METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient Psychiatric Services for Individuals under Age 21 (42 CFR 440.160) *(continued)*

16.a. Inpatient Psychiatric Services for Individuals under Age 21 *(continued)*

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

iii. Add-on Payments

(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 an acute level 2 ~~or PRTF~~ setting when it is determined that there is medical necessity for non-acute care, the services are documented in the facilities' records, and are 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 in an acute level 2 setting. These services must be medically necessary, documented in the facilities' record, and prior authorized.

(c) Specialty Add-on Per diem

A per diem of **$210.00** will be allowed to recognize the increased cost of serving children with specialized needs in an acute level 2 setting. These services must be medically necessary, documented in the facility's record, and prior authorized.

(d) 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 services beyond the cost of services provided by ~~both~~ ITS, ~~and~~ Prospective Complexity, and Specialty add-on payments.

(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 private psychiatric hospital and general hospital with a psychiatric unit 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 must be less than 6 days.
3. The outlier adjustment will be the lessor of the following:
   a. 100% of the private psychiatric hospital's and general hospital's with a psychiatric unit 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 private psychiatric hospital or general hospital with a psychiatric unit 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 psychiatric hospital's or general hospital's with a psychiatric unit 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 psychiatric hospital or general hospital with a psychiatric unit 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.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

16. Inpatient Psychiatric Services for individuals under age 21 (42 CFR 440.160) *(continued)*

16.b. Residential Level of Care in a Psychiatric Residential Treatment Facility (PRTF)

(A) Payment to State-owned Government Providers

State-owned PRFTs 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.

(B) Payment to PRTFs with 17 beds or more

i. Base Rate.

A prospective per diem payment is made based on the 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 following services will not be reimbursed outside of the base rate:

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

Refer to paragraph 16.a.(C)iii.(a)-~~(b)~~(c) for add-on payment and 16.b.(E). 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.

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

iii. 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 services beyond the cost of services provided by ~~both~~ ITS, ~~and~~ Prospective Complexity, and Specialty add-on payments.

(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 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 Services for individuals under age 21 (42 CFR 440.160) *(continued)*

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

(B) Payment to PRTFs with 17 beds or more *(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.

(C) Payment to Private, in-state PRTFs with 16 beds or less

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.

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.

Refer to paragraph 16.a.(C)iii(a)-~~(b)~~(c) for add-on payment and 16.b.(E). for services provided under arrangement.

ii. Physician and Other Ancillary Services

All other medically necessary services, i.e., EPSDT services, are arranged by the PRTF with 16 beds or less and billed separately. The reimbursement for the EPSDT service does not duplicate billing for inpatient psychiatric services under section 1905(a)(16)(A) of the Act by the PRTF with 16 beds or less or a provider furnishing inpatient psychiatric services under arrangement with the PRTF with 16 beds or less. Payment for the EPSDT service is made in accordance with the applicable State plan payment methodologies and fees. Claiming of such expenditures for federal financial participation (FFP) are in accordance with the CMS-64 form claiming guidance for EPSDT services

(D) Payment for Out–of–State Services

Reimbursement for out-of-state placements for individuals under the age of 21 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 using Medicaid established rates, 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.