A. MONTANA MEDICAID REIMBURSEMENT FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

PRTF services must be medically necessary. A provider will not be reimbursed unless services are authorized by the department or their utilization review contractor.

Reimbursement will be made to a PRTF provider for no more than 14 patient days per youth per SFY for reserving a bed while the youth is temporarily absent for a therapeutic home visit (THV). A THV is 3 days or less, unless authorized by the department.

1) IN-STATE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

The department will reimburse in-state PRTFs a bundled per-diem interim rate. The interim rate consists of the bundled psychiatric service reimbursement rate, plus a facility specific add-on ancillary rate and a direct care wage rate. The interim rate includes reimbursement for all psychiatric, medical and ancillary services provided in and by the PRTF, and ancillary services provided by outside providers under contract with the PRTF.

a) PRTF REIMBURSEMENT

i) Psychiatric Service Rate

The bundled psychiatric service rate is a set fee and adjusted subsequently through provider rate increases at the beginning of the state fiscal year. The current bundled psychiatric service rate was set as of September 1, 2011, and is effective for services on or after that date. All rates are published on the department's website at MTMedicaid.org. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

The Montana Medicaid program will pay a provider, for each Medicaid inpatient day, a bundled per diem psychiatric rate less any third party or other payments. The bundled per diem psychiatric rate for hospital based and free standing psychiatric residential treatment facility services provided by all Montana providers is the lesser of:

- The amount specified in the department's Medicaid Mental Health fee schedule; or
- The provider's usual and customary charges (billed charges).

Medicaid payment is not allowable for treatment or services unless provided in a hospital based or free standing psychiatric residential treatment facility as defined in service 16 of the supplement to attachments 3.1A and 3.1B of Montana's State Medicaid plan.

The per diem psychiatric service rate provided above for hospital based and free standing psychiatric residential treatment facility providers located in the state of Montana is the final rate, and such rate will not be adjusted retrospectively based upon more recent cost data or inflation estimates. Cost settlements will not be performed.

The per diem psychiatric service rate includes all services related to treating the youth's psychiatric condition provided in and by a PRTF with the exception of psychiatrist services and psychotropic medication prescribed during the youth's stay in the PRTF and post-discharge. Psychiatrist services are paid as part of the facility specific ancillary rate and psychotropic medication expenses will be cost-settled at the end of the SFY.

ii) Facility Specific Ancillary Add-On Rate

A facility specific daily rate was added to the bundled psychiatric service rate on the department's fee schedule July 1, 2009. The facility specific ancillary rate is based on Medicaid paid claims for medical and ancillary services youth received while in an in-state PRTF during the base year. All Medicaid State Plan services reimbursed for youth residing in an in-state PRTF in federal fiscal year (FFY)2007 were totaled and divided by the total number of PRTF bed days in FFY 2007(paid by Montana Medicaid) per facility, to calculate a daily ancillary rate per facility.

iii) Direct Care Wage Add-On Rate

The direct care wage add-on rate is additional funding paid through a contract with the department to Medicaid providers, including PRTFs, to increase the wages and benefits of their direct care workers as part of their per diem rate. The direct care wage increase was added to enhance service delivery by retaining and hiring qualified staff. The department determines a maximum monthly payment for each provider as a pro rata share of the allocated funds.

The rate calculation includes a census of full-time equivalent (FTE) direct care workers; a ratio of Montana Medicaid youth served to all youth served; the PRTF portion of the total FTE direct care worker wages; and the portion of PRTF direct care workers from the total number of workers from qualified providers divided by the appropriation. (FTE is based on 40 hours a week.) Rate = appropriation ($5,013,724)/ # of direct care workers x % of Montana Medicaid paid facility bed days in state fiscal year.

iv) PRTF Assessment Service (PRTF-AS) Rate

PRTF-AS services are reimbursed higher than the bundled psychiatric service rate and includes the facility specific ancillary and direct care wage add-on rate. PRTF-AS ancillary expenses will be included in the PRTF cost report in section b.

PRTF-AS services are provided by in-state PRTFs and are short-term lengths of stay of 14 days or less. The department increased the daily PRTF rate 15% for

"assessment services" to incentivize in-state PRTFs to evaluate SED youth with multiple and special treatment needs and to offset the higher professional staff expenses in a short PRTF stay. Fifteen % was a negotiated amount between the Department and providers.

If short-term PRTF-AS services will not meet the youth's needs, a regular PRTF authorization will be requested and the PRTF interim rate will be paid versus the higher PRTF-AS rate. Readmissions to a PRTF, following a PRTF-AS stay will be closely monitored for medical necessity.

b) COST REPORTS

The in-state PRTFs will complete a cost report within 150 days of the end of the state fiscal year (SFY), and identify their ancillary expenses. The department will only cost-settle the PRTF's ancillary expenses.

Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants. Definitions of allowable and non-allowable costs are further defined in accordance with the Medicare Provider Reimbursement Manual, CMS Publication 15-1, subject to the exceptions and limitations provided in the department's administrative rules. Publication 15-1 is a manual published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, which provides guidelines and policies to implement Medicare regulations which set forth principals for determining reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended.

The department will reimburse PRTFs for ancillary expenses that exceed 100% of the base year, FFY 2007. The facility specific ancillary rate is determined from the base year ancillary expenses and included in the per diem rate. The PRTFs will reimburse the department for expenses below 100% of the base year. The department may approve interim payments to the PRTFs for the treatment of unusually expensive medical conditions. Interim payments will be included in the cost report.

c) HOSPITAL-BASED PRTF CONTINUITY OF CARE PAYMENT

In-state hospital-based PRTFs receive a continuity of care payment as defined in Montana State Plan Amendment 4.19A.

2. OUT-OF-STATE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Out-of-state PRTFs will be reimbursed 50% of their usual and customary charges and will not exceed 100% of the cost of doing business. Reimbursement will include all Medicaid covered psychiatric, medical, and ancillary services provided in and by the PRTF, and ancillary services provided by outside providers under contract with the PRTF. Out-of-state PRTFs will not be cost settled as outlined in section b for in-state PRTFs.

OS Notification

State/Title/Plan Number: **Montana 11-040**

Type of Action: **SPA Approval**

Required Date for State Notification: **November 28, 2011**

Fiscal Impact:

FFY 2011	($ 26,659)
FFY 2012	($174,164)
FFY 2013	($174,164)

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective September 1, 2011, MT 11-040 is a 4.19-D psychiatric residential treatment facility (PRTF) amendment that proposes a two percent reduction to the psychiatric service component of the all-inclusive rate. Montana's PRTF rate is comprised of three components: (1) psychiatric service rate derived from the Medicaid mental health fee schedule; (2) direct care wage add-on; and (3) facility specific ancillary add-on for Medicaid services not provided for in component (1) and provided by PRTF employees or contractors either within the walls of the PRTF or by contracted outside providers. There is no change in methodology for the direct care wage add-on or facility specific ancillary add-on component of the rate.

The reduction in payment for all Montana providers was based on a one-time only provider rate increase that went into effect in FY 2010, and was held constant in FY 2011. The 2010 provider rate increase was paid for with one-time only funding appropriated by Montana's 61st Legislative session meeting in 2009. This one-time only funding was not included in the base budget for SFY 2012.

Providers were notified during the State's Administrative Rule process in 2009 that any of

these increases were deemed "one-time" only funds. No negative comments were received during the public comment period in 2009 and again in the spring of 2011. The State considered but rejected eliminating optional services because of the impact on vulnerable Medicaid clients who would lose coverage for services. For these reasons, the State pursued the across the board provider rate decrease.

In order to assure that access to care will not be negatively impacted by the rate reduction, the State intends to monitor provider enrollment, disenrollment, and client utilization rates for the applicable provider type for 6 months (beginning in September 2011).

The State's development plan consists of:

- Monitoring the number of providers currently enrolled in the program prior to the rate change.
- Monitoring the number of providers disenrolled after the rate changes.
- Measure the percentage of total eligible clients accessing the specific provider type in any given month. Calculated by: total number of clients accessing service divided by total number of clients = % client utilization rate.
- Monthly DSS claims based data runs: Responsible program officers will monitor and report to supervisor on a monthly basis. Any anomalies will be reported to State leadership.

Non-Federal share is derived from General Funds appropriated through the legislature. Public notice/public requirements were met. Tribal consultation requirements were met. The State did not receive any adverse feedback or comments as a result of tribal consult or through public process communication. The responses to the funding questions were deemed appropriate.

Other Considerations: This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

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