John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

May 20, 2016

Bill Brooks
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health Operations
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, TX 75202

Dear Mr. Brooks:

RE: LA SPA TN 15-0028 RAI Response
Psychiatric Residential Treatment Facilities- Behavioral Health Integration

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 15-0028 with a proposed effective date of December 1, 2015. The purpose of this SPA is to amend the provisions governing psychiatric residential treatment facilities (PRTFs) to: 1) allow an Office of Behavioral Health appointed designee to certify providers; 2) revise the terminology to be consistent with current program operations; and 3) revise the reimbursement methodology to remove the provisions governing interim payments, and to establish capitation payments to managed care organizations for children's services other than Coordinated System of Care (CSoC). For children/youth enrolled in CSoC, the non-risk payments shall be continued and payments made to a CSoC contractor. We are providing the following in response to your request for additional information (RAI) dated December 2, 2015:

FORM-179

1. Form 179 - Box 7: No financial impact was noted due to the proposed revisions. Please provide a detailed analysis of how this determination was made and provide supporting documentation of the calculation.

   RESPONSE: The State anticipates no fiscal impact to the Medicaid Program as a result of the revisions to the PRTF State Plan amendment. The purpose of the revision is to align the SPA with the change from a non-risk to a risk based

reimbursement methodology which is a result of the integration of specialized behavioral health services into the Bayou Health managed care program. The current costs for the non-risk program have been accounted for in the rates for the integrated risk program by our actuarial firm. Specifically, in reference to the shift away from risk sharing, the State informed the actuarial firm of those PRTF providers that have historically been subject to risk sharing arrangements under the current program. The prior risk sharing process resulted in additional payments to those providers as the per diem documented in the cost reports was higher than the interim rates. The actuarial firm has built in consideration of provider specific rates for these providers based on the cost report per diems. The State provided them with the risk sharing calculations that were based on the base paid and final targeted per diem rates for these two providers. The actuarial firm then leveraged the final calculations to determine the program change impact. This resulted in the current cost under the non-risk contract, which was inclusive of both the original interim payment as well as the subsequent supplemental payments made per the cost reporting process, being incorporated into rates for the risk based program. Therefore, the payment mechanism is changing via this revision, but the current costs will transfer to the new contract with no anticipated financial impact.

UPPER PAYMENT LIMIT (UPL)

2. Please note CMS has not received the other inpatient and outpatient facility services (PRTF) demonstration for SFY 2015. Regulations at 42 CFR 447.325 for other inpatient and outpatient facility services upper limits of payments, state the agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

   Please submit the SFY 2015 UPL demonstration and include a detailed narrative description of the methodology for calculating the upper payment limit.

   RESPONSE: The State does not believe that a demonstration needs to be done for PRTF since it is part of the managed care program. The payments for these services are included in line 18b2 on the CMS 64.

STATE PLAN LANGUAGE

3. The State plan methodology must be comprehensive enough to determine the required level of payment and the FFP to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Claims for federal matching funds cannot be based upon estimates or projections. The reimbursement methodology must be based upon actual historical utilization and actual trend factors. Please clarify, remove, or add the following items to the plan pages and submit revisions for CMS review.

a. The Institution for Mental Diseases (IMD) under the age of 21 benefit is under Section 1905(a)(16) of the Social Security Act. Additionally, inpatient psychiatric hospital services for individuals under age 21are defined in subsection (h).

Therefore, please add the following title, "Institution for Mental Diseases (IMD) for individuals under 21 years of age", for all of the coverage and reimbursement plan pages.

RESPONSE: Please see revisions to the plan pages, including Attachment 3.1-A, Item 16, page 1-2; Attachment 4.19-A, Item 16, Page 5, 5a and 6. The State requests to substitute the revised pages for the original submitted pages.

b. On Attachment 4.19-A, Item 16 page 5, and page 5a, there are a typographical errors. It states the following:

4.19-A, Item 16 page 5
Hospital-Based PRTFs: Hospital-based PRTFs shall be reimbursed a per diem rate for covered services. The per diem rate shall also include reimbursement for the following services when included on the active treatment plan:
a) Dental;
b) Vision;

4.19-A, Item 16 page 5a
4. hospital-based PRTFs specializing in sexually-based treatment programs;
5. hospital-based PRTFs specializing in substance use treatment programs; and
6. hospital-based PRTFs specializing in behavioral health treatment programs.

RESPONSE: The State has made revisions on the pages identified above.

On February 16, 2007, Survey and Certification issued **S&C-07-15**. It clarified Section 4755 of the Omnibus Budget Reconciliation Act (OBRA '90) amended section 1905(h) of the Act to specify that the psych under 21-benefit can be provided in psychiatric hospitals that meet the definition of that term in section 1861(f) of the Act "or in another inpatient setting that the Secretary has specified in regulations."

This amendment affirmed and effectively ratified preexisting CMS policy, as articulated in subpart D of 42 C.F.R. part 441, which interpreted sections 1905(a)(16) and 1905(h) of the Act as not being limited solely to psychiatric hospital settings. OBRA '90 provided authority for CMS to specify inpatient settings in addition to the psychiatric hospital setting for the psych under 21-benefit. In 2001, CMS established PRTFs as a new category of Medicaid facility, and as an additional setting for which the psych under 21-benefit can be provided. (See interim final regulations, 66 FR 28111).

The Social Security Act and federal regulations, expressly identify that services under the psych under 21-benefit can be provided in distinct parts found in psychiatric hospitals; however, a PRTF is not identified as a distinct part of another facility.

A PRTF is a separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis under the direction of a physician.

The purpose of such comprehensive services is to improve the resident's condition or prevent further regression so that the services will no longer be needed. Current regulation, §483.352, states that a PRTF means "a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting."

c. On Attachment 4.19-A, Item 16, page 5, it references publicly owned and operated PRTF. Please replace the word 'publicly" with either State and/or Non-State.

RESPONSE: Please see revision to Attachment 4.19-A, Item 16, Page 5a.

d. On Attachment 4.19-A, Item 16, page 5 and 5a, there are partial references to fee schedules. CMS requires specific language if the State intends to use an established fee schedule. The language requires states to include in the plan the last date on which the schedule was updated. The language identifies the published location of the fee schedule. Most States adjust rates annually or quarterly. Please use the paragraph below to describe the fee schedule.

"Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (ex. case management for persons with chronic mental illness). The agency's fee schedule rate was set as of (insert date here) and is effective for services provided on or after that date. All rates are published (ex. on the agency's website)."

RESPONSE: Please note the suggested paragraph has been inserted to page 5.

e. On Attachment 4.19-A Item 16, page 5 and 5a, there are references to managed care organizations (MCOs) and the Coordinated System of Care (CSoC) contractor. Please remove these references and how the managed care organizations or contractors will reimburse the PRTFs.

Additionally, on Attachment 4.19-A, Item 16 page 5, the first 3 paragraphs should be deleted. Attachment 4.19-A section is limited to including a State's methods and standards for setting Fee-For-Service (FFS) rates paid by Medicaid to purchase PRTFs services. The MCO discussion is misplaced and should deleted from this attachment. Please contact Janice Arceneaux, your Dallas Regional Office managed care specialist, for the appropriate location of this language.

RESPONSE: **Please see the revision/deleted language as directed by CMS on Attachment 4.19-A, Item 16, Page 5.**
According to the ***CMCS Informational Bulletin dated November 2012***, it allows for **Services Provided under Arrangement** for inpatient psychiatric hospital services for individuals under age 21.
The PRTF may wish to obtain services reflected in the plan of care under the arrangement with the qualified non-facility provider. On page 2, of the Bulletin, it states that "In some cases a psychiatric facility may wish to obtain services reflected in the plan of care under arrangement with qualified non-facility providers. Such services would be components of the inpatient psychiatric facility benefit when included in the child's inpatient psychiatric plan of care and furnished by a qualified provider that has entered into a contract with the inpatient psychiatric facility to furnish the services to its inpatients. To comply with the requirement that services be "provided by" a qualified psychiatric facility, the psychiatric facility must arrange for and oversee the provision of all services, must maintain all medical records of care furnished to the individual, and must ensure that all services are furnished under the direction of a physician.

f. The State has two options regarding payment. **Louisiana must document in the 4.19-A, reimbursement section of the State plan, which payment option the State will utilize.** According to the 2012 Bulletin, either payment option must be claim on the Mental Health Facility Services line of the CMS-64 Medicaid expenditures report. Please advise your State Financial staff of this requirement.

- The first option is that Louisiana can pay the PRTF provider, who has an arrangement with the qualified non-facility provider.
- The second option is to **directly** reimburse individual practitioners or suppliers of arranged services **using payment methodologies that are applicable when the services are otherwise available under the State plan.** However, the reimbursement for services are the **same fees** to such practitioners or suppliers as would otherwise be applicable when the services are furnished to Medicaid beneficiaries **outside** the inpatient psychiatric facility benefit.

RESPONSE: The State will use the second option to directly reimburse individual practitioners or suppliers of arranged services using payment methodologies that are applicable when the services are otherwise available under the State Plan. PRTF expenditures will be reported on the managed care lines of the CMS 64 (not the Mental Health Facility line) since Louisiana provides these benefits through managed care organizations.

STATE PLAN LANGUAGE- 3.1-A

4. In accordance with § 440.160, services must be provided under the direction of a physician. Please add language to the plan page accordingly. Additionally, please add language indicating that services are included in an individual's plan of care.

   RESPONSE: The language has been added. Please see Attachment 3.1-A, Item 16, Page 2.

5. Please specify any services that will be provided under arrangement with outside providers.

   RESPONSE: The language has been added. Please see Attachment 3.1-A, Item 16, Page 2.

6. The plan page indicates that services on the inpatient psychiatric active treatment plan that are not related to the provision of inpatient psychiatric care are excluded. Please remove this language as active treatment should be comprehensive and include medical and psychiatric services.

   RESPONSE: The language has been removed. Please see Attachment 3.1-A, Item 16, Page 2.

FUNDING QUESTION

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State plan, including payments made outside of those being amended with this SPA.

7. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

   RESPONSE: Providers will receive and retain 100 percent of the payments. No portion of the payments is returned to the State.

8. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services

available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

i. a complete list of the names of entities transferring or certifying funds;
ii. the operational nature of the entity (state, county, city, other);
iii. the total amounts transferred or certified by each entity;
iv. clarify whether the certifying or transferring entity has general taxing authority; and,
v. whether the certifying or transferring entity received appropriations (identify level of appropriations).

RESPONSE: The state share is paid from the state general fund which is directly appropriated to the Medicaid agency.

9. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

RESPONSE: Not applicable to this State Plan amendment.

10. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

RESPONSE: The annual UPL demonstration does not apply to these services as they are under the managed care program.

11. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

    RESPONSE: We do not have any public/governmental providers receiving payments that exceed their reasonable costs of services provided.

Please consider this a formal request to begin the 90-day clock. We trust that this additional information will be sufficient to result in the approval of the pending plan amendment. We look forward to negotiating with CMS to ensure approval.

As always, we appreciate the assistance of Tamara Sampson in resolving these issues. If further information is required, you may contact Darlene A. Budgewater at Darlene.Budgewater@la.gov or by phone (225) 342-3881.

Sincerely,

Jen Steele
Medicaid Director

JS:DAB:JH

Attachments (3)

c: Darlene Budgewater
Cheryl Rupley
Tamara Sampson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-0028**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 1, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.160, 441 Subpart D
42 CFR 483 Subpart G

7. FEDERAL BUDGET IMPACT:
a. FFY **2016** **$0**
b. FFY **2017** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Item 16, Page 2
Attachment 3.1-A Item 16, Page 1
Attachment 3.1-A Item 16, Page 2
Attachment 4.19-A Item 16, Pages 5 and 5a
Attachment 4.19-A Item 16, Pages 6, 7 ~~and 8~~
Attachment 4.19-A, Item 16, Page 2a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SAME (TN 10-73)
SAME (TN 11-12)
NONE – New Page
SAME (TN 13-41)
~~SAME (TN 11-12)~~ Remove Page 8
SAME (TN 09-30)

10. SUBJECT OF AMENDMENT: **The SPA proposes to amend the provisions governing psychiatric residential treatment facilities (PRTFs) to: 1) allow an Office of Behavioral Health appointed designee to certify providers; 2) revise the terminology to be consistent with current program operations; and 3) revise the reimbursement methodology to remove the provisions governing interim payments, and to establish capitation payments to managed care organizations for children's services other than Coordinated System of Care (CSoC). For children/youth enrolled in CSoC, the non-risk payments shall be continued and payments made to a CSoC contractor.**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
September 28, 2015

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS: **The State requests a pen and ink change to box 8 and 9, above.**

FORM HCFA-179 (07-92)

STATE OF LOUISIANA

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

LIMTATIONS OF THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

CITATION	Medical and Remedial Care and Services
42 CFR 440.160	Item 16
42 CFR 441 Subpart D	
42 CFR 483 (Subpart G)	**Institution for Mental Diseases for Individuals Under 21 Years of Age**

Individuals under the age of 21 with an identified mental health or substance use diagnosis, who meet Medicaid eligibility and clinical criteria, shall qualify to receive inpatient psychiatric residential treatment facility (PRTF) services.

Coverage is limited to services provided in Title XVIII certified psychiatric hospitals enrolled in Title XIX and psychiatric facilities which are accredited by an approved accrediting body that is recognized by the State. Providers must comply with Federal regulations and policies and any Standards for Payment and licensure and certification standards promulgated by the State.

For PRTFs providing this service:

- Providers of these services will be subject to the uniform admission criteria and exclusionary criteria.
- Providers must comply with pre-admission process, length of stay assignment, extension of-stay and discharge criteria in order to be reimbursed by the Medicaid program.
- There will be no Medicaid payment for reservation of a bed for a recipient who is temporarily absent from the facility.
- All services will be certified consistent with federal requirements through a prior authorization process.

Institution for Mental Diseases for Individuals Under 21 Years of Age

- Providers must comply with all active treatment requirements, including developing a plan of care based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care, under the direction of a physician.
- All services shall be included in the individual's plan of care.
- Recipients must continue to meet Medicaid certification requirements for continuation of stay.
- The inpatient psychiatric service is equal in amount, duration & scope regardless of setting. All facilities are required to provide all activities on the active treatment plan. Beneficiaries may choose among providers.
- Services provided under arrangement can include dental, vision and diagnostic/radiology services.
- Psychiatric services for children shall be provided within the context of the family and not as an isolated unit.

Service Exclusions

The following services shall be excluded from Medicaid reimbursement:
1. Group education, including elementary and secondary education; and
2. Activities not on the inpatient psychiatric active treatment plan.

STATE OF LOUISIANA
PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

e. Effective for dates of service on or after February 20, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals shall be reduced by 3.5 percent of the rate on file as of February 19, 2009.

f. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals shall be reduced by 5.8 percent of the rate on file as of August 3, 2009.

g. Effective for dates of service on or after October 1, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals shall be increased by 3 percent of the rate on file.

h. Effective for dates of service on or after February 3, 2010, the prospective per diem rate paid to non-rural, non-state free standing psychiatric hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

i. Effective for dates of service on or after August 1, 2010, the prospective per diem rate paid to non-rural, non-state free standing psychiatric hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

j. Effective for dates of service on or after January 1, 2011, the prospective per diem rate paid to non-rural, non-state free standing psychiatric hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

k. PRTF

The reimbursement rates for physician services rendered under the LBHP shall be a flat fee for each covered service as specified on the established Medicaid fee schedule. The reimbursement rates shall be based on a percentage of the Louisiana Medicare Region 99 allowable for a specified year.

Effective for dates of service on or after April 20, 2013, the reimbursement for behavioral health services rendered by a physician under the LBHP shall be 75 percent of the 2009 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Effective for dates of service on or after September 1, 2013, the reimbursement for procedure codes 90791, 90792, 90832, 90834 and 90837 shall be excluded from the January 2013 Medicare rate changes and shall remain at the Medicaid fee schedule on file as of December 31, 2012.

2. Provisions for Disproportionate Share Payments

   a. Effective for services provided on or after July 1, 1988, hospitals qualifying as disproportionate share providers shall have payment adjustment factors applied in accordance with the guidelines outlined in Attachment 4.19-A, Item 1, Section D.

   b. Disproportionate share payments cumulative for all DSH payments under the pools or any other DSH payment methodology shall not exceed the federal disproportionate share state allotment for each federal fiscal year established under Public Law 102-234.

3. Supplemental Payments for Non-Rural, Non-State Hospitals

   Effective for services provided on or after July 1, 2009, Medicaid Supplemental payment will be made to qualifying non-rural non-state public and private hospitals for dates of service from July 1, 2009 through December 31, 2010 as follows:

   a. Other hospitals impacted by Hurricanes Katrina and Rita.

      Maximum aggregate payments to all qualifying hospitals in this group (which includes inpatient psychiatric hospital supplemental payments described in Attachment 4.19-A, Item 14a and Item 16) will not exceed $10 million.

      1) Qualifying criteria – Non-state freestanding psychiatric hospital which is located in either the New Orleans or Lake Charles metropolitan statistical area (MSA), and had at least 1,000 paid Medicaid days for SFY 2008 dates of service and is currently operational.

STATE OF LOUISIANA

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Institution for Mental Diseases for Individuals Under 21 Years of Age

Psychiatric Residential Treatment Facility Reimbursement

Covered inpatient psychiatric residential treatment facility (PRTF) activities for individuals under 21 years of age shall be reimbursed by Medicaid. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of December 1, 2015 and is effective for services provided on or after that date. All rates are published on the agency's website and can be accessed at the following link:

http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm

Covered inpatient, physician-directed PRTF services rendered to children and youth shall be reimbursed according to the following criteria:

Inpatient psychiatric services provided by PRTFs will be reimbursed a per diem rate for the following when included on the patient's active treatment plan:

a) Occupational Therapy, Physical Therapy and Speech Therapy;
b) Laboratory services; and
c) Transportation.

The PRTF shall arrange through contract(s) with outside providers to furnish dental, vision and diagnostic/radiology services as listed on the treatment plan. The treating provider will be directly reimbursed by the contractor.

Pharmacy and physician services shall be reimbursed when included on the recipient's active treatment plan of care and are components of the Medicaid covered PRTF service. Any payments made directly to a treating physician and pharmacy shall be excluded from the PRTF's per diem rate for the facility.

Institution for Mental Diseases for Individuals Under 21 Years of Age (continued)

State Psychiatric Residential Treatment Facility Reimbursement Rates

State and privately-owned and operated PRTFs shall be reimbursed for covered PRTF services according to the following provisions. The rates paid shall take into consideration the following ownership and service criteria:

1. PRTF specializing in sexually-based treatment programs.

2. PRTF specializing in substance abuse treatment programs.

3. PRTF specializing in behavioral health treatment programs.

Out-of-State Psychiatric Residential Treatment Facility Reimbursement Rates

Out-of-state PRTFs shall be reimbursed in accordance with the established rate for these services.

Psychiatric Residential Treatment Facility Cost Reports

1. All in-state Medicaid-participating PRTF providers are required to file an annual Medicaid cost report in accordance with Medicare/Medicaid allowable and non-allowable costs. Cost reports shall be submitted on or before the last day of the fifth month after the end of the provider's fiscal year end.
2. Separate cost reports must be submitted by central/home offices when costs of the central/home office are reported in the PRTF provider's cost report.
3. If the PRTF provider experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension request must be submitted to DHH prior to the cost report due date.
4. Facility filing a reasonable extension request will be granted an additional 30 days to file their cost reports.

STATE OF LOUISIANA

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Institution for Mental Diseases for Individuals Under 21 Years of Age (continued)

New Psychiatric Residential Treatment Facilities and Change of Ownership of Existing Facilities

A. Changes of ownership (CHOW) exist if the beds of a new owner have previously been certified to participate in the Medicaid program under the previous owner's provider agreement. The acceptance of a CHOW will be determined solely by DHH. Reimbursement will continue to be based on the State of Louisiana Medicaid Fee Schedule.

B. New providers are those entities whose beds have not previously been certified to participate in the Medicaid program.

Initial and On-going Rate Setting Methodology:

Per diem PRTF rates effective July 1, 2011, will be developed as follows:

1. Comparable PRTF rates from other Medicaid programs will be examined.
2. These rates will be adjusted for cost of living variances between Louisiana and state from which they came.
3. The adjusted rates will be indexed (inflated used the inflation factor) from the home state's rate effective date to July 1, 2011.
4. These rates will then be average or other measures of central tendency will calculated.
5. The rate may be further adjusted to reflect ownership cost variances anticipated, or to recognize PRTF specialization. Additional adjustment to the average rates may be made as deem necessary.

6. The initial rates will be subject to the risk-sharing provision contained in subsection III to mitigate financial risk for both the Medicaid program and its PRTF providers.

The Louisiana Medicaid program will collect cost information from providers participating in the PRTF program as indicated under the cost reporting section. This cost information will be utilized to monitor PRTF rates effective July 1, 2013 to ensure our fee schedule payments continue to be adequate to attract provider participation in the program, while also ensuring that rates are not excessive.