AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

16. Inpatient Psychiatric ~~Facility~~ Services for individuals under Age 21

(A) Eligible Providers (42 CFR 441.151; 42 CFR 440.160)

Inpatient psychiatric ~~facility~~ services for individuals under age 21 (or age 22 if the individual was receiving services prior to reaching age 22) are provided under the direction of a physician pursuant to an individual's plan of care and are limited to those who are receiving such services in an institution which is:

- ~~A psychiatric hospital that meets requirements for participation in Medicare as a psychiatric hospital,~~ Certified as a Medicare and/or Medicaid hospital provider or that is accredited by The Joint Commission (TJC)~~, American Osteopathic Association (AOA), or Commission on Accreditation of Rehabilitation Facilities (CARF)~~; or
- ~~A hospital with an in-patient psychiatric program that meets participation in Medicare; or~~
- A psychiatric facility that is not a hospital (defined as a Psychiatric Residential Treatment Facility (PRTF) in 42 CFR 483.352) that is accredited by TJC, ~~AOA~~ Council on Accreditation (COA), or Commission on Accreditation of Rehabilitation Facilities (CARF).

(B) Prior Authorization

Inpatient psychiatric services for individuals under age 21 will be prior authorized for an approved length of stay by the Medicaid Agency or its designated agent. Extensions beyond the approved length of stay may be granted when medically necessary and approved by the Medicaid agency or its agent. Medical documentation must be submitted by the facility and/or physician for consideration.

The State assures that it meets all requirements in 42 CFR 440.160, 42 CFR 441, Part D, 42 CFR 441.151(b), and 42 CFR 483.350.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient Psychiatric ~~Facility~~ Services for individuals under age 21 Provided in a Medicare Certified Hospital (42 CFR 440.160)

16.a. Acute Level ~~of Care~~ 1

(A) Payment to Providers
Private and Government hospitals will be paid in accordance with the methodologies described in Attachment 4.19-A of this plan.

(B) Active treatment
Active treatment in Acute Level 1 is the most intense and requires 17 hours of physician directed active treatment provided per week pursuant to an individual care plan by an interdisciplinary team.

16.b. ~~Residential Level of Care~~ Acute Level 2

(A) General
Except as otherwise noted in the plan, all Medicaid services furnished to individuals receiving residential services in Institutions for Mental Disease (IMDs) are considered all-inclusive of the service, i.e., all medical services provided to residents of IMDs with ~~more than 16 beds~~ 17 beds or more should be billed to the IMD.

(B) Payment to Government Providers
Effective July 1, 2015, services provided by State-Owned psychiatric hospitals will be paid an interim rate based on the previous year's cost report (HCFA 2552) data and settled to total allowable costs based on the current year's cost report. Total allowable cost will be determined in accordance with Medicare principles of reimbursement.

(C) Payment to State–licensed, Private Psychiatric Hospitals (IMDs) and General Hospitals with Psychiatric Units

i. Base Rate
A prospective per diem payment is made for covered services based on facility peer group. State licensure requires RN staffing 24 hours per day for hospitals at a ratio of one RN for up to 15 patients. An additional RN must be added for more than 15 patients; however, an LPN may be substituted for 16-20 patients. A second RN is needed for 21 patients and above.

The rates listed below are effective as of 05-01-2016 and are equivalent to a 15 percent rate reduction from the rates in effect on 04-30-2016 for private psychiatric hospitals (IMDs) and general hospitals with psychiatric units.

Peer Group	Psychiatric Hospital	Hospital Psychiatric Unit
Standard	$293.29	$293.29
Specialty 1 – Sexual Offender	$293.29	$293.29
Specialty 2 – Eating Disorder, TBI	$367.42	$367.42

ii. The base rate also includes the following when included in the plan of care:
- Dental (excluding orthodontia);
- Vision;
- Prescription Drugs;
- Practitioner Services; and
- Other medically necessary services not otherwise specified.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient Psychiatric ~~Facility~~ Services for individuals under age 21 Provided in a Medicare Certified Hospital (42 CFR 440.160) ~~(cont'd)~~ *(continued)*

16.b. ~~Residential Level of Care *(cont'd)*~~ Acute Level 2 *(continued)*

(C) Payment to State–licensed, Private Psychiatric Hospitals (IMDs) and General Hospitals with Psychiatric Units ~~(cont'd)~~ *(continued)*

iii. Active Treatment

Active treatment in Acute Level 2 requires 14 hours of physician directed active treatment provided per week pursuant to an individual care plan by an interdisciplinary team.

iv. Add-on Payments

Comment [OHCA1]: Language from iii.

(a) Intensive Treatment Services (ITS) Add-on Per Diem

An ITS per diem of **$110.99** will be allowed for children requiring intensive staffing supports in private, specialized programs. These services must be medically necessary, documented in the facilities' records, and prior authorized.

(b) Prospective Complexity Add-on Per diem for Non-verbal Children

A per diem of **$77.51** will be allowed to recognize the increased cost of serving children with a mental health diagnosis complicated with non-verbal communication. These services must be medically necessary, documented in the facilities' record, and prior authorized.

(c) Outlier Intensity Adjustment

(A) An outlier payment adjustment may be made on a case by case basis for complex cases. The intent of the outlier payment is to promote access to inpatient psychiatric services for individuals under 21 for those patients who require expensive care, and to limit the financial risk of a Medicare certified hospital treating unusually costly patients.

(B) The outlier adjustment may be a short stay outlier adjustment or a high cost outlier adjustment.

(C) In order to be eligible for the short stay outlier adjustment:

1. The Medicare certified hospital must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The total length of stay for the discharge must be less than 6 days.
3. The outlier adjustment will be the lessor of the following:
   a. 100% of the Medicare certified hospital's cost; or
   b. 120% of the peer group per diem multiplied by the LOS.

(D) In order to be eligible for the high cost outlier adjustment:

1. The Medicare certified hospital must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The outlier payment will be made if the Medicare certified hospital's total cost of care exceeds 115% of the Medicaid payment.
3. The appropriate outlier amount will be determined by comparing the total cost and 115% of the Medicaid payment for the entire stay, and multiplying the difference by a loss sharing ratio of .20 to the Medicare certified hospital and .80 to the state, if the stay is less than or equal to 90 days, and .40 to the Medicare certified hospital and .60 to the state for a stay > 90 days.

(E) Refer to Attachment 4.19-A, Page 38 for an example of the Outlier Intensity Adjustment for Medicare certified hospitals.

Comment [OHCA2]: Language from Page 34

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient Psychiatric Services for individuals under age 21 Provided in a Medicare Certified Hospital (42 CFR 440.160) *(continued)*

16.b. Acute Level 2 *(continued)*

(C) Payment to State–licensed, Private Psychiatric Hospitals (IMDs) and General Hospitals with Psychiatric Units *(continued)*

v. Services Provided under Arrangement

Comment [OHCA3]: Language from iv.

Separate payment may be made directly to individual practitioners or suppliers for services provided under arrangement using existing State plan methodologies and fees. The State assures there is no duplication of payment between the ~~PRTF~~ Medicare certified hospital's base rate and the items paid for separately. The State also assures that no duplication of payment will be made for transitioning services to both a community Case Manager provider and a Health Home provider for the same person.

(a) Case Management Transitioning Services – Transitional case management services, for the provision of comprehensive transitional care to existing members, are considered to be ~~PRTF~~ Medicare certified hospital services, when services exceed and do not duplicate ~~PRTF~~ Medicare certified hospital discharge planning during the last 30 days of a covered stay. Case management transitioning services to assist children transitioning from a ~~PRTF~~ Medicare certified hospital to a community setting will not duplicate ~~PRTF~~ Medicare certified hospital discharge planning services. Case management transitioning services will be billed by the ~~PRTF~~ Medicare certified hospital as ~~PRTF~~ inpatient psychiatric services for individuals under age 21 services and claimed as ~~PRTF~~ Medicare certified hospital services. Payment for Case Management transition services provided under arrangement with the ~~PRTF~~ Medicare certified hospital will be directly reimbursed to a qualified community-based Case Management provider. Payment is made to Outpatient Behavioral Health Agencies with qualified case managers in accordance with the methodology in Attachment 4.19-B, Page 22.

(b) Health Home Transitioning Services – Health Home services, for the provision of comprehensive transitional care to existing members, are considered to be ~~PRTF~~ inpatient psychiatric services for individuals under age 21 services, when services exceed and do not duplicate ~~PRTF~~ Medicare certified hospital discharge planning during the last 30 days of a covered stay. Payment for Health Home transitioning services provided under arrangement with the ~~PRTF~~ Medicare certified hospital will be directly reimbursed to the Health Home. Payment is made to certified Health Homes at the Tier 2 Resource Coordination level of care rate, in accordance with the methodology in OK HHA Page 22.

(c) Evaluation and psychological testing by a licensed Psychologist - Payment is made in accordance with the methodology in Attachment 4.19-B, Page 8.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of services provided under arrangement. The agency's fee schedule rate was set as of January 1, 2015 and is effective for services provided on or after that date. All rates are published on the Agency's website www.okhca.org.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

16. Inpatient Psychiatric ~~Facility~~ Services for individuals under age 21 Provided in a Medicare Certified Hospital (42 CFR 440.160) ~~*(cont'd)*~~ *(continued)*

16.~~b~~c. Residential Level of Care in a Psychiatric Residential Treatment Facility (PRTF) ~~(cont'd)~~
~~(D)~~ (A) Payment to ~~Private, in-state PRTFs with 17 beds or more (~~IMDs~~)~~

i. Base Rate.
A prospective per diem payment is made based on facility peer group for a comprehensive package of services and room and board which requires 24-hour nursing care supervised by an RN. An RN or LPN must be onsite to meet the ratio of 1:30 during routine waking hours and 1:40 during times residents are asleep.

ii. The base rate ~~is inclusive of other medically necessary services~~ includes the following when included in the plan of care~~. Refer to paragraph (C) ii for a description of these services.~~:

- Dental (excluding orthodontia);
- Vision;
- Prescription drugs;
- Practitioner services; and
- Other medically necessary services not otherwise specified.

Refer to paragraph (C)~~-iii-IV~~ and (D) for add-on services~~,~~ and for services provided under arrangement.

The rates listed below are effective as of 05-01-2016 and are equivalent to a 15 percent rate reduction from the rates in effect on 04-30-2016 for private, in-state, PRTFs with 17 beds or more (IMDs).

Peer Group	Base Rate
Special Populations (Developmental Delays, Eating Disorders)	$340.04
Standard	$286.08
Extended	$271.61

iii. Active Treatment.
~~The service requirements for PRTFs with 16 beds or less are less intense.~~ Individuals in PRTFs with 17 beds or more (IMDs) ~~must~~ receive 14 hours of documented active treatment services each week~~; the requirement for individuals in PRTFs with 16 beds or less is 10 hours per week~~.

iv. Outlier Intensity Adjustment

(A) An outlier payment adjustment may be made on a case by case basis for complex cases. The intent of the outlier payment is to promote access to inpatient psychiatric services for individuals under 21 for those patients who require expensive care, and to limit the financial risk of a Medicare certified hospital treating unusually costly patients.

(B) The outlier adjustment may be a short stay outlier adjustment or a high cost outlier adjustment.

(C) In order to be eligible for the short stay outlier adjustment:

1. The facility must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The total length of stay for the discharge must be less than 6 days.
3. The outlier adjustment will be the lessor of the following:
   a. 100% of the facility's cost; or
   b. 120% of the peer group per diem multiplied by the LOS.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

16. Inpatient Psychiatric ~~Facility~~ Services for individuals under age 21 Provided in a Medicare Certified Hospital (42 CFR 440.160) ~~(cont'd)~~ *(continued)*

16.~~b~~c. Residential Level of Care in a PRTF ~~(cont'd)~~ *(continued)*

(A) Payment to IMDs *(continued)*

iv. Outlier Intensity Adjustment *(continued)*

(D) In order to be eligible for the high cost outlier adjustment:
1. The facility must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The outlier payment will be made if the facility's total cost of care exceeds 115% of the Medicaid payment.
3. The appropriate outlier amount will be determined by comparing the total cost and 115% of the Medicaid payment for the entire stay, and multiplying the difference by a loss sharing ratio of .20 to the facility and .80 to the state, if the stay is less than or equal to 90 days, and .40 to the facility and .60 to the state for a stay > 90 days.

(E) Refer to Attachment 4.19-A, Page 38 for an example of the Outlier Intensity Adjustment for Medicare certified hospitals.

~~(E)~~ (B) Payment to Private, in-state PRTFs with 16 beds or less (non-IMD)

Comment [OHCA4]: Language from page 35

i. Base Rate

The rate listed below is effective as of 05-01-2016 and is equivalent to a 15 percent rate reduction from the rate in effect on 04-30-2016 for private, in-state PRTFs with 16 beds or less (non-IMD). An RN must be on site at least one hour each day and be available 24 hours a day when not on site.

A prospective per diem payment of $187.42 is made for a comprehensive package of services provided under the direction of a physician, as well as and room and board. The rate was developed from a market-based study.

ii. Physician and Other Ancillary Services

All other medical services are separately billable. Payment is made in accordance with the applicable State plan payment methodologies and fees.

The service requirements for PRTFs with 16 beds or less (non-IMDs) are less intense. Individuals ~~in PRTFs with 17 beds or more must receive 14 hours of documented active treatment services each week; the requirement for individuals~~ in PRTFs with 16 beds or less ~~is~~ receive 10 hours of documented active treatment services per week.

~~(F)~~ (C) Payment for Out–of–State Services

Reimbursement for out-of-state placements shall be made in the same manner as instate providers. In the event that comparable services cannot be purchased from an out-of-state provider, a rate may be negotiated that is acceptable to both parties. The rate will generally be the lesser of usual and customary charges or the Medicaid rate in the state in which services are provided. Reimbursement shall not be made for private PRTF services provided in out of state unless the services are medically necessary and are not available within the State and prior authorization has been granted.

State developed fee schedule rates are the same for both public and private providers. The fee schedule(s) and any annualized/periodic adjustments to the fee schedule are published on the agency website.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient psychiatric ~~facility~~ services for individuals under age 21 Provided in a Medicare Certified Hospital (42 CFR 440.160) *(continued)*

16.~~b~~c. Residential Level of Care in a PRTF *(continued)*

~~**i. Outlier Intensity Adjustment**~~

~~(A) An outlier payment adjustment may be made on a case by case basis for complex cases. The intent of the outlier payment is to promote access to PRTF care for those patients who require expensive care, and to limit the financial risk of PRTF's treating unusually costly patients.~~

~~(B) The outlier adjustment may be a short stay outlier adjustment or a high cost outlier adjustment.~~

~~(C) In order to be eligible for the short stay outlier adjustment:~~

~~1. The facility must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and~~

~~2. The total length of stay for the discharge must be less than 6 days.~~

~~3. The outlier adjustment will be the lessor of the following:~~

~~a. 100% of the facility's cost; or~~

~~b. 120% of the peer group per diem multiplied by the LOS.~~

~~(D) In order to be eligible for the high cost outlier adjustment:~~

~~1. The facility must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and~~

~~2. The outlier payment will be made if the facility's total cost of care exceeds 115% of the Medicaid payment.~~

~~3. The appropriate outlier amount will be determined by comparing the total cost and 115% of the Medicaid payment for the entire stay, and multiplying the difference by a loss sharing ratio of .20 to the facility and .80 to the state, if the stay is less than or equal to 90 days, and .40 to the facility and .60 to the state for a stay > 90 days.~~

(D) Services Provided under Arrangement

Separate payment may be made directly to individual practitioners or suppliers for services provided under arrangement using existing State plan methodologies and fees. The State assures there is no duplication of payment between the PRTF base rate and the items paid for separately. The State also assures that no duplication of payment will be made for transitioning services to both a community Case Manager provider and a Health Home provider for the same person.

i. **Case Management Transitioning Services** – Transitional case management services for the provision of comprehensive transitional care to existing members, are considered to be PRTF services, when services exceed and do not duplicate PRTF discharge planning during the last 30 days of a covered stay. Case management transitioning services to assist children transitioning from a PRTF to a community setting will not duplicate PRTF discharge planning services. Case management transitioning services will be billed by the PRTF as PRTF services and claimed as PRTF services. Payment for Case Management transition services provided under arrangement with the PRTF will be directly reimbursed to a qualified community-based Case Management provider. Payment is made to Outpatient Behavioral Health Agencies with qualified case managers in accordance with the methodology in Attachment 4.19 B Page 22.

ii. **Health Home Transitioning Services** – Health Home services for the provision of comprehensive transitional care to existing members, are considered to be PRTF services, when services exceed and do not duplicate PRTF discharge planning during the last 30 days of a covered stay. Payment for Health Home transitioning services provided under arrangement with the PRTF will be directly reimbursed to the Health Home. Payment is made to certified Health Homes at the Tier 2 Resource Coordination level of care rate, in accordance with the methodology in OK HHA Page 22.

iii. **Evaluation and psychological testing by a licensed Psychologist** - Payment is made in accordance with the methodology in Attachment 4.19 B page 8.

Comment [OHCA5]: Language from page 36 and revised language moved to pages 34 and 35.

Comment [OHCA6]: Language from Page 37

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient psychiatric ~~facility~~ services for individuals under ~~22~~ 21 ~~years of age with non institutional payment made separately from per diem payment~~ Provided in a Medicare Certified Hospital (42 CFR 440.160) ~~(cont'd)~~ *(continued)*

6.c. Residential Level of Care in a PRTF *(continued)*

(E) ~~PRTF Outlier Calculation~~ Outlier Intensity Adjustment for Medicare Certified Hospital

		Example 1	***Example 2***
1	Reported Per Diem Cost	$ 375	$ 375
2	Covered Days	235	90
3	Sub-Total Projected cost for the stay	$ 88,125	$ 33,750
4	~~Extroardinary~~ Extraordinary Costs	$ 10,000	$ 10,000
5	Total Costs (Lines 3 + 4)	$ 98,125	$ 43,750
6	Peer Group Per Diem Base Rate	$ 348	$ 348
7	Covered Days	235	90
8	Total Regular Payments	$ 81,780	$ 31,320
9	ITS Per Diem Payments/Day	-	-
10	ITS Days	-	-
11	Est. Medicaid ~~Pymt~~ Payment for the stay (Lines 8+9x 10)	$ 81,780	$ 31,320
12	Cost Threshold Percentage	1.15	1.15
13	Payment x Threshold (Line 11 x 12)	$ 94,047	$ 36,018
14	Eligible for Outlier?	Y	Y
15	Available for Outlier (If line 14 = "Y", line 5 - line 14)	$ 4,078	$ 7,732
16	State Loss Sharing Ratio	0.60	0.80
17	Outlier Payment	$ 2,447	$ 6,186