved and were supported by documentation that demonstrated adherence to applicable guidelines per CBH policies and procedures. Lastly, we verified that the provider rate increase was not implemented until after the documented date of approval.

CBH Reimbursement from DBHIDS

We inquired of CBH and DBHIDS regarding the process by which CBH is reimbursed for both clinical/medical and administrative/operating costs related to the HealthChoices Program. We reviewed the written Reimbursement Process between CBH and DBHIDS and obtained an understanding of the controls and levels of review in place.

We requested copies of all the weekly reimbursement requests submitted by CBH during the testing period. These requests typically include payments made to providers, operating expenses, and on a biweekly basis, payroll, and related expenditures. Supporting documentation is attached to the payment voucher. These amounts were summarized in detail and traced to the CBH check register. We also obtained copies of the biweekly payroll registers and performed a separate reconciliation to the payroll reimbursements requested.

We obtained a copy of all voided transactions covering the testing period and compared to the check register for the same period. All voided transactions were traced to reimbursement requests to determine whether the voided transactions were backed out of subsequent requests. Additionally, any replacement transactions were traced to ensure they were not duplicated in the reimbursement process.

CBH Procurement Process

We inquired of CBH management regarding the procurement process in place for both administrative and clinical contracts. We reviewed the CBH Procurement Process Protocol which

details the process for clinical providers and were informed by CBH management that this document also applies to administrative contracts.

The purpose of the Procurement Testing was to test whether both CBH administrative and clinical procurements were properly supported by documentation that demonstrated adherence to applicable guidelines per CBH policies and procedures. Additionally, we reviewed compliance with the applicable sections of Philadelphia Code, Chapter 17-1400, Non-Competitively Bid Contracts. First, we requested a listing of all administrative and clinical procurements during the testing period of July 1, 2016 through June 30, 2017. The provided list only contained one procurement for each type. To better assess the process, we supplemented our procurement testing by selecting additional procurements through our Expenditure Testing (noted above). We selected expenditures from the General Ledger detail that occurred within the testing period. For each selected procurement, we obtained all supporting documentation, including copies of the Requests for Proposals and the signed contracts between CBH and the awarded vendors, copies of the submitted proposals, evaluation results by the review group and documentation of all procurement approvals. Our procedures included verifying whether the procurement was made publicly available on the CBH and DBHIDS websites and sent via CBH news emails, verifying that the procurement summary was reviewed and approved by the review group, verifying the final procurement was approved by the CBH Chief Operating Officer and Commissioner of DBHIDS for final decision after review of the procurement summary and verifying that the awarded vendor was not on any city debarment lists. Lastly, we verified that the contract between CBH and the vendor was signed prior to any payments being made to the vendor.

Documents Inspected

In addition to discussions with key DBHIDS and CBH management and staff, the following documents inspected by us were provided by the DBHIDS, CBH and the Controller's Office:

- CBH Policies and Procedures
- CBH Procurement Process Protocol
- CBH Network development Departmental Overview and Review of Procurements
- CBH Credentialing Handbook for Network Providers
- CBH Listing of rate increases for FY 2017

- CBH GL Detail for July 2016 – June 2017
- CBH Payroll Registers July 2016 – June 2017
- CBH Payment Vouchers to DBHIDS July 2016 – June 2017
- CBH 403(b) Summary Plan Description
- CBH Administrative Budgets CY 2016 & 2017
- CBH Quarterly Administrative Expense Variance Analysis CY 2017
- CBH Board minutes July 2016 – June 2017
- CBH By-laws
- CBH OPEB Actuarial Valuation 2017
- CBH Quarterly State Reports to PA OMHSAS
- CBH Form 990 FY 2016
- Contract terms between DBHIDS and CBH
- DBHIDS Reimbursement Process Between CBH and DBHIDS
- DBHIDS and CBH Organizational Charts
- DBHIDS FY 2017 Operating Budget
- Mitchell Titus AUP Report on Duplicate Reimbursement issued to DBHIDS
- PA HealthChoices Program Standards and Requirements including Attachment P Financial Reporting Requirements
- PA HealthChoices Behavioral Health Program, Program Evaluation Performance Summary, Review of CY 2016 for CBH
- Phila HealthChoices Behavioral Health Program Audited Financial Statements FY 2016
- Phila HealthChoices Behavioral Health Program Audited Financial Statements FY 2017
- Philadelphia Code, Chapter 17-1400, Non-Competitively Bid Contracts

DBHIDS RESPONSE TO THE CITY CONTROLLER'S AUDIT

Submitted April 16, 2021

(Revised June 16, 2021)

Jill Bowen, PhD
Commissioner



Department of Behavioral Health and Intellectual disAbility Services

April 16, 2021

Christy Brady
Deputy City Controller
Office of the Controller
1230 Municipal Services Building
1401 John F. Kennedy Boulevard
Philadelphia, PA 19102-1679

RE: REPORT ON HEALTHCHOICES BEHAVIORAL HEALTH PROGRAM

Dear Christy Brady:

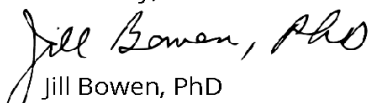
We are in receipt of the HealthChoices Behavioral Health Program Draft Report submitted to us on March 26, 2021. We appreciate the opportunity to provide feedback on the findings and observations prior to the report being finalized.

Enclosed you will find our responses to the findings and recommendations from your auditing teams and the consultant, Mercadien P.C.

If you have any questions about any items outlined in this response, please contact Joe Lowry, CFO DBHIDS (joe.lowry@phila.gov) and cc Robert Bickford, CFO CBH (robert.bickford@phila.gov).

We look forward to discussing further at a formal exit conference.

Sincerely,


Jill Bowen, PhD
Commissioner, DBHIDS

Department of Behavioral Health and Intellectual disAbility Services

MONITORING AND OVERSIGHT OF COMMUNITY BEHAVIORAL HEALTH

The Department of Behavioral Health and Intellectual DisAbility Services (DBHIDS) serves as the Primary Contractor (PC) for the Philadelphia Behavioral HealthChoices Medicaid Program. DBHIDS contracts with Community Behavioral Health (CBH), a 501 (c)(3) non-profit organization, to administer the Behavioral HealthChoices Program. As the Behavioral Health Managed Care Organization (BH-MCO), CBH is responsible for assuring access to quality behavioral health treatment services for Medical Assistance recipients in Philadelphia. CBH meets this mandate by contracting with a diverse network of providers, including independent practitioners, group practices, and facilities.

As the Primary Contractor, DBHIDS contracts with the Pennsylvania Department of Human Services (PA DHS) to oversee the Behavioral HealthChoices Program for Philadelphia. The PA DHS and DBHIDS HealthChoices Agreement is renewed annually pursuant to state requirements governing the HealthChoices program. DBHIDS' contract with CBH, as the BH-MCO, is reviewed and renewed annually to assure alignment with applicable federal, state, and local laws. The review process includes feedback and guidance from the City of Philadelphia Law Department and CBH's Counsel.

CBH's budget is fully funded by federal and state Medicaid dollars. There is no city funding included in CBH's administrative budget or medical expenses budget.

DBHIDS provides oversight and monitoring of the Behavioral HealthChoices program and its BH-MCO, CBH. CBH embraces a continuous quality improvement philosophy; in 2019, CBH achieved a full 3-year accreditation through the National Committee for Quality Assurance (NCQA).

The CBH Chief Executive Officer reports to the DBHIDS Commissioner who also serves as the President/Chair of the CBH Board of Directors.

The CBH Board of Directors is largely composed of City of Philadelphia leadership including the DBHIDS Commissioner, Deputy Commissioners, and Director of Behavioral Health, the Deputy Managing Director, the Health Commissioner, School District of Philadelphia Superintendent, Director of the Office of Homeless Services, and the Commissioner of Philadelphia Department of Human Services. The CBH Board of Directors also includes a youth member and family member with lived experience.

The CBH Board of Directors reviews and approves CBH's Administrative Budget. The Board also reviews and approves CBH's quarterly financial statements and annual external financial audit.

Members of the DBHIDS executive management team participate on CBH's Finance, Credentialing, Compliance, and Quality Improvement Committees as well as several

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operational committees and workgroups. DBHIDS leadership and staff participate in CBH's external reviews conducted by the PA DHS Office of Mental Health & Substance Abuse Services (OMHSAS) and its external review entity, Mercer. DBHIDS, CBH and OMHSAS collaborate routinely, and more formally at OMHSAS' quarterly monitoring meetings.

The DBHIDS Commissioner and CBH CEO review and approve all clinical procurements, including finalists, and awardees. CBH is aware that it is subject to Chapter 17-1400 of the Philadelphia Code, as referenced in the DBHIDS-CBH Agreement. A reference to Chapter 17-1400 of the Philadelphia Code is embedded in CBH's Vendor Contracting Policy (created in 2019). CBH's contracting process and its Vendor Contracting policy have undergone significant modification since 2018 in an effort to close previous gaps and vulnerabilities.

CBH's main objective is to assure that children, youth, adults, and families receive evidenced based, trauma informed, culturally and linguistically competent and recovery-oriented treatment and services. To accomplish that objective, CBH contracts with a diverse network of providers; all CBH in network providers must be licensed by the applicable state licensing entity and enrolled in the Pennsylvania Medicaid Program.

DBHIDS and CBH provide an array of ongoing training and technical assistance to the provider network to support implementation and sustainability of best practices in clinical care.

RESPONSE TO OFFICE OF THE CITY CONTROLLER AUDITORS' REPORT

The audit conducted from November 2018 to February 2020 was based on the City's fiscal year 2017 (July 1, 2016 - June 30, 2017). CBH operates on a calendar year, thus the audit spanned CBH calendar years 2016 and 2017 (July 2016-June 2017).

CBH is a 501(c)(3) organization under contract to the City of Philadelphia, through the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), to administer the behavioral health Medicaid program for Philadelphia. CBH is funded exclusively by state and federal Medicaid dollars; no City funding is apportioned to the Medicaid program. Thus, the \$1 billion dollar budget noted in the audit report is exclusively Medicaid funding provided to Philadelphia through the Pennsylvania Department of Human Services (PA DHS).

As a Medicaid managed care entity, CBH is governed by PA DHS and all its applicable requirements related to the administration of the HealthChoices program. PA DHS routinely monitors and evaluates CBH's performance related to the PA DHS Program Standards and Requirements (PS&R). Additionally, the City requires an annual external audit of CBH's financials, and the outcome of the audit is presented to the CBH Board of Directors.

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Access, quality, and fiscal accountability are the “triple aim” for the Behavioral HealthChoices Program; CBH welcomes external review and recommendations as part of its continuous quality improvement philosophy and approach.

Upon review of the City Controller’s Audit Report, CBH is providing specific feedback related to the findings and recommendations, as well as the audit process in general. The audit process, from the entrance interview to draft report, spanned three (3) years, beginning on February 1, 2018. This timeframe is inordinately long and inconsistent with industry standards related to timeliness. The start of the audit review period was almost five (5) years ago and CBH has made many changes and improvements over that span of time, which are described later throughout this document. There has been a new DBHIDS Commissioner and a new CBH CEO since the time the scope of this audit represents. At the beginning of this engagement, it was stated publicly by the Controller that the audit was anticipated to take 6 months. There were several challenges the auditors experienced along the way, including turnover of staff, lack of understanding of the processes and the content area they were auditing, as well as privacy issues. At points over the years the Controller’s auditing teams indicated they were finalizing their results but then seemed to decide otherwise. In 2020, the City Controller brought in an outside consulting team, Mercadien, certified public accountants, who essentially restarted the audit process, reviewing information previously submitted and re-interviewing staff that had previously been interviewed by the City’s auditing teams. As an entity operating in New Jersey, the Mercadien team had no experience in Pennsylvania Medicaid or in the provision of behavioral health services.

The use of auditing personnel, lacking in the necessary background to conduct a meaningful and robust review, consumed valuable time and resources, and more importantly resulted in a report that contains inaccuracies and offers generalizations based on a limited understanding of the Behavioral HealthChoices Program.

Within the Audit Scope of the Auditor’s Report, it was noted that “certain documentation was withheld from the auditors.” CBH would like to clarify that although redacted information was provided to the auditors to ensure member information was safeguarded, CBH did not withhold information. Additionally, the City Controller’s audit team was not versed in behavioral health, managed care, or the HealthChoices program standards or financials. DBHIDS/CBH leadership and staff provided education about CBH operations and services throughout the course of the audit. Moreover, the audit team conducted provider agency site visits, which included the review of Members’ medical records, without the appropriate training in Protected Health Information (PHI) and HIPAA. Only after CBH expressed concerns, did the City Controller obtain this training for its team.

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OTHER SIGNIFICANT CHANGES SINCE THE AUDIT REVIEW PERIOD

CBH is always seeking ways to ensure continuous quality improvement across the organization. In FY17, CBH did not have a standalone website; however, limited CBH information was available on the DBHIDS website. Currently, the CBH website contains substantial information for the network, including CBH rate setting policy and processes, information about Alternative Payment Arrangements (APA) and much more. Additionally, CBH continues to work towards strong documentation of its financial processes. You will see detailed responses below related to CBH's financial processes.

In addition to creating the CBH website, we have also created an Internal Risk Management Department and a Risk Management Committee, which has allowed CBH to create and strengthen existing processes and controls.

In the fall of 2019, CBH achieved *full* accreditation status for the National Committee for Quality Assurance (NCQA) for a Medicaid Managed Behavioral Healthcare Organization. For a healthcare organization to earn an NCQA Health Plan Accreditation, it is required to meet standards encompassing more than 100 measured elements. According to NCQA, the accreditation process helps "guarantee that organizations making these decisions are following objective, evidence-based best practices." Its purpose is to help health plans improve operational efficiencies, satisfy state requirements and employer needs, keep patients happy and healthy, and demonstrate their commitment to quality (Advanced Medical Reviews; July 2020; [admire.com/amr-blog/ncqa-accreditation-what-does-it-mean](https://www.admire.com/amr-blog/ncqa-accreditation-what-does-it-mean)). Achieving this accreditation positions CBH to continuously review and strengthen processes, which will impact provider performance and higher quality member care.

The DBHIDS Senior Director for Clinical Quality Management position was created in 2019. In addition to other responsibilities, DBHIDS Quality Management monitors ongoing compliance of CBH with respect to meeting standards and requirements set forth by the Pennsylvania HealthChoices Program Standards and Requirements (PS&R), Appendices H and AA, Program Evaluation Performance Summary (PEPS), CBH's Policies & Procedures, and any associated corrective action plan (CAP).

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RESPONSE TO OFFICE OF THE CITY CONTROLLER AUDITORS' REPORT FINDINGS**Summary****CREATION OF DBHIDS/CBH****Finding**

The report indicated that The Office of Behavioral Health and Mental Retardation Services (OBH/MRS) officially became known as the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) in 2018. Also, within this section of the report, there is a statement about how CBH engages with third parties to provide mental health and substance abuse services.

Conclusion Summary

This finding was inaccurate as OBH/MRS became known as DBHIDS and transitioned to its own City Office in 2012. CBH does not "engage with" third parties. As a division of DBHIDS, CBH contracts with providers to deliver behavioral health treatment to CBH members.

REQUIRED CLINICAL DOCUMENTATION MISSING FROM PATIENT FILES**Finding**

The report indicates, "that the auditors, using a random sample of 27 providers, we haphazardly selected 284 transactions from the Weekly City Invoices submitted to CBH for the fiscal year July 1, 2016 to June 30, 2017. We asked the providers to produce the documents, when applicable to the required treatment, to substantiate delivery of the services and validate billing for the transactions selected."

Based on the auditors' review, the report asserts that required documentation missing from member files "calls into question the validity of the services, and the quality of care administered," thereby calling into question "possible fraud, waste or mismanagement."

Conclusion Summary

Erroneous conclusions were drawn based on a lack of understanding of required documentation for behavioral health treatment providers, and for particular services, as governed by the PA HealthChoices program.

PROVIDER PROFILES IDENTIFIED DOCUMENTATION ISSUES SIMILAR TO AUDIT RESULTS**Finding**

The report asserts that CBH's provider profiles "detail significant claims related deficiencies including insufficient or missing documentation, incomplete treatment plans, billing for nonbillable services, conflicting information in supporting

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documentation, reuse of progress notes and late entries in progress notes.” Additionally, Table II in the report and the accompanying narrative attempt to illustrate pervasive documentation issues and non-adherence to CBH policies. For ease of reference, below is Table II from the report.

Conclusion Summary

The findings in this section of the report are inaccurate, as the profiles are not intended to be used for the purpose of documenting compliance with regulatory requirements. The table and findings failed to consider CBH's Compliance Error Codes for documentation discrepancies and the distinction between an item that is non-billable versus insufficient, which is significantly different. CBH regularly recoups, as part of its Compliance reviews, funds associated with payments where the documentation fails to adhere to standards.

COMPLIANCE UNIT OVERSIGHT INSUFFICIENT TO ADDRESS DOCUMENTATION CONCERNS

Finding

The report concludes that CBH's Compliance team is unable to identify and address what are referred to as “systemic issues” at CBH network providers. Specifically, the report seems to focus on the staffing levels and the “depth” of the reviews completed by Compliance staff as leading to this determination.

Conclusion Summary

This finding is unfounded as the report does not cite, nor is CBH aware of any clear standards from Federal or State oversight entities for such staffing ratios. The report fails to appropriately consider relevant training for CBH staff and expertise to identify and address potential Fraud, Waste, & Abuse (FWA). Other key components of CBH compliance efforts are also not recognized in the report. Auditing is only one part of any effective compliance plan. In addition, self-auditing is viewed as a key component in any effective compliance plan and many self-audits are more detailed and thorough than audits conducted by outside entities.

CBH MONITORING/OVERSIGHT LACKED COORDINATED EFFORT

Finding

The report indicated the following: “There appears to be a lack of coordination between the Compliance, NIAC, and Quality Management Departments. Monitoring and oversight work conducted by the units appear to be disjointed and siloed.” There was also a notation in the report about large gaps of time between site visits by the monitoring units, as well as inconsistencies in monitoring efforts and recommendations.

Conclusion Summary

CBH disputes the allegation that the oversight and monitoring departments lacked coordination. The CBH Compliance Committee membership consists of participants

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from several other CBH departments as well as DBHIDS and serves as a direct oversight body to the CBH Compliance Department. A Credentialing Committee was created to provide oversight to the initial credentialing and recredentialing processes and all decisions made therein.

CIRC PROGRAM PAYMENT STRUCTURE NOT COST EFFECTIVE

Finding

The Community Integrated Recovery Centers (CIRCs) were reviewed as part of the audit process. It was noted in the report that most providers did not reach the established capacity in the program.

Conclusion Summary

CIRC programs were collaboratively developed in 2006 when the old partial hospitalization programs were transformed from an institutionalized, center-based and illness-focused culture to a peer-driven, person-first, family-involved and community-integrated approach.

CBH recognized the challenge of this transformational shift for providers in that the number of members being served in the CIRC program was showing a reduction each year, while expenses remained flat. This issue was resolved in 2018 by the implementation of a cost effective, Value Based Payment arrangement for CIRC services.

CBH REIMBURSED FOR ADMINISTRATIVE COSTS NOT NECESSARY FOR OPERATION OF HEALTHCHOICES PROGRAM

Finding

The report indicated that “the City will not reimburse ineligible administrative or program costs, citing two (2) instances where CBH submitted administrative costs for reimbursement from DBHIDS that did not appear to be related to its responsibility as the MCO administering the HealthChoices Program.” These two instances were the CBH 20th Anniversary celebration and the CBH Health and Wellness Program.

Conclusion Summary

This finding is inaccurate, as the administrative expenses identified in this section, including the 20th Anniversary and employee wellness costs, are well within the purview of reasonable administrative expenses of a non-profit organization. CBH consistently spends less per year on administrative expenses than the budgeted administrative capitation provided by the PA DHS Office of Mental Health & Substance Abuse Services (OMHSAS).

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PAY-FOR-PERFORMANCE INCENTIVE PROGRAM LACKED TRANSPARENCY WITH PROVIDERS

Finding

The report indicated that “providers stated there is confusion and a lack of transparency among network providers caused by the complexity of the incentive formula for the Pay-for-Performance (P4P) program. The P4P incentives appear to conflict with the results of monitoring evaluations performed by the Compliance Unit and Quality Management Unit and are more driven by the electronic information in the claims payment system.” The report also recommended that the “scoring matrix to calculate the P4P financial incentive be regularly discussed with providers as part of CBH’s plan to help providers meet each program’s targeted performance standards.”

Conclusion Summary

The P4P process is transparent and engages providers on a regular basis. Performance measures used for P4P programs are either selected from nationally validated Healthcare Effectiveness Data and Information Set (HEDIS) measures used by OMHSAS to evaluate service quality for all Behavioral Health- Managed Care Organizations (BH-MCOs), or are developed by CBH Quality staff in conjunction with Clinical Subject Matter Experts and presented to providers for feedback. All P4P information, including eligibility for a P4P award, the scoring methodology, and the definitions for all performance measures, is detailed in an Operational Definitions Master Document that is made available to providers and the public through a Provider Notice on CBH’s website, and is also announced to the public through the CBH News blast.

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CBH RESPONSE TO OBSERVATIONS AND RECOMMENDATIONS FROM MERCADIEN, P.C.

Summary

CBH COMPLIANCE OVERSIGHT:

OBSERVATION 1

CBH's Credentialing Oversight for Facility/Organization Providers was Inadequate

The audit review team observed that the potential exists for unqualified staff to be delivering services to CBH members at contracted providers.

Conclusion Summary

This observation is inaccurate because the review team incorrectly attributed it to a CBH Compliance function. The full delegation of credentialing of agency staff has been in place since 2017. CBH received a three-year accreditation by the National Committee for Quality Assurance (NCQA) in 2019. CBH's credentialing practices meet, if not exceed, the requirements set forth by NCQA.

CBH REIMBURSEMENT PROCESS:

OBSERVATION 2

Review Process Failed to Identify Duplicate Reimbursements in a Timely Manner

The report noted that reimbursement requests for HealthChoices did not properly exclude the payments that were issued for non-HealthChoices purposes. The reimbursement request process was not sufficiently designed to identify and exclude non-HealthChoices expenditures from the reimbursement request. It was also noted that the review processes failed to identify duplicative invoices prior to reimbursement.

Conclusion Summary

CBH's contract with the City allows CBH to function as an Administrative Services Organization (ASO), providing administrative support to the City for various initiatives as directed by DBHIDS. Expenses related to MCO vs. ASO functions are now separated in the CBH accounting system and includes a separate general ledger. However, there was never any impact on the accuracy of the classification as HealthChoices or Non-HealthChoices funds for audit purposes. The only impact of a duplicate payment between DBHIDS and CBH results in funds being transferred from one HealthChoices Cash Account to another. All cash transfers were settled between HealthChoices accounts and postings were made to account for the transfers. There was also no impact on claim payments to providers. This

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has been substantiated through multiple external financial audits with clean opinions and no material variances notes.

OBSERVATION 3

CBH Inaccurately Reimbursed for Voided Transactions

The consulting report noted that CBH's process used to produce weekly city invoices did not consistently identify scenarios for void and replacement transactions, nor did CBH perform a reconciliation of the total cash payments made.

Conclusion Summary

Voided and reissued checks for which reimbursement has been made would have no effect on the total HealthChoices cash balance. The reissued check is included in the reimbursement request, as well as the voided check as a refund.

OBSERVATION 4

CBH Inaccurately Reimbursed for Payroll Related Expenses

The consulting report noted that CBH did not consistently follow its own policies and procedures for payroll and payroll expense reimbursement. The report recommended that CBH develop more detailed procedures for the preparation of the weekly city invoices.

Conclusion Summary

CBH did not inaccurately reimburse for payroll related expenses. These transfers had no effect of the HealthChoices cash balance as a whole and did not cause inaccurate information to be reported in financial statements.

CBH PROCUREMENT PROCESS: OBSERVATIONS 5, 6, 7, 8, 9

OBSERVATION 5

CBH Did Not Follow Philadelphia Code for Awarding Sole Source Contracts

The consulting report noted that CBH improperly awarded professional services contracts on a sole source basis under Philadelphia Code, subsection 17-1406(2). It was also noted that CBH lacks a comprehensive formal procurement process for professional services that complies with the sections of the Philadelphia Code to which it is subject.

OBSERVATION 6

CBH Did Not Follow Philadelphia Code for Contract Renewals

The consulting report noted that CBH entered into three separate administrative contracts without conducting a new procurement process. Instead, CBH utilized old RFPs to procure services. As a result, CBH violated the Philadelphia Code requirements for contract renewals.

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OBSERVATION 7

CBH Did Not Comply with Its Own Procurement Protocol

The consulting report noted that CBH did not comply with its own Procurement Protocol by not providing supporting documentation to verify that required steps were taken.

OBSERVATION 8

DBHIDS Did Not Provide Adequate Oversight of CBH Procurement

The consulting report noted that DBHIDS did not provide adequate oversight of the CBH procurement process. It was recommended for the contract between DBHIDS and CBH to be reviewed and revised to include clearly defined duties, roles, and responsibilities of all parties.

OBSERVATION 9

Contractors Performed Services/Were Paid Prior to Signed Contract with CBH

The consulting report noted that CBH entered into three (3) professional services contracts with outside contractors in which the contractor provided services, billed for services, or was paid for services prior to the contract being signed by both parties and/or the contract's effective date.

Conclusion Summary

CBH acknowledges that the use of the sole source exception in the two instances cited in Mercadien's report, Clinical Consultation services and IT Infrastructure services, did not fully meet the sole source definition in the Philadelphia Code.

CBH's contracting process and its Vendor Contracting policy have undergone significant modification since 2018 in an effort to close previous gaps and vulnerabilities. In addition, CBH's Administrative Expenditures Policy was significantly modified in 2018 and 2019, and more effectively controls and monitors the contracting process.

The audit findings identified a gap in the CBH contract renewal process. This was addressed in the CBH Vendor Contracting Policy and in the CBH Procurement Protocols. CBH updated the Clinical Procurement Protocol and finalized an Administrative Procurement Protocol in August 2020. Both protocols are posted on the CBH website.

PROVIDER LOANS AND ADVANCES: OBSERVATIONS 10, 11

OBSERVATION 10

CBH Did Not Comply with Its Own Policies and Procedures for Provider Advances/Loans

The consulting report noted that there were instances of "non-compliance with CBH policy and procedure" for temporarily advancing funds to providers if the provider is unable to submit claims for services rendered due to a contracting or billing system issue.

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OBSERVATION 11

CBH Did Not Comply with Its Own Policies and Procedures for Provider Rate Increases

The consulting report noted that there were instances of “non-compliance with CBH policy and procure” for rate increase requests.

Conclusion Summary

CBH recognizes the need to maintain a critical balance between controlling costs, maintaining cash flow, and keeping the provider network viable. CBH is in the process of reviewing the Advances Policy and Procedure. In the interim, the existing policy will be adhered to. CBH issued a Request for Rate Increase Policy on 10/3/2019, which is also posted on the CBH website. This policy describes CBH's commitment to assuring quality and value in the services provided by CBH providers.

In accordance with the CBH Provider Agreement, providers are notified 30 days in advance of any rate changes. CBH's goal is to regularly provide both Standard and Non-Standard Rate increases. CBH annually reviews current rates and will consider rate increases based on several factors outlined in the policy. Providers will have the opportunity to request rate increases for Non-Standard Rates if they have not had an increase within the past three years or can demonstrate extenuating circumstance.

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OVERARCHING CATEGORIES AND THEMES COVERED IN THE AUDIT

OVERSIGHT AND MONITORING: PAYOR RESPONSIBILITIES VS. PROVIDER VS PA DHS

Provider agencies, in the CBH network, are required to be licensed by the state and enrolled in the PA Medical Assistance Program. Each year, provider agencies are required to submit an [Application for Certificate of Compliance](#) to PA DHS prior to receiving their annual state licensure visit. The state's annual licensure visit is one of many ways in which the CBH provider network is monitored.

The audit report also conflates CBH responsibilities with those of the provider agencies relative to the oversight of provider agency staff. CBH conducts credentialing, compliance, and quality management activities, which while related, are distinct functions targeting specific areas of clinical operations. CBH utilizes a "teaming" structure where all three functional areas review a provider to determine a holistic approach to recommendation action steps.

PROVIDER DOCUMENTATION

A fundamental flaw in the audit, and a presumption that permeates the report, is the erroneous assertion that missing documentation equates to fraud. Another fundamental flaw noted early in the report was the notation that CBH "delivers medically necessary services" when in fact, CBH *reimburses* contracted providers to deliver the services. Providers are required to maintain documentation, in member charts, that is consistent with the requirements for the specific clinical level of care being provided. For example, one would not expect to find a Pennsylvania Client Placement Criteria (PCPC) in a licensed mental health outpatient provider's treatment chart.

The audit report also fails to indicate that when CBH conducts its own audits of provider documentation and finds errors or other documentation concerns, CBH Compliance recoups payments, made to the provider, for the service associated with the documentation. That is, the dollars associated with the claim for which there is a documentation error, are returned to CBH. This is a standard practice across the Commonwealth.

Additionally, the CBH mission statement noted in the report indicates that the mission is to integrate medical assistance and program funding streams; this is not an accurate statement. The CBH mission is: CBH will meet the behavioral health needs of the Philadelphia community by assuring access, quality, and fiscal accountability through being a high performing, efficient, and nimble organization driven by quality, performance, and outcomes.

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The audit assumes a lack of oversight and monitoring by CBH based on *point in time* internal provider profiles. However, the audit is silent on remediation activities undertaken by CBH as a result of its reviews of providers, including the referrals that CBH is required to submit to the state's Bureau of Program Integrity and Office of the Attorney General, when appropriate.

It should be noted that within the *Behavioral HealthCare Providers* section of the report, it states that "medical coding for each service or level of care is consistent throughout the City for behavioral healthcare services." DBHIDS/CBH does not understand what is meant in the report by "medical coding for each service or level of care is consistent." Therefore, it was difficult for us to respond.

CBH ADMINISTRATIVE EXPENSES

Research has shown that health and wellness programs in the workplace can reduce healthcare costs, reduce health risks, increase employee productivity, increase employee satisfaction, and increase retention. CBH has invested in a robust health and wellness program for many reasons. In previous years, the CBH insurance broker would directly pay for incentives to encourage health and wellness among employees. Today, CBH receives wellness credits from its insurance provider which helps pay for health and fitness incentives such as wearable devices, cooking demos, some exercise classes, and webinars; these credits cover a portion of the wellness program costs.

CBH has maintained a low administrative budget since its inception. The celebration for the 20th Anniversary was a one-time event and a proud milestone for the City, CBH, and its stakeholders. There are additional details about the 20th Anniversary celebration reflected in the specific findings section.

DBHIDS/CBH FINANCIAL PROCESSES

DBHIDS' oversight of CBH has yielded a robust continuum of clinical services while containing costs and maintaining low administrative costs.

Below please find a chart from the CBH website that illustrates a comparison across Pennsylvania BH-MCO. As noted, CBH is the only BH-MCO that does not retain administrative savings.

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MCO Name	CBH	CCBHO	MBH	PerformCare	VBH of PA
Organizational Status	Non-Profit	Non-Profit	For-Profit	For-Profit	For-Profit
Corporate Affiliation	None	UPMC	Magellan	Americhoice	Beacon
County Administrative Oversight Structure	Division of DBHIDS	County Oversight Entity in some counties*	None	County Oversight Entity	County Oversight Entity
Board of Directors	County Officials & Stakeholders	UPMC & Community Members	None	None	None
Percent Profit	None	1.5-2%, performance-based contract	1.5-2%	1.5-2%	1.5-2%



As a non-profit organization contracted by the City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), CBH returns all administrative and medical savings to the City for reinvestment. Additionally, CBH has no spend on corporate overhead, additional county oversight, or marketing costs.

The remaining four MCOs retain their administrative savings and spend additional resources to varying degrees on corporate overhead, county administrative oversight costs, and county administration costs.

*County oversight entity incorporated and receiving Healthchoices administrative dollars

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RESPONSE TO FINDINGS AND RECOMMENDATIONS

CREATION OF DBHIDS/CBH

Finding

The report indicated that The Office of Behavioral Health and Mental Retardation Services (OBH/MRS) officially became known as the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) in 2018. Also, within this section of the report, there is a statement about how CBH engages with third parties to provide mental health and substance abuse services.

Conclusion Summary

This finding was inaccurate as OBH/MRS became known as DBHIDS and transitioned to its own City Office in 2012. CBH does not engage in third parties. As a division of DBHIDS, CBH contracts with providers to deliver behavioral health treatment to CBH members.

Response to FY17 Audit

The OBH/MRS transitioned to DBHIDS in 2012, which is when it also transitioned from a division of the Department of Health to its own City Office. CBH does not engage in third parties. Instead, CBH contracts with providers to deliver behavioral health treatment to CBH members; these providers are licensed by the respective state licensing body and enrolled in Medicaid.

Current State

The DBHIDS continues to be its own Office and is comprised of seven (7) divisions, with CBH being one of the divisions.

REQUIRED CLINICAL DOCUMENTATION MISSING FROM PATIENT FILES

Finding

The report indicates, "that the auditors, using a random sample of 27 providers, we haphazardly selected 284 transactions from the Weekly City Invoices submitted to CBH for the fiscal year July 1, 2016 to June 30, 2017. We asked the providers to produce the documents, when applicable to the required treatment, to substantiate delivery of the services and validate billing for the transactions selected."

Based on the auditors' review, the report asserts that required documentation missing from member files "calls into question the validity of the services, and the quality of care administered", thereby calling into question "possible fraud, waste or mismanagement."

Conclusion Summary

Erroneous conclusions were drawn based on a lack of understanding of required documentation for behavioral health treatment providers, as governed by the HealthChoices program.

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Response to FY17 Audit

Selecting providers and or records “haphazardly” raises questions and concerns about the auditors’ methodology, or lack thereof, and overall approach to the review. It is unclear if the sample was random and representative, and therefore unclear how conclusions can be determined or generalized.

The auditors identified a list of documents that were incorrectly described as required “when applicable to the required treatment, to substantiate delivery of the services and validate billing for the transaction selected.”

- **Release of Information:** Is not required or related to the ability to bill or be paid under current HealthChoices rules and requirements.
- **The Intake Form:** Is not required or related to the ability to bill or be paid under current HealthChoices rules and requirements.
- **A Comprehensive Biopsychosocial Evaluation/Re-evaluation or Pennsylvania Client Placement Criteria (PCPC):** A CBE/R is conducted when clinically appropriate and is not required in all cases. The auditors appeared to have mistakenly assumed that all clinical charts must contain an annual CBE/R, which is inaccurate. Please see following [Provider Notification](#) for additional clarification. The table below was provided in the report, ostensibly to illustrate the instances of missing documentation. CBH asserts that Table 1 has no utility in that there is no context provided including the denominator and how records/claim lines with more than one omission scored. Additionally, the table, nor the approach for this review, accounts for what is an acceptable error rate based on the sample reviewed. It is also misleading to include the Release of Information and Intake Forms as they are not required to bill services or receive payment for services delivered.

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Table I: Missing or Unavailable Documentation								
Provider	ROI Form	Intake Form	Encounter Form	Progress Notes	Treatment Plan	CBE/CBR Evaluation	PCPC Form	Total Per Provider
1		1		2		1		4
2	2	2				3		7
3	4	1		1	2			8
4	1							1
5			5	5	1	1		12
6	1			1				2
7				2				2
8			5	1				6
9	1			2	2	2	3	10
10	1							1
11	1					6		7
12				4		2		6
13	10	10		2	10	8		40
14			9			1		10
15	2	1	2	5	1	1	1	13
16	1		10			1		12
17	3	3		1		5	3	15
18	1							1
# Exceptions	28	18	31	26	16	31	7	157
# Providers	12	6	5	11	5	11	3	

Source: Prepared by the Office of the City Controller.

PROVIDER PROFILES IDENTIFIED DOCUMENTATION ISSUES SIMILAR TO AUDIT RESULTS

Finding

The report asserts that CBH's provider profiles "detail significant claims related deficiencies including insufficient or missing documentation, incomplete treatment plans, billing for nonbillable services, conflicting information in supporting documentation, reuse of progress notes and late entries in progress notes." Additionally, Table II in the report and the accompanying narrative attempt to illustrate pervasive documentation issues and non-adherence to CBH policies. For ease of reference, below is Table II from the report.

Conclusion Summary

The findings in this section of the report are inaccurate, as the profiles are not intended to supplant documentation necessary to fill regulatory requirements. The table and findings failed to consider CBH's Compliance Error Codes for documentation discrepancies and the distinction between an item that is non-billable versus insufficient, which is significantly different. CBH regularly recoups, as part of its Compliance reviews, funds associated with payments where the documentation fails to adhere to standards.

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Provider	Insufficient or Missing Documentation		Claims Without a Valid Treatment Plan		Non-Billable Activities		Conflicting Information		Reuse of Content		Late Note Entries	
	Per CBH Profiles	Per Auditor	Per CBH Profiles	Per Auditor	Per CBH Profiles	Per Auditor	Per CBH Profiles	Per Auditor	Per CBH Profiles	Per Auditor	Per CBH Profiles	Per Auditor
1		X	X									
2		X					X					
3							X					
4	X		X		X		X		X		X	
5	X	X		X			X				X	
6	X	X	X		X		X		X			
7	X	X	X	X	X		X		X			X
8		X				X						
9	X	X				X	X					
10	X	X						X				
11	X	X		X		X	X	X		X	X	
12	X						X		X		X	
13		X	X		X							
14	X	X			X		X					
15												
16	X	X	X		X		X				X	
17	X		X		X		X				X	
18	X						X		X			
19	X	X	X	X		X	X					
20	X						X				X	
21	X	X					X					
22	X		X		X		X					
23		X		X		X		X		X		
24	X				X		X		X			
25	X	X				X						
26	X	X							X			
27		X	X								X	
Total	19	18	10	5	9	6	18	3	7	2	8	1

Source: Prepared by the Office of the City Controller using Provider Profile Reports obtained from CBH and audit testing results.

RESPONSE TO FY17 AUDIT

The auditors reviewed CBH's *internal* provider profiles, which are a point in time synopsis of an agency, typically used to orient new members of the CBH leadership team and often used to prepare for meetings between CBH leadership and provider agency leadership. The profiles are updated annually based on information provided by the contributing departments, including the Network Improvement and Accountability Collaborative (NIAC), Quality Management, and Compliance. CBH uses these profiles for internal use only and they are not intended to supplant documentation necessary to fill regulatory requirements.

CBH regularly recoups, as part of its Compliance reviews, funds associated with payments where the documentation fails to adhere to standards. This should be noted in the report. *This point cannot be emphasized enough as it directly contradicts the auditors' depiction of unaddressed fraud and CBH's failure to maintain oversight of its provider network.*

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Additionally, Table II and presumably the underlying hypothesis, fail to consider CBH's Compliance Error Codes for documentation discrepancies and the distinction between an item that is non-billable versus insufficient which is significantly different.

As an example, Provider #8's audit report, which was shared with the City auditors, was based on a data run that revealed the provider billed CBH for more psychiatric consults during physical health hospital admissions than were allowed per Medicaid regulations. No complete chart audit was completed, as the audit findings were based on claims data, and only related to the CBH Compliance Department audit finding of "Services Exceeded MA-allowable Contacts per Time Period." The audit resulted in an overpayment recoupment of nearly \$160,000.00. *The CBH findings on Table II do not reflect this finding since it was not one of the issues selected by the City auditors for review.* The fact that the city auditors found Insufficient or Missing Documentation and Non-Billable Activities for provider #8 when CBH did not, is not an accurate reflection of the two auditing bodies' ability to detect fraud, as the particular CBH audit of this provider had been initiated for a specified purpose and therefore appropriately limited in scope.

Many of the CBH Compliance Department audits are conducted as a result of concerns regarding specific charts or issues. Of the Compliance Reports submitted for auditor review, 16 were 100% claims review, meaning that the audit reviewed all claims related to the reason for referral.

Since there was no methodology utilized for the sampling completed by the City audit team, it is also not possible to extrapolate findings to larger generalizations. The ability to generalize findings is diminished further by the lack of appropriate context. For example, there is no indication from the City audit team if an error was a single claim line out of 1,000 claim lines, if the audit was related to a single chart out of potentially hundreds or thousands of members seen, etc. The distinction between large error rates and repeated vs. isolated occurrences are vital in understanding and determining the need for additional action beyond recoupment for the observed overpayment.

It is also important to note that CBH is required to reimburse contracted practitioners or facilities for services provided to CBH eligible members. Providing an address outside of Philadelphia County does not equate to ineligibility. Eligibility is determined by the Commonwealth of Pennsylvania alone. There are a number of examples of temporary residences outside of Philadelphia that would not change eligibility determination. These include children in placement outside of Philadelphia or adults receiving non-hospital residential substance abuse treatment services.

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CURRENT STATE

While Provider Profiles continue to be maintained, they represent only a point in time reference. Reviewing any one provider profile out of context of other point in time references can result in misleading and ill-informed conclusions.

CBH continues to act on concerns with documentation that are in proportion to the concerns observed. The ability to determine the severity, egregiousness, patterns, or impact of errors without appropriate context is key to determining an appropriate response. CBH's response can vary from recoupment and provider education, to referrals to law enforcement entities, and prepayment reviews, when needed. This process for CBH Compliance begins at the identification of a potential concern. Compliance utilizes a decision matrix to triage the concern based on several factors that include risk to member safety, potential overpayment, potential for fraud, and repeated concerns for specific providers. In cases where providers continue to exhibit problematic documentation or service delivery concerns, CBH has the ability to tailor its response in a planful, escalating manner to elicit behavior change.

Finally, the utilization of corrective action plans (CAPS) is under continuous reevaluation not only for Compliance but for the other departments of DBHIDS involved with oversight and monitoring. CBH's aim is to utilize CAPs, which are often intense drains on human resource capital for both provider and CBH, when other less intensive interventions have failed.

COMPLIANCE UNIT OVERSIGHT INSUFFICIENT TO ADDRESS DOCUMENTATION CONCERNS

Finding

The report concludes that CBH's Compliance team is unable to identify and address what are referred to as "systemic issues" at CBH network providers. Specifically, the report seems to focus on the staffing levels and the "depth" of the reviews completed by Compliance staff as leading to this determination.

Conclusion Summary

This finding is unfounded as the report does not cite, nor is CBH aware of any clear standards from Federal or State oversight entities for such staffing ratios. The report fails to appropriately address the need for staff to have relevant training and expertise to identify and address potential Fraud, Waste, & Abuse (FWA). Key components of CBH compliance efforts are also not addressed in the report. Auditing is only one part of any effective compliance plan. Self-auditing is viewed as a key component in any effective

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compliance plan and many self-audits are more detailed and thorough than audits conducted by outside entities.

Response to FY17 Audit

While accepted that any MCO must maintain staffing in Special Investigative Units (SIU) (Compliance) to effectively monitor and address potential FWA, the Report does not cite, nor is CBH aware of any clear standards from Federal or State oversight entities for such staffing ratios. The report fails to appropriately address the need for staff to have relevant training and expertise to identify and address potential FWA. The statement "Given the small staffing size" is not supported in the report by evidence of any industry requirement/standard or comparison to peer organizations. At the time of the audit, all staff were receiving FWA related trainings to stay on top of current trends, schemes, risks, best practices, etc. and to achieve and/or maintain relevant certifications. All Compliance staff who review clinical records are also clinicians. This allows them a better understanding of the information in the patient files they review and to determine FWA concerns.

Key components of CBH compliance efforts are also not addressed in the report. Auditing is only one part of any effective compliance plan; please reference this helpful resource: [Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans](#). CBH has continued to also target education and development of strategies to eliminate improper payment from ever being made. Eliminating a "Pay and Chase" approach to a more preventative, front-end approach is also widely accepted as an industry standard that is not adequately addressed in the report. While the report mentions that improperly formatted claims are typically rejected, claim edits extend beyond simple formatting concerns. This can be achieved in a number of ways, from increasing use of value-based payment models, blocking excluded individuals or entities from participating in the Medicaid system, and increasing individual accountability for FWA. The CBH approach to balance auditing with education and focusing on individual accountability is consistent with current industry guidance. Please reference the following helpful resources that support CBH's response: [an Article about CMS](#) and a [Memo from the Deputy Attorney General](#).

The assertion that "self-audits are not as thorough as the compliance reviews conducted by CBH and should not be used as a replacement for them" is not supported by evidence presented in the finding nor in industry standards. *In fact, self-auditing is viewed as a key component in any effective compliance plan.* In CBH's experience, many self-audits are more detailed and thorough than audits conducted by outside entities. A review of Commonwealth ([Medical Assistance Provider Self Audit Tool](#)) and [CBH required self-audit protocols](#) would show that self-audits typically require a high level of coordination with any payer. The Commonwealth notes that self-audits serve "our common interest to protect the financial integrity of the MA Program" and that MCOs must "educate their network providers about the self-audit protocol and encourage the providers to use it."

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It is concerning that a selected sample of work utilizing unclear methodology is being used to draw any conclusions regarding the depth of audits by CBH Compliance staff. CBH Compliance uses sound and generally industry accepted standards for sample selection based on the investigation; CBH's sampling methodology generally exceeds that required by Federal auditors. A review of the Compliance Reports submitted to the City auditors reveals that 10 of the 34 audits were conducted using statistically significant random samples. A suggestion to exceed what is required to obtain a representative sample is, in CBH's view, inappropriate and would cause CBH to inefficiently use the resources available to us.

Current State

CBH currently has 19 staff devoted full-time to prevent, detect, and address incidents of FWA in the CBH network. Seven of these staff hold a certification related to FWA that include Accredited Healthcare Fraud Investigator (AHFI), Certified in Healthcare Compliance (CHC), Certified Fraud Examiner (CFE), and Certified Compliance and Ethics Professional (CCEP). Several staff hold multiple certifications. All staff who review clinical records are, at minimum, Master's prepared clinicians. Finally, all Compliance staff have access to and participate in trainings specific to FWA. CBH also supports its mission by joining with select peer MCOs in participating as member organization in the National Healthcare Antifraud Association (NHCAA). This designation enables CBH to participate in information sharing and coordination efforts with other MCOs and law enforcement entities to have the most current information possible on emerging threats to the integrity of the Medicaid system. This level of commitment to highly skilled and trained Compliance staff, partnered with the ability to stay updated on current and emerging threats, make the CBH team more than capable of addressing FWA concerns across the CBH network.

CBH continues to recognize the need to eliminate improper payments from ever being made. To this end, CBH utilizes front-end claim edits that disallow claims from being paid. Current claim edits prevent payments for services such as those with unacceptable place of service, exceeding maximum allowable daily units and number of hours per week, and services that are incompatible to be billed for the same member on the same date of service. Additionally, CBH has utilized prepayment reviews in exceptional cases to screen high-risk claims prior to the provider receiving payment.

CBH Compliance regularly makes use of randomized and statistically significant or relevant sample sizes. This far exceeds the City audit team's self-described haphazard selection for the review of CBH activities. In fact, the use of statistically significant and random samples is necessary to draw conclusions from any sampling activity. CBH uses this sample selection process to ensure that it has, with statistical certainty, selected a sample that is representative of the entire population. This allows CBH Compliance to utilize extrapolation audits. Without a statically valid and random sample, it is not possible to draw conclusions from a sample to a larger population with any level of certainty.

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Finally, CBH continues to work with the CBH provider network at all levels to educate and strengthen the partnership born from the common interest with providers to protect the integrity of the Medicaid system. When possible, CBH works with provider leadership to focus efforts to hold individuals accountable. This is consistent with directives given by Federal authorities in the "Yates memo" to protect the integrity of the Federal healthcare system by, when appropriate, excluding individuals from further participation in the system.

In the majority of cases CBH investigates, there is insufficient evidence of intent to support referrals for fraud. The actual determination of fraud is not legally permissible by CBH staff. This is only determined in a court of law. Please reference the following document for additional insight: cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R425PI.pdf.

CBH does make every effort to discern in its reviews, if evidence is present, information that would support additional investigation by law enforcement and program integrity partners. In cases where it appears that there was a lack of intent to defraud, or that the agency involved is an active partner in a CBH investigation of individual staff who are being investigated, CBH not only recoups the identified overpayment and returns it to the Medicaid system, but also works to educate the providers so that the concerning billing is not repeated moving forward.

CBH MONITORING/OVERSIGHT LACKED COORDINATED EFFORT

Finding

The report indicated the following: "There appears to be a lack of coordination between the Compliance, NIAC, and Quality Management Departments. Monitoring and oversight work conducted by the units appear to be disjointed and siloed." There was also a notation in the report about large gaps of time between site visits by the monitoring units, as well as inconsistencies in monitoring efforts and recommendations.

Conclusion Summary

CBH disputes the allegation that the oversight and monitoring departments lacked coordination. The CBH Compliance Committee membership consists of participants from several other CBH departments as well as DBHIDS and serves as a direct oversight body to the CBH Compliance Department. A Credentialing Committee was created to provide oversight to the initial credentialing and recredentialing processes and all decisions made therein.

Response to FY17 Audit

CBH disputes the allegation that the oversight and monitoring departments are disjointed and siloed. Of the Compliance Reports submitted to the City auditors for review, 15 were

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referred from other CBH departments: five (5) from the Quality Management Department, six (6) from Clinical Management, two (2) from Data Informatics, and two (2) from Member Services, and one (1) was conducted as a result of a NIAC six-month credentialing status.

The CBH Compliance Committee membership consists of participants from several other CBH departments as well as DBHIDS and serves as a direct oversight body to the CBH Compliance Department. The responsibilities of the Compliance Committee include, but are not limited to, review and approval of all Compliance priorities, Annual Work Plan, policies and procedures, review and approval of all Clinical Audit Team audit recommendations and results, and evaluation of the Compliance Department's effectiveness and performance. In FY17, the outcome of all re-credentialing NIAC reviews were presented to the CBH Board of Directors for a final determination of the re-credentialing status.

If significant concerns are noted at any time by any department, a provider teaming is held. A provider teaming is an interdisciplinary team meeting representing CBH departments and, if applicable, other departments within DBHIDS. Provider teaming members will collectively decide the strategy for how to proceed. This may include, but is not limited to: no further action, additional record review, a site visit, request for additional data, referral for technical assistance, request for a Quality Improvement Plan (QIP) from the provider, request for a CAP from the provider, increased monitoring via NIAC or Compliance, referral to the Bureau of Program Integrity, closure to admissions, financial restitution, and/or recommendation for termination from the CBH Network.

The report cites differences in scores/status/audit outcomes as evidence for the "disjointed" and "siloeed" nature of oversight and monitoring. With even a basic understanding of the functions of each department, it should be clear that some degree of difference in scores and outcomes is expected. The oversight and monitoring teams have an overlapping but distinct focus for each group. This allows NIAC, for example, to dig deeper into adherence to City specific requirements while Compliance can focus intensely on Federal, State, and CBH requirements related to payment. Citing differences in views as problematic seems to demonstrate a lack of understanding of the basic function of each group.

It should also be noted that the definition of the NIAC Unit was not accurately captured. NIAC is responsible for conducting the re-credentialing reviews of facilities. They ensure provider adherence to relevant regulatory requirements and provide monitoring oversight for providers related to the implementation of recovery and resiliency standards set forth within Network Inclusion Criteria (NIC) Standards for Excellence; this is inclusive of staff qualifications, facility standards, written policies, clinical recordkeeping, required business documents, and recovery-oriented practices as part of the recredentialing process. If NIAC finds a Quality of Care Concern while at a site visit, NIAC will refer the concern to the Quality Management Department for review and follow up as appropriate.

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Current State

A Credentialing Committee was created in November 2017 to provide oversight to the initial credentialing and recredentialing processes and all decisions made therein. The Credentialing Committee is chaired by the CBH Chief Medical Officer and is comprised of membership across CBH and DBHIDS. Recommendations for re-credentialing from NIAC are reviewed in the Credentialing Committee and determinations about the re-credentialing status are now made by the Credentialing Committee. All perspectives about a provider are shared at the Credentialing Committee and a decision on the status is based on all information presented. In the presentation of NIAC's findings, both Compliance and Quality provide information that is factored in to recredentialing decisions.

The current reporting process, via Credentialing, Compliance and Quality Improvement Committees allow each of the monitoring arms of DBHIDS/CBH to present relevant information. Decisions are then made based on the totality of information available. Differences, when observed, are discussed, and acted on, as appropriate. For example, a provider may document strong adherence to key portions of City related Network Inclusion Criteria but fail to sign several treatment plans. In this case, the differences observed are valid and are discussed in the relevant Committee.

CIRC PROGRAM PAYMENT STRUCTURE NOT COST EFFECTIVE**Finding**

The Community Integrated Recovery Centers (CIRCs) were reviewed as part of the audit process. It was noted in the report that most providers did not reach the established capacity in the program.

Conclusion Summary

CIRC programs were collaboratively developed in 2006 when the old partial hospitalization programs were transformed from an institutionalized, center-based and illness-focused culture to a peer-driven, person-first, family-involved and community-integrated approach. CBH recognized the challenge of this transformational shift for providers in that the number of members being served in the CIRC program was showing a reduction each year, while expenses remained flat. This issue was resolved by the implementation of a Value Based Payment arrangement for CIRC services in 2018, which is cost effective.

Response to FY17 Audit

CBH would like to provide background and context for how the CIRC programs were developed. In 2006, the old partial hospitalization programs (PHPs) were transformed from an institutionalized, center-based and illness-focused culture to a peer-driven, person-first, family-involved and community-integrated approach. This collaborative transformation built a foundation to allow participants to consider things like employment, educational

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attainment, a broader range of leisure activity, independence, and family connectedness in ways that people with chronic and severe mental health challenges had not experienced.

Several outcomes were achieved as a result of this transformation – examples include increased community tenure; promoting independent living; reduction in psychiatric inpatient hospital admissions; reduction in the use of Crisis Response Centers; and increased family involvement.

In addition to working through the redesign of the program, CBH worked with the CIRC providers to determine the best payment methodology. It was noted in the report that most providers did not come close to the established capacity in the program.

CBH recognized the challenge of this transformational shift for providers in that the number of members being served in the CIRC program was showing a reduction each year, while expenses remained flat. CBH began meeting with providers to negotiate an Alternative Payment Arrangement (APA) that was acceptable to both CBH and the provider community. At present, CBH has a Value Based Payment (VBP) Arrangement for CIRC services approved by OMHSAS.

Current State

This issue was resolved by the implementation of a Value Based Payment arrangement for CIRC services in 2018. A VBP arrangement was agreed upon in 2018, with the implementation of a shadow (trial) period beginning in January 2019. The final VBP arrangement was implemented in August 2019 and included a bundled payment (Case Rate) for all services where a member was serviced four (4) or more times per month. Providers also agreed to quality measures which included a WHOQOL (World Health Organization Quality of Life) Questionnaire, 7-day follow-up of inpatient admissions, and 30-day inpatient readmissions. Since the implementation of the VBP for CIRC services, providers have only been reimbursed when a member is seen at least four (4) times in a month.

CBH REIMBURSED FOR ADMINISTRATIVE COSTS NOT NECESSARY FOR OPERATION OF HEALTHCHOICES PROGRAM

Finding

The report indicated that “the City will not reimburse ineligible administrative or program costs, citing two (2) instances where CBH submitted administrative costs for reimbursement from DBHIDS that did not appear to be related to its responsibility as the MCO administering the HealthChoices Program.” These two instances were the CBH 20th Anniversary celebration and the CBH Health and Wellness Program.

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Conclusion Summary

This finding is inaccurate, as the administrative expenses identified in this section, including the 20th Anniversary and employee wellness costs, are well within the purview of reasonable administrative expenses of a non-profit organization, which has run year after year well below the budgeted administrative capitation provided by OMHSAS.

Response to FY17 Audit

As noted in the opening statement, research has shown that health and wellness programs in the workplace can reduce healthcare costs, reduce health risks, increase employee productivity, increase employee satisfaction, and increase retention. CBH invests in employee wellness programs as a means to improve the overall health of its workforce and reduce the upward trend of health insurance. CBH's benefits broker, NFP, reports that CBH has averaged 2.1% premium increases over the last six (6) years, which is 6.4% lower than IBC's annual trend for Philadelphia accounts, translating to a \$2.04 Million savings over that same six (6) year period.

The administrative expenses identified in this section, including the 20th Anniversary and employee wellness costs, are well within the purview of reasonable administrative expenses of a non-profit organization, which has run year after year well below the budgeted administrative capitation provided by OMHSAS.

Current State

The comparatively lower trending in premium increases noted above drew the attention of IBC, who in late 2019 agreed to partner with CBH and conduct a three (3) year study to crosswalk participation in CBH wellness programming to actual paid claims. CBH will continue to offer the employee Health and Wellness Program for all the reasons listed within this response. It is an upfront investment and a win-win situation for CBH/DBHIDS and the City of Philadelphia as a whole in terms of administrative costs, and employer of choice recognition, as well as for the employees who in turn lead healthier and happier lives.

**PAY-FOR-PERFORMANCE INCENTIVE PROGRAM LACKED
TRANSPARENCY WITH PROVIDERS****Finding**

The report indicated that "providers stated there is confusion and a lack of transparency among network providers caused by the complexity of the incentive formula for the Pay-for-Performance (P4P) program. The P4P incentives appear to conflict with the results of monitoring evaluations performed by the Compliance Unit and Quality Management Unit and are more driven by the electronic information in the claims payment system." The report also recommended that the "scoring matrix to calculate the P4P financial incentive

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be regularly discussed with providers as part of CBH's plan to help providers meet each program's targeted performance standards."

Conclusion Summary

The P4P process is transparent and engages providers on a regular basis. Performance measures used for P4P programs are either selected from nationally validated HEDIS measures used by OMHSAS to evaluate service quality for all BH-MCOs, or are developed by CBH Quality staff in conjunction with Clinical Subject Matter Experts and presented to providers for feedback. All P4P information, including eligibility for a P4P award, the scoring methodology, and the definitions for all performance measures, is detailed in an Operational Definitions Master Document that is made available to providers and the public through a Provider Notice on CBH's website, and is also announced to the public through the CBH News blast.

Response to FY17 Audit

P4P is a quality improvement initiative that offers incentive pay to CBH providers who meet certain standards in performance on key performance indicators. This initiative went into effect in 2007 and has been used in lieu of automatic rate increases as a way to incentivize performance. The process is transparent and engages providers on a regular basis.

Performance measures used for P4P programs are either selected from nationally validated HEDIS measures (ncqa.org/hedis/measures) used by OMHSAS to evaluate service quality for all BH-MCOs, or are developed by CBH Quality staff in conjunction with Clinical Subject Matter Experts and presented to providers for feedback. Provider feedback on performance measures is solicited by CBH each year during spring webinars that are open to all providers and are announced through a Provider Notice. Performance measures developed by CBH are based on CBH contractual requirements and other clinical goals and best practices and align with the DBHIDS *Practice Guidelines*. All HEDIS and CBH-developed performance measures use paid claims data, as this is how CBH and all other Medicaid (both physical health and behavioral health) payers determine what services members have received.

The oversight and monitoring conducted by the CBH Compliance Department and the CBH Quality Management Department are critical functions but do not directly impact a providers P4P score unless a provider is placed on a Corrective Action Plan (CAP) by the Compliance Department or placed on a QIP (Level 2) by the Quality Management Department. In these instances, a provider is deemed ineligible for P4P. However, the scores on the Network Inclusion Criteria (NIC) Tool completed by NIAC are included and contribute 10% towards the provider's total score. In the examples provided in the report, despite the deficiencies and actions cited, providers that received an award were not placed on a CAP or QIP Level 2, and therefore were eligible for a P4P award. In addition, those providers may have not received a high score on the NIC tool but may have scored

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high enough overall to receive sufficient points towards their total P4P score to achieve an award.

Current State

All P4P information, including eligibility for a P4P award, the scoring methodology, and the definitions for all performance measures, is detailed in an Operational Definitions Master Document that is made available to providers and the public through a Provider Notice on CBH's website, and is also announced to the public through the CBH News blast. Prior to 2019, the Operational Definitions Master Document was e-mailed to all providers along with their performance reports. To make the Operational Definitions available to the public and increase the efficiency of the P4P report dissemination process, the Master Document was posted on the CBH website as a Provider Notice beginning in 2019. The 2020 Operational Definitions can be found here: cbhphilly.org/wp-content/uploads/2020/12/2020-12-23_CBH_2020_P4P_Operational_Definitions.pdf. Eligibility for a P4P award is also reviewed with all providers during the spring webinars.

Lastly, CBH created a P4P Advisory Committee in 2017, which is comprised of CBH providers and CBH staff; this committee was created to ensure there is ongoing collaboration, transparency, and input from the provider network on operational definitions, performance measures, thresholds, and overall trends.

CBH will continue ongoing collaboration and communication with the provider network related to P4P. This process has been transparent to date and will continue to be transparent. Additionally, the PA Department of Human Services (PA-DHS) has a Value-Based Purchasing (VBP) initiative to transition providers from volume to value payment models for the delivery of behavioral health services. VBP Payment Strategies and VBP Models are critical for improving quality of care, efficiency of services and reducing costs. In 2021, CBH is expected to have 20% of the medical expenses be expended through VBP payment strategies. At least 50% of the 20% of medical expenses must be from a combination of medium or high financial risk categories – this strategy requires CBH to move more programs into a VBP model and away from P4P.

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CBH RESPONSE TO OBSERVATIONS AND RECOMMENDATIONS FROM MERCADIEN, P.C.

CBH COMPLIANCE OVERSIGHT:

OBSERVATION 1

CBH's Credentialing Oversight for Facility/Organization Providers Needs Strengthening

The audit review team observed that the potential exists for unqualified staff to be delivering services to CBH members at contracted providers due to insufficient oversight of the credentialing processes.

Conclusion Summary

Mercadien's Observations and Recommendations about CBH Credentialing processes lack a fundamental understanding of a payor's responsibilities related to its contracted providers (agencies and practitioners). As a payor, CBH is obligated to conduct credentialing activities for facilities and individuals with whom it intends to enter into a contractual relationship for the provision of behavioral health services for Philadelphia's Medicaid recipients. The report does recognize the distinction between the different credentialing activities utilized for individual practitioners (CAQH) versus facilities (in house via CBH staff and NIAC). However, the Mercadien consultants continue to erroneously attribute to CBH the responsibility for ensuring that provider facility staff have the appropriate education, training, and experience for their positions. Provider agencies are solely responsible for ensuring that their employed and contracted staff meet the requirements for positions held.

Mercadien also appears to incorrectly contend that Facility staff are "providers." Providers are entities and individuals with whom CBH holds a contract.

Response to FY17 Audit

The Pennsylvania Health Choices program standards clearly state: "In maintaining the Provider network, the Primary Contractor or its BH-MCO must establish written credentialing and recredentialing policies and procedures. Primary Contractor or its BH-MCOs must adhere to credentialing requirements under the Pennsylvania Department of Health regulations, 28 Pa. Code §§ 9.761 and 9.762 for all State Plan Services Provider types as well as for Providers of in lieu of and in addition to services in the BH-MCO Provider network. Provider types interested in participating as a Provider within the network must obtain credentialing from the Primary Contractor or its BHMCO (who will ensure the service is within the Provider's scope of practice) and approval from a county who wishes to offer the service. Credentialing policies and procedures must include, but not be limited to, the

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following criteria: a. Applicable license or certification as required by Pennsylvania law, including the Department's license or certification number of the Provider. b. Verification of enrollment in good standing with Medicaid (Providers of in lieu of and in addition to services must be enrolled in the MA program). c. Verification of an active MA Provider Agreements. d. Evidence of malpractice/liability insurance. e. Disclosure of any past or pending lawsuits/litigations. f. Board certification or eligibility, as applicable."

Additionally, the Mercadien consultants placed far too much emphasis on, and drew erroneous conclusions about, the staff rosters collected from agencies. CBH collects provider facility staff rosters on an annual basis to obtain a point in time overview of staffing capacity across the network, especially for certain hard to fill positions such as psychiatry. CBH is the only BHMCO in the Commonwealth that undertakes this activity. The rosters have been helpful, in certain situations, when external entities, such as the US Attorney's Office has an interest in a provider facility. The report references an email from the US Attorney's Office recommending that CBH collect the rosters biannually and solicit additional documentation from the facilities about their staff. We want to highlight that while CBH cooperates with the US Attorney's Office, it should be noted that the PA Department of Human Services (OMHSAS) and CMS, at the federal level, determine the requirements for Medicaid Managed Care Organizations. While the information that the US Attorney recommended that CBH collect might be of assistance to them in their investigations, the recommendation falls outside the boundaries of a payor's obligations regarding facility staff. While we consider the US Attorney's Office, and all law enforcement entities, our partners, the email does not constitute a deficiency in CBH practices. It is merely a desire for additional information.

Current State

CBH's current NCQA as a managed care organization credentialing practices meet, if not exceed, the requirements set forth by NCQA. The distinction in credentialing requirements based on provider type is a requirement in NCQA. CBH's current practice of the full credentialing of independent practitioners, group practice members, and staff working at Federally Qualified Health Centers, while requiring contracted agencies to maintain staff files demonstrating minimum qualifications are met, exceed industry standards as outlined by NCQA. This also allows for targeted looks and analysis of potential staffing related issues.

CBH has received feedback that its practice is particularly helpful to its Commonwealth partners, as they hope to replicate this for other MCOs. While CBH continually reevaluates ways to improve the process to ensure the least burden on CBH providers, while continuing to enrich its FWA efforts with roster information, the current process exceeds minimum standards industry-wide.

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CBH REIMBURSEMENT PROCESS: OBSERVATIONS 2, 3 & 4

The following is a general response related to Observations 2, 3, and 4. More specific responses will follow the Observations below:

CBH contracts with an independent auditor on an annual basis to provide financial statements for HealthChoices and Non-HealthChoices activity. For the past several years, the auditor has been Mitchell Titus. These audits are available for review. Each year, these audits have provided an unqualified opinion regarding the audited income statements, balance sheets, and cash flows for HealthChoices and Non-HealthChoices funds. While observations 2, 3 and 4 raised questions regarding short-term transfers of funds between DBHIDS and CBH, there was never any impact on the accuracy of their classification as HealthChoices or Non-HealthChoices funds for audit purposes and the inconsistency was self-identified and corrected.

CBH continually assesses the need to strengthen or create policies and procedures to ensure that there is consistency and internal controls are in place. The CBH Finance Committee, consisting of CBH Management, CBH Finance, DBHIDS Management and DBHIDS Finance, meets regularly to discuss CBH's financial transactions and condition. The discussions include cash flow analyses and projections, review of the financial statements, analytical reviews of the components of the statements, analysis of solvency accounts, review of accounting policies, fiscal compliance, and other financial oversight, as needed.

OBSERVATION 2

Review Process Failed to Identify Duplicate Reimbursements in a Timely Manner

The report noted that CBH functions as both the MCO for HealthChoices payments and an Administrative Services Organization (ASO) for non-HealthChoices payments under contracts with the City. However, it noted that reimbursement requests for HealthChoices did not properly exclude the payments that were issued for non-HealthChoices purposes. The reimbursement request process was not sufficiently designed to identify and exclude non-HealthChoices expenditures from the reimbursement request. It was also noted that the review processes failed to identify duplicative invoices prior to reimbursement.

Response to FY17 Audit

CBH contracts with the City of Philadelphia (City) through DBHIDS to be the primary MCO subcontractor under the City's contract with the Commonwealth of Pennsylvania for the Behavioral Health HealthChoices program. CBH's contract with the City also allows CBH to function as an ASO, providing administrative support to the City for various initiatives as directed by DBHIDS. However, there was never any impact on the accuracy of the classification as HealthChoices or Non-HealthChoices funds for audit purposes. The only

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impact of a duplicate payment between DBHIDS and CBH results in funds being transferred from one HealthChoices Cash Account to another. All cash transfers were settled between HealthChoices accounts and postings were made to account for the transfers. There was also no impact on claim payments to providers. This has been substantiated through multiple external financial audits with clean opinions and no material variances notes.

Current State

As acknowledged in the report, CBH opened a new checking account in December 2018 to pay for identified expenses incurred for the work performed as an ASO for other city initiatives. Expenses related to MCO vs. ASO therefore have been separated in the CBH accounting system and includes a separate general ledger.

Documented procedures were updated in 2017 to ensure accurate invoicing. Non-HealthChoices expenses are not included in HealthChoices invoices to DBHIDS for reimbursement; however, any potential duplication of HealthChoices expenses on invoices to DBHIDS will not result in a duplicate claims payment. If this were to occur, the condition would result in funds being transferred from one HealthChoices cash account to another.

The established internal controls over payments at CBH ensure that no payment to a provider or employee is duplicated. Both CBH and DBHIDS continually evaluate and updates procedures for cash and other accounting transactions.

OBSERVATION 3

CBH Inaccurately Reimbursed for Voided Transactions

The consulting report noted that CBH's process used to produce weekly city invoices did not consistently identify scenarios for void and replacement transactions, nor did CBH perform a reconciliation of the total cash payments made. It was recommended for CBH to develop more detailed procedures for the weekly city invoicing, inclusive of formal reconciliation between HealthChoices cash payments and the amounts in the weekly reimbursement requests.

RESPONSE TO FY17 AUDIT

Voided and reissued checks for which reimbursement has been made would have no effect on the total HealthChoices cash balance. The reissued check is included in the reimbursement request, as well as the voided check as a refund, which is deducted from the reimbursement.

As part of the month-end reporting close process, all balance sheet accounts are analyzed for accuracy and completeness by either a senior accountant or a staff accountant. The analyses are reviewed and approved by the Director of Accounting Operations. This process is outlined in the Financial Close Reporting Narrative, which is a summary of the end of the month procedures performed prior to issuing the financial statements.

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OBSERVATION 4

CBH Inaccurately Reimbursed for Payroll Related Expenses

The consulting report noted that CBH did not consistently follow its own policies and procedures for payroll and payroll expense reimbursement. The report recommended that CBH develop more detailed procedures for the preparation of the weekly city invoices.

CONCLUSION SUMMARY

CBH did not inaccurately reimburse for payroll related expenses. The result of these inaccurate transfers had no effect of the HealthChoices cash balance as a whole and did not cause inaccurate information to be reported in financial statements. Further, the amounts in question were returned to the City via credits reflected on the reimbursement request for March 1, 2018.

RESPONSE TO FY17 AUDIT

The procedures in place in FY17 did not yield errors in the amount of payroll expenses or inaccurate payments to vendors or employees; however, certain selection of incorrect amounts for reimbursement caused amounts to be transferred from the HealthChoices General cash account to the HealthChoices Operating account. The result of these inaccurate transfers had no effect of the HealthChoices cash balance as a whole and did not cause inaccurate information to be reported in financial statements. Further, the amounts in question were returned to the General cash account via credits reflected on the reimbursement request for March 1, 2018.

CURRENT STATE

CBH's procedures for the preparation of requests for reimbursement of payroll expenses have improved as part of the weekly invoice process. The weekly invoice process has been updated with detailed instructions to provide the necessary guidance on how to generate weekly invoice. It now outlines the proper source for payroll cash outlay, name of report from ADP and includes report images. The document is included in the onboarding process.

CBH PROCUREMENT PROCESS: OBSERVATIONS 5, 6, 7, 8, 9

OBSERVATION 5

CBH Did Not Follow Philadelphia Code for Awarding Sole Source Contracts

The consulting report noted that CBH improperly awarded professional services contracts on a sole source basis under Philadelphia Code, subsection 17-1406(2). It was also noted that CBH lacks a comprehensive formal procurement process for professional services that complies with the sections of the Philadelphia Code to which it is subject.

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OBSERVATION 6

CBH Did Not Follow Philadelphia Code for Contract Renewals

The consulting report noted that CBH entered into three separate administrative contracts without conducting a new procurement process. Instead, CBH utilized old RFPs to procure services. As a result, CBH violated the Philadelphia Code requirements for contract renewals.

OBSERVATION 7

CBH Did Not Comply with Its Own Procurement Protocol

The consulting report noted that CBH did not comply with its own Procurement Protocol by not providing supporting documentation to verify that required steps were taken.

OBSERVATION 8

DBHIDS Did Not Provide Adequate Oversight of CBH Procurement

The consulting report noted that DBHIDS did not provide adequate oversight of the CBH procurement process. It was recommended for the contract between DBHIDS and CBH to be reviewed and revised to include clearly defined duties, roles, and responsibilities of all parties.

OBSERVATION 9

Contractors Performed Services/Were Paid Prior to Signed Contract with CBH

The consulting report noted that CBH entered into three (3) professional services contracts with outside contractors in which the contractor provided services, billed for services, or was paid for services prior to the contract being signed by both parties and/or the contract's effective date.

RESPONSE TO FY17 AUDIT

CBH acknowledges that the use of the sole source exception in the two instances cited in Mercadien's report, Clinical Consultation services and IT Infrastructure services, did not fully meet the sole source definition in the Philadelphia Code:

- The individual who was awarded the clinical consultation contract was selected based on both her previous work with CBH and also her implementation of an identical children's services model for Community Care, the BHMCO for Allegheny County. She has been a child psychiatrist for over 30 years.

The second contract referenced was entered into to maintain the functionality of CBH's IT infrastructure. CBH contracted with the individual who was responsible for creating CBH's behavioral health database for all clinical information used and maintained by CBH for its HealthChoices operations. Given her behavioral health background and her familiarity with the software, CBH engaged her to help implement the software that replaced the legacy

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system developed in 1996 exclusively for CBH. She filled the role of CIO as CBH actively worked to recruit and fill the role with a new hire.

CURRENT STATE

CBH's contracting process and its Vendor Contracting policy have undergone significant modification since 2018 in an effort to close previous gaps and vulnerabilities. CBH's Finance and Operations staff have implemented controls to prevent payments to vendors where a signed contract is not present. To ensure prevention of fraud, waste, and abuse, individual contract managers (responsible for overseeing the work of CBH vendors) are responsible for confirming all services rendered prior to vendor invoices entering the CBH accounting process. In addition, CBH's Administrative Expenditures Policy underwent significant modifications in 2018 and 2019, and more effectively controls and monitors the contracting process.

A reference to Chapter 17-1400 of the Philadelphia Code is embedded in CBH's Vendor Contracting Policy created in 2019. A reference to this Chapter is also included in the CBH Supplier Diversity Policy, also created in 2019. These policies are reviewed annually and updated as needed by the CBH Policy Workgroup. The CBH Policy Workgroup is comprised of members from all CBH departments and is charged with maintaining the body of policies that support CBH operations in a manner that is consistent with federal, state, and local laws.

The audit findings identified a gap in the CBH contracting process related to the contract renewal process. This vulnerability was addressed in the CBH Vendor Contracting Policy and in the CBH Procurement Protocols for administrative and clinical procurement. The CBH template vendor and Provider Agreements now clearly identify terms and any contract renewals available to subcontractors. CBH updated the Clinical Procurement Protocol and finalized an Administrative Procurement Protocol in August 2020. Both protocols are posted on the CBH website.

CBH strives to ensure consistent and transparent processes and agrees that internal controls are critical to ensuring integrity and promoting accountability. As such, on an annual basis, the Risk Management Department at CBH conducts audits of recently issued procurements in order to ensure CBH is following its protocols.

CBH also has made strides in more effectively managing the contracting process. In 2019, CBH shifted from a paper process into an electronic contract management database. This shift to electronically executed and maintained contracts has allowed CBH to implement greater controls over the contract process, ensure that alerts are in place where contracts are set to expire and where the dollar amounts of potential agreements trigger a competitive bid process, and ensure that Business Associate Agreements are in place where protected health information is used, disclosed, or created. This database also

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enables CBH to have more reporting capability to continually self-audit the contracting and budgeting process through the CBH Risk Management Department.

PROVIDER LOANS AND ADVANCES: OBSERVATIONS 10, 11

OBSERVATION 10

CBH Did Not Comply with Its Own Policies and Procedures for Provider Advances/Loans

The consulting report noted that there were instances of “non-compliance with CBH policy and procedure” for temporarily advancing funds to providers if the provider is unable to submit claims for services rendered due to a contracting or billing system issue.

OBSERVATION 11

CBH Did Not Comply with Its Own Policies and Procedures for Provider Rate Increases

The consulting report noted that there were instances of “non-compliance with CBH policy and procure” for rate increase requests.

Response to FY17 Audit

CBH recognizes the need to maintain a critical balance between controlling costs, maintaining cash flow, and keeping the provider network viable. CBH is in the process of reviewing the Advances Policy and Procedure. In the interim, the existing policy will be adhered to, which states the following:

CBH will temporarily advance funds to providers due to the provider’s inability to submit claims for services rendered, as the result of a contracting or billing system issue. If the provider is requesting funds unrelated to a claims issue and a repayment plan is included, interest will be charged based on the balances due over the outstanding period.

When the provider requests an advance from CBH, the provider is required to pay back the dollars through new claims submission as quickly as possible. When the provider is not able to pay back immediately, the proceeds would be paid back with interest as agreed upon on the request form. The interest rate is prime plus 2% at the request received date.

The procedure for providers to follow is also embedded in this policy.

Current State

CBH is in the process of reviewing the Advances Policy and Procedure to determine what changes, if any, need to be made.

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CBH issued a Request for Rate Increase Policy on 10/3/2019, which is also posted on the CBH website. This policy describes CBH's commitment to assuring quality and value in the services provided by CBH providers. This document describes the process for which providers can submit requests for rate adjustments and is consistent with the policies of OMHSAS in relation to the Pennsylvania Behavioral HealthChoices Program. Additionally, in accordance with the CBH Provider Agreement, providers are notified 30 days in advance of any rate changes. CBH's goal is to regularly provide both Standard and Non-Standard Rate increases. CBH will annually review current rates and will consider rate increases based on several factors outlined in the policy. Providers will have the opportunity to request rate increases for Non-Standard Rates if they have not had an increase within the past three years or can demonstrate extenuating circumstance. Additional details can be found in this policy.

CBH is committed to paying competitive provider reimbursement rates and its goal is to ensure that CBH providers are able to pay their staff a quality wage that appropriately matches their job duties and supports the current cost of living. CBH is committed to streamlining the across-the-board rate increase process as well as individual rate requests to ensure that CBH providers are financially stable and fully supported.

CLOSING STATEMENT

In closing, DBHIDS/CBH would like to thank you for allowing a review of the findings and recommendations prior to finalization of the report and to comment on them. If you have any questions about these responses, please don't hesitate to contact DBHIDS/CBH.



Rebecca Rhynhart
City Controller

OFFICE OF THE CITY CONTROLLER

AUDITORS' COMMENTS ON DBHIDS' RESPONSE

Government Auditing Standards require auditors to report instances where the auditee's comments to the auditors' report are not, in the auditors' opinion, valid or do not address the findings, observations, or recommendations contained in the report. We believe this to be the case with the following statements made in DBHIDS' response.

Response to Office of the City Controller Auditors' Report

In its response on page 3-5, DBHIDS makes several assertions that refer to the length of the audit, the challenges encountered during our fieldwork, and the ability of the Controller's Office to conduct the audit. Specifically, DBHIDS stated that:

"The audit process, from the entrance interview to draft report, spanned three (3) years, beginning on February 1, 2018. This timeframe is inordinately long and inconsistent with industry standards related to timeliness."

"There were several challenges the auditors experienced along the way, including turnover of staff, lack of understanding of the processes and the content area they were auditing, as well as privacy issues."

"In 2020, the City Controller brought in an outside consulting team, Mercadien, certified public accountants, who essentially restarted the audit process.... As an entity operating in New Jersey, the Mercadien team had no experience in Pennsylvania Medicaid or in the provision of behavioral health services."

"The use of auditing personnel, lacking in the necessary background to conduct a meaningful and robust review, consumed valuable time and resources, and more importantly resulted in a report that contains inaccuracies and offers generalizations based on a limited understanding of the Behavioral HealthChoices Program."

We disagree with DBHIDS' comments. The scope and depth of our audit included specific procedures designed to address our unique audit objectives. As such, there are no "industry standards" or established timeframes to use for comparison. Furthermore, the auditee does not dictate the length or focus of the audit. We follow *Government Auditing Standards*, which require us to obtain evidence based specifically on our objectives and perform procedures necessary in the circumstances.

We disagree with the challenges DBHIDS stated that we experienced during our audit. Our professional standards require that we invest the time necessary to gain an understanding of the auditee's policies and procedures. This can be a time-consuming process for any size audit. However, in the case of the HealthChoices Program, extended inquiries and observations were an essential part of understanding an operating environment that in the 20 years since its inception, had not been subject to a performance review by the Controller's Office. We also needed to consider the complex relationship between DBHIDS and CBH, an annual budget that now regularly exceeds \$1 billion, added federal and state regulatory requirements, and the contracting with and oversight of numerous behavioral health service providers offering many levels of care, across hundreds of locations. In 2019, we engaged the services of Mercadien, P.C. (MPC), a highly respected accounting and consulting firm, as subject matter experts to assist us in evaluating the accuracy and significance of our initial findings, while also looking into related matters of concern identified during our review.

MPC did not restart the audit. The major focus areas pursued by MPC had not been previously addressed by the Controller's Office. Furthermore, while MPC has extensive experience operating in New Jersey, both states develop regulations and policies to implement Federal Medicaid guidelines. The delivery method for behavioral health in Pennsylvania is through County based Managed Care Organizations, while in New Jersey, the delivery is a combination of Fee for Service and state Managed Care. MPC has been in partnership with the State of New Jersey for almost a decade in the delivery of compliance oversight services to help ensure that Medicaid guidelines are followed. This experience is especially relevant to this audit and makes MPC particularly qualified to serve as subject matter experts assisting in the audit.

We also disagree with the assertion that our staff lacked the necessary background to conduct the audit. Our audit was staffed with degreed auditors, including certified public accountants, having numerous years of experience auditing intricate operations within City departments and related agencies, the City and School District financial statements, and federal and state grant programs, all of which makes us particularly qualified to perform this audit.

The consumption "*of valuable time and resources*" is another unreasonable statement given the size and complexity of operations, and delays that were frequently caused by DBHIDS and CBH themselves. We often had to wait weeks when trying to set up meetings with program officials or for documentation to be provided to us. Additionally, DBHIDS and CBH made the decision to include all their upper-level management staff in many of the focus area meetings, as opposed to delegating that responsibility to supervisory level staff, who were responsible for these functions on a day-to-day basis. Furthermore, as noted in the Audit Scope section of our report, certain information was withheld from us during the audit, which required further follow-up. For example, in lieu of the Quality Management monitoring reports requested for the 27 providers in our sample, we received pages that only briefly summarized when quality improvement plans (QIPs) were in place or when certain programs were closed to admissions. The information we received offered few reasons for why Quality Management services were needed, no details on how the monitoring review was conducted, and no indication

as to how or why the matter was eventually resolved. In many cases, the response we received from the Quality Management Unit was simply “No closures, QIPs, or DCAPs.”¹

Finally, we believe DBHIDS’ argument about our auditors’ lack of early training in PHI and HIPAA is unwarranted. Ultimately, DBHIDS and CBH are responsible for protecting client privacy and for determining who is given the necessary clearances to review patient records. As such, at our initial Entrance Conference in February 2018, our auditors specifically asked about HIPAA and our ability to request information from patient files to support the payment of medical claims. CBH management stated that this would not present a problem. To further demonstrate our commitment to protecting the privacy of confidential data, we invited CBH staff to accompany us in our fieldwork, which they did at some of our early site visits. We also offered the providers the ability to redact PHI information since, as stated in our report, our audit objectives were focused on identifying that the proper documents, required by federal, state, and CBH policies were readily available to support the providers’ claims for reimbursement. Some providers freely assisted us in this endeavor, others did not. We did not request or receive copies of the information shown to us. When CBH eventually informed us that our auditors needed to receive PHI and HIPAA training, we willingly and quickly complied.

Other Significant Changes Since the Audit Review Period

Page 3-6 of DBHIDS’ response states that in the fall of 2019, CBH “achieved full accreditation status for the National Committee for Quality Assurance (NCQA) for a Medicaid Managed Behavioral Healthcare Organization (MBHO).” We commend CBH for pursuing and earning this accreditation, as it provides evidence-based best practices for the organization to follow. However, it does not appear to address Medicaid documentation requirements. Furthermore, while DBHIDS offered this accreditation as proof of CBH’s oversight competencies, it did not indicate how this accreditation mitigates our specific findings.

RESPONSE TO OFFICE OF THE CITY CONTROLLER AUDITORS’ REPORT FINDINGS - Summary

The findings and conclusion summaries on pages 3-7 to 3-14 are repeated almost verbatim in the section of the response starting on page 3-18. Therefore, we will move forward to page 3-15 and address DBHIDS’ comments to our findings and observations, as they appear, in the applicable sections below.

OVERARCHING CATEGORIES AND THEMES COVERED IN THE AUDIT

Provider Documentation

In its response on page 3-15, DBHIDS stated that *“a fundamental flaw in the audit, and a presumption that permeates the report, is the erroneous assertion that missing documentation equates to fraud.”* In our report, we specifically state that the inability to provide required clinical documentation calls into question

¹ **D**irected **C**orrective **A**ction **P**lan

the validity of the claims tested, as well as the validity of the services provided, and the quality of care administered. We also note that failure to comply with CBH policies may result in providers being inappropriately reimbursed for these transactions. We did not state, or imply, that fraud was detected.

CBH Administrative Expenses

On page 3-16 DBHIDS also asserts that “*CBH receives wellness credits from its insurance provider which help pay for health and fitness incentives and these credits cover a portion of the wellness program costs.*” However, neither DBHIDS nor CBH provided us with documentation supporting this assertion, as requested, so we have no way of determining what portion of these incentives were covered by the credits.

RESPONSE TO FINDINGS AND RECOMMENDATIONS

Creation of DBHIDS/CBH

It should be noted that this section of the report is simply background and not an audit finding.

In its response on page 3-18, DBHIDS disagrees with the dates we used to explain the history of DBHIDS as a department. They also question the use of the phrase “engages with” to describe the contractual relationship between CBH and the providers. As these issues relate to earlier discussions that do not appear in the final report, it is unclear as to why DBHIDS included these statements in its response.

Required Clinical Documentation Missing from Patient Files

In its response on page 3-19, DBHIDS misunderstood how we selected our audit sample. Specifically, it stated that:

“Selecting providers and or records “haphazardly” raises questions and concerns about the auditors’ methodology, or lack thereof, and overall approach to the review. It is unclear if the sample was random and representative, and therefore unclear how conclusions can be determined or generalized.”

As stated in our finding on page 1-5, and further clarified in our audit methodology on page 1-22 we randomly selected a sample of providers and weekly invoices for testing. We indiscriminately selected the detailed transactions that were part of the invoice total. We even allowed the providers to make the selection themselves, from the thousands of transactions included in the support for the invoices (i.e., the “835 Reports”). Selecting samples haphazardly is a legitimate sampling method according to the American Institute of Certified Public Accountants. Furthermore, as our audit objective simply addressed compliance with CBH policies, and not the recouping of funding, the extrapolation of a statistically valid sample was not necessary for our testing purposes. It was not an inaccuracy or generalization to raise the concern that the number of findings across the small sample could be more widespread, especially when CBH’s own provider profiles identified similar concerns.

We also reviewed DBHIDS' statements regarding required clinical documentation. While we agree that the Release of Information (ROI) and Intake Forms do not directly support the services provided, the validity of the claims must also consider the underlying documentation that authorizes providers to share their medical records with CBH (for billing purposes) and places clients into the appropriate level of care. Our understanding was reinforced through discussions with the providers we visited. Our finding addresses the distinction between forms with a direct impact on billing and those that contribute to the overall legitimacy of the claim.

Concerning the differences between the Comprehensive Biopsychosocial Evaluation/Reevaluation (CBE/R) and the Pennsylvania Client Placement Criteria (PCPC), as mentioned on pages 3-15 and 3-19, auditors did not assume that all clinical charts must contain an annual CBE/R. Auditors asked to see the most recent version of the CBE/Rs for mental health claims or a PCPC when the charge related to addiction treatment. The exceptions we noted were based on the providers inability to provide us with any relevant evaluation.

Finally, DBHIDS stated that **Table I** had no utility since *"there was no context provided including the denominator..."* We disagree with that statement. In the narrative preceding **Table I**, we presented context by noting that 284 transactions were tested and the percentage on non-compliance associated with each form. **Table I** further contributed to the message by showing the types of missing documentation and the distribution between providers.

Provider Profiles Identified Documentation Issues Similar to Audit Results

In its response on page 3-21, DBHIDS disagrees with our use of CBH provider profiles on the grounds that these documents show a *"point in time synopsis of an agency"* that are for *"internal use only and are not intended to supplant documentation necessary to fill regulatory requirements."*

As previously discussed with DBHIDS, we used the profiles as a tool for comparison. They contained accurate and reliable summaries of CBH's own monitoring reviews and therefore, could be reasonably used to corroborate our clinical documentation findings. We do not question CBH's use of the profiles for internal purposes, nor did we state that the profiles are intended to replace regulatory monitoring reports.

On page 3-21, DBHIDS also states that our report does not reflect the fact that the Compliance Unit recoups funds from providers when documentation fails to adhere to established standards. It notes that *"this point cannot be emphasized enough as it directly contradicts the auditors' depiction of fraud...."* We disagree with both assertions. Our report does not state, or imply, that fraud was detected. Also, on page 1-11 and 1-13, we acknowledge that CBH recoups reimbursements for unsupported claims.

Finally, on page 3-20 and 3-22, DBHIDS stated that we did not consider CBH's Compliance Error Codes that would have allowed us to distinguish between a finding that was *"non-billable vs. insufficient, which is significantly different."* We acknowledge that while there are some error types that are more serious than others, for the purposes of our testing, the fact that non-compliance was noted, and often repeated, without noticeable correction, was the most significant concern.

Compliance Unit Oversight Insufficient to Address Documentation Concerns

In its Conclusion Summary on page 3-23 and 3-24, DBHIDS stated that our finding regarding Compliance Unit oversight is unfounded “*as the report does not cite, nor is CBH aware of any clear standards from Federal or State oversight entities for staffing ratios. The report fails to appropriately address the need for staff to have relevant training and expertise to identify and address potential Fraud, Waste, & Abuse. Key components of CBH compliance efforts are also not addressed in the report. Auditing is only one part of any effective compliance plan. Self-auditing is viewed as a key component in any effective compliance plan and many self-audits are more detailed and thorough than audits conducted by outside entities.*” Page 3-24 further asserts that our statements about the staffing size of the Compliance Unit “*are not supported by evidence of any industry requirement/standard or comparison to peer organizations,*” while the response on page 3-25 states that “*a selected sample of work utilizing unclear methodology is being used to draw any conclusions regarding the depth of audits by CBH Compliance staff.*”

DBHIDS’ response does not address the premise of the comment – that the depth and frequency of Compliance Unit site visits are inadequate to ensure recordkeeping requirements are identified and corrected in a timely manner. Furthermore, it presents inaccurate and misleading statements concerning the methodology involved in reaching our conclusions.

Our review of Compliance Unit monitoring visits did not involve sampling, nor did we question the sampling methodology used by the Compliance staff during their audits. Our analysis of the frequency and sampling size of the Compliance audits was based on reviewing the audit history recorded in the profiles and population of audit reports given to us for the 27 providers we selected. We noted that there were multi-year gaps between site visits and program reviews. Also, as confirmed during our interviews, targeted audits only involve a limited review of patient records, while probe audits only focus on select programs. Neither audit type addresses the entire population of claims at a specific site or within a specific provider. Yet, several of the audits reported significant error rates relating to missing or insufficient documentation, with no indication that the Compliance Unit expanded its testing to identify additional instances of non-compliance within that program or a wider extension of the problem(s) across other programs or a provider’s other locations.

While we did not address comparable standards for staffing, our conclusion considered the time between site visits and program reviews, and the simple, yet reasonable, calculation of the Unit’s 17 members compared to a population of 176 in-network providers offering 19 levels of care across 700 locations. We were informed that the Compliance Unit staff usually performs their site visits in teams of two or three people and a visit could take several days to complete, depending on the number of programs and the size of the programs. A conservative count of five teams would require each team to cover approximately 140 locations per year. This calculation does not include the time needed for Compliance Unit staff to analyze their findings, prepare their reports, follow-up on corrective action plans, focus on other matters referred to them by the other monitoring units or, as stated in DBHIDS’ response, address “*other components of CBH compliance efforts,*” such as educating providers and developing strategies to prevent improper payments. Therefore, the current staff size does not seem adequate to audit every provider location annually.

Finally, we do not question the qualifications, training requirements, or competency of the Compliance Unit staff. We commend CBH for employing dedicated individuals with professional qualifications needed to recognize and report on matters that may have an impact on medical quality of care issues. Our finding focuses on the types of audits they use and the ability of a relatively small staff to cover all programs and locations in a timely manner. As noted in the report, while both probe audits and self-audits may be approved by federal and state oversight agencies, they do not appear sufficient to protect the validity and accuracy of HealthChoices expenses. Probe audits focus on a specific level of care, at the expense of other, possibly higher-risk programs. Self-audits may be useful for identifying problematic areas, but their effectiveness can be compromised as the “audits” are performed by the provider’s own staff.

CBH Monitoring/Oversight Lacked Coordinated Effort

In its response starting on page 3-26, DBHIDS believes that the efforts of CBH’s three primary monitoring units are not siloed or disjointed. As evidence that the units work together, DBHIDS reported that Compliance Unit reviews were based on referrals from other CBH units. DBHIDS also refers to the “provider teamings” that are held whenever significant concerns are noted by any CBH unit.

We do not dispute these assertions. However, while high level meetings and provider teamings are held to discuss significant matters, there is no evidence that repeated deficiencies at the provider sites are being adequately addressed. There still appears to be a disconnection between the units, with Compliance continually citing providers for high error rates (which could also indicate quality of care concerns) and NIAC scoring the same providers as “excellent” or “sufficient.”

CBH Reimbursed for Administrative Costs Not Necessary for Operation of HealthChoices Program

On page 3-30 of its response, DBHIDS disagreed with our position that the use of HealthChoices funding for entertainment expenses and employee benefit programs was inappropriate. Specifically, DBHIDS emphasized that:

“... the administrative expenses identified in this section, including the 20th Anniversary and employee wellness costs, are well within the purview of reasonable administrative expenses of a non-profit organization, which has run year after year well below the budgeted administrative capitation provided by OMHSAS.”

DBHIDS also stated that:

“CBH invests in employee wellness programs as a means to improve the overall health of its workforce and reduce the upward trend of health insurance.”

While we accept the premise that employee wellness programs and workplace satisfaction are important matters, CBH fails to acknowledge that the funding for these non-essential incentives come from the taxpayer-

supported Medicaid program. The anniversary celebration, Zumba classes, fitness trackers, and other perks are far more generous than benefits offered to city employees and, more importantly, come at the expense of city residents needing essential mental health services. DBHIDS' claim that its annual administrative expenses are well below its budgeted administrative capitation bears no weight if the expenses are inappropriate.

Furthermore, while DBHIDS contends that its annual health insurance premiums increased at a slower rate than the current trend for Philadelphia, it did not provide us with evidence, as requested, showing the correlation between its benefit incentives and the lower premiums.

Pay-for-Performance Incentive Program Lacked Transparency with Providers

Finally, in its response on page 3-31, DBHIDS stated that the process for providing P4P performance bonuses is transparent and engages providers on a regular basis. It also stated that the criteria for calculating the bonus *"is based on nationally validated measures used by OMHSAS to evaluate service quality or are developed by CBH Quality staff in conjunction with clinical subject matters experts,"* and that *"All P4P information is made available to the providers through provider notices and other channels."* Additionally, DBHIDS asserted that:

"The oversight and monitoring conducted by the CBH Compliance Department and the CBH Quality Management Department are critical functions but do not directly impact a providers P4P score."

We acknowledge that P4P information is sent out to providers through CBH's website, but there still appeared to be confusion among the providers. At several of the sites we visited, providers were unaware that the bonuses were awarded, did not understand the criteria for selection or the how the bonuses were calculated, or questioned why one provider received it over another.

Furthermore, while a component of the NIAC Unit's review is included in the final determination of the P4P award, the results of Compliance audits and Quality Management reviews are not, unless provider infractions are serious enough to warrant an active correction or quality improvement plan. We believe that providers high error rates resulting from Compliance audits and any matter that involves a Quality Management investigation should be factored into CBH's adaptation of the P4P scoring.

CBH RESPONSE TO OBSERVATIONS AND RECOMMENDATIONS FROM MERCADIEN, P.C.

CBH Credentialing Oversight

In its response to "Observation 1 – Credentialing" on page 3-11, DBHIDS stated that MPC's observation *"is inaccurate because the review team incorrectly attributed it to a CBH Compliance function."* The observation does not state anywhere that this is attributed to a CBH Compliance function.

Moreover, on page 3-33 of the response, DBHIDS states that our Observations and Recommendations lack a fundamental understanding of CBH's responsibilities as a payor. However, in the same paragraph, DBHIDS

acknowledges that *“the report does recognize the distinction between the different credentialing activities utilized for individual practitioners (CAQH) versus facilities (in house via CBH staff and NIAC),”* demonstrating our understanding of this process. DBHIDS’ response also states that the report erroneously attributes the responsibility for ensuring that provider facility staff have the appropriate credentials to CBH. This is incorrect, as the report clearly states that facility type agencies are solely responsible for ensuring that the staff they employ meet credentialing requirements.

While we acknowledge that CBH has established a NCQA that meets the HealthChoices program standards, we feel that the overall oversight function could be strengthened to ensure credentialing requirements are being met and qualified individuals are delivering services to patients.

CBH Reimbursement Process: Observations 2, 3, & 4

On pages 3-11–3-12 and pages 3-33–3-37, DBHIDS’ responses to the observations regarding the process by which CBH is reimbursed by DBHIDS consistently failed to acknowledge the lapses in internal controls that allowed these over-reimbursements to occur. In its response, DBHIDS cited policies and procedures in place at DBHIDS and CBH regarding the reimbursement process. However, as detailed in the report, these policies were not consistently followed. The responses did not specifically address the observations we identified but seemed to reference issues not included in the report. While the HealthChoices reports submitted to the Commonwealth of Pennsylvania as a whole were not affected, certain financial accounts on CBH’s books were affected as a result of the inaccurate reimbursements.

In DBHIDS’ general response on page 3-35 it is stated that while MPC *“raised concerns regarding short term transfers of funds between DBHIDS and CBH, there was never any impact on the accuracy of their classification as HealthChoices or Non-HealthChoices funds for audit purposes and the inconsistency was self-identified and corrected.”* We disagree with this comment. The observations made never stated that there was an issue of classification between HealthChoices and Non-HealthChoices, but that CBH was inappropriately reimbursed for Non-HealthChoices expenditures by DBHIDS. The issues identified are a result of CBH and DBHIDS’ failure to adhere to their own policies and procedures regarding reimbursements. Moreover, these issues were not identified in a timely manner. Since the reimbursement issues took up to four years to correct and some remained outstanding as of March 2020, we would not refer to them as short-term transfers. The inappropriate reimbursement resulted in the audited financial statements for CBH being misstated for various accounts.

Additionally, in DBHIDS’ response to specific observations on pages 3-36 and 3-37, the following statements are made:

Observation 3 - *“Voided and reissued checks for which reimbursement has been made would have no effect on the total HealthChoices cash balance. The reissued check is included in the reimbursement request, as well as the voided check as a refund, which is deducted from the reimbursement.”*

Observation 4 – “*CBH did not inaccurately reimburse for payroll related expenses*”.

DBHIDS' response to Observation 3 is incorrect. CBH has failed to recognize that they did not deduct the voided check from the reimbursement request. Furthermore, of the \$1,435,139 total, \$1,065,355 still had not been returned to the City. There was also no corrective action.

Regarding Observation 4, we disagree with DBHIDS' response. The observation was that CBH did not consistently follow its own policies and procedures for payroll and payroll expense reimbursement. DBHIDS' Conclusion Summary stated that CBH did not inaccurately reimburse for payroll related expenses but returned the amounts in question to the City. DBHIDS' Response to FY17 Audit section does not address the observation as stated in the report. The Current State section of DBHIDS' response acknowledges that the policies and procedures in place at CBH during FY17 were not sufficient to ensure that accurate payroll and payroll related expenses were appropriately requested for reimbursement purposes. The Current State also does not specifically address the lack of controls in place at DBHIDS nor any improvements initiated in conjunction with the CBH updated policies and procedures.

CBH Procurement Process: Observations 5, 6, 7, 8, & 9

DBHIDS did not dispute the five observations related to the procurement process. DBHIDS stated that CBH has made modifications to their contracting policies and procedures to address the deficiencies noted in the report. However, we did not review the modified policies and procedures.

CBH Provider Loans and Advances: Observations 10 & 11

DBHIDS did not dispute the observations related to provider loans and advances. DBHIDS stated that CBH issued a Request for Rate Increase Policy on 10/3/2019. However, we did not review the updated policies and procedures.