STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: September 28, 2017

TO: Ms. Nicole Cunningham, DMMA
Planning & Policy Development Unit

FROM: Ms. Jamie Wolfe, Chairperson
State Council for Persons with Disabilities

RE: 21 DE Reg. 187 [DMMA Proposed "Psych Under 21" Reimbursement (9/1/17)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance (DMMA) proposal to amend its reimbursement methodology for inpatient psychiatric residential treatment facilities ("PRTFs"). DMMA notes (p. 188) that this benefit is often referenced as "Psych under 21". The proposed regulation was published as 20 DE Reg. 187 in the September 1, 2017 issue of the Register of Regulations.

As background, most states have elected to provide the "Psych under 21" optional benefit in their Medicaid plans. At 188. The benefit covers the costs of residential psychiatric services for individuals under age 21. Consistent with the attached CMS Bulletin, states have several options in establishing reimbursement rates. Some states have a single "bundled" per diem rate which covers all costs. Some states have a base per diem rate with add-on payments based on additional services which can be provided by non-facility professionals.

The current reimbursement standards are listed on pp. 189-190. DMMA posits that the revised standards will have no fiscal impact:

> The proposed amendment imposes no increase in cost on the General Fund as the proposed services in this State plan amendment will be budget neutral. The federal fiscal impact associated with this amendment will be zero dollars.

At 189.

Delaware includes many services in the per diem rate, including dental services, OT, PT, ST, lab work, and transportation. In-state facilities are currently paid the lesser of (a) a facility's usual and customary charge; and (b) the standard per diem rate plus additional funds for services in the plan of care not in the

per diem rate. Out of state facilities are paid using the home state's per diem rate plus additional funds for services in the plan of care not in the per diem rate.

The SCPD has the following observations.

First, DMMA proposes to strike the current, discrete approach for out-of-state facilities. However, the proposed revision is not clear. I believe the Division intends to limit the following new third bullet on p. 189 to out-of-state facilities:

- The lesser of a negotiated per diem reimbursement rate, the facilities (sic "facility's) usual and customary charge, or the Delaware Medicaid per diem rate.

If that is the intent, DMMA should amend the provision as follows:

- If an out of state facility, ~~T~~the lesser of a negotiated per diem reimbursement rate, the facilities (sic "facility's) usual and customary charge, or the Delaware Medicaid per diem rate.

Otherwise, the first and second bullets are meaningless or superfluous and the "add on" for supplemental plan of care services in the first bullet would never be applicable. The new third bullet (with no "add on" authorization") would always be "lesser" than the first bullet.

Second, apart from inserting "(i)f in out of state facility", the Division should substitute "facility's" for "facilities" in both the second and new third bullets to correct the grammar.

Third, adopting the Delaware per diem reimbursement rate (as opposed to the home state reimbursement rate) should contribute to ease of administration, especially since a minority of states may have no "Psych under 21" rate. However, the deletion of the "add on" for "activities in the plan of care but not in the per diem" is not revenue neutral. Assuming the new third bullet only applies to out-of-state facilities, the deletion creates a lower reimbursement methodology for out-of-state facilities versus in-state facilities. DMMA may wish to consider amending the new third bullet to authorize an "add on" for "activities in the plan of care but not in the per diem".

Thank you for your consideration and please contact SCPD if you have any questions regarding our observations on the final regulation.

cc: Ms. Susan Cycyk, DPBHS
Mr. John McKenna, Rockford Center
Mr. William Mason, Meadowood Hospital
Dr. Paul B. Rothman, Johns Hopkins Hospital
Ms. Carol Oliver, Devereux Behavioral Health
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Center for Medicaid and CHIP Services

CMCS Informational Bulletin

DATE: November 28, 2012

FROM: Cindy Mann, Director
Center for Medicaid and CHIP Services (CMCS)

SUBJECT: Inpatient Psychiatric Services for Individuals under age 21

This Informational Bulletin clarifies that states may structure coverage and payment for the benefit category of inpatient psychiatric hospital or facility services for individuals under age 21(hereinafter referred to as inpatient psychiatric facility benefit) to ensure that children receiving this benefit obtain all services necessary to meet their medical, psychological, social, behavioral and developmental needs, as identified in a plan of care. This clarification is intended to describe flexibility currently available to states to ensure the provision of medically necessary Medicaid services to children in inpatient psychiatric facilities.

Background

Under section 1905(a) of the Social Security Act (the Act), there is a general prohibition on Medicaid payment for any services provided to any individual who is under age 65 and who is residing in an Institution for Mental Diseases (IMD) unless the payment is for inpatient psychiatric hospital services for individuals under age 21 pursuant to section 1905(a)(16) of the Act, as defined in section 1905(h) of the Act. Implementing regulations at 42 Code of Federal Regulation 440.160 and 441 Subpart D define these inpatient psychiatric hospital services as services furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility that meets certain requirements. These requirements include that the services must be provided under the direction of a physician, pursuant to a certification of need and plan of care developed by an interdisciplinary team of professionals, and must involve "active treatment" designed to achieve the child's discharge from inpatient status at the earliest possible time.

The Centers for Medicare and Medicaid Services (CMS) has historically prohibited states from claiming expenditures under the inpatient psychiatric facility benefit unless the expenditures were made to qualified providers of such services. This had the effect of denying coverage for other medically necessary Medicaid items and services, such as prescription drugs or practitioner services that were not included by the state as part of the rate paid to the facility for care. These items and services would be available under other benefit categories for individuals who did not reside in an IMD, such as the benefit for Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and states had separate payment methodologies for such items and services.

Recently, several Departmental Appeals Board decisions have clarified that other covered services can be furnished as part of the inpatient psychiatric facility benefit even when payment was made to an individual practitioner or supplier other than the inpatient psychiatric facility itself, when such services are furnished to a child residing in such a facility, authorized under the child's plan of care, and provided under an arrangement with the facility. In essence, the Departmental Appeals Board indicated that payment for such services does not need to be bundled into a single per diem rate for

the IMD facility, but could be authorized under the approved State plan to be paid directly to the treating practitioner. In light of these decisions, CMS is currently applying this flexibility in the approval of State Plan amendments, and seeks to clarify the ability that states have in covering and paying for a more robust benefit for children receiving the inpatient psychiatric facility benefit.

Services Provided under Arrangement

The inpatient psychiatric facility benefit is defined in part to include a needs assessment and the development of a plan of care specific to meet each child's medical, psychological, social, behavioral and developmental needs. 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. Services being furnished under arrangement do not need to be provided at the psychiatric facility itself if these conditions are met.

Payment for Services Provided under Arrangement

States have a number of options in electing a methodology in their Medicaid State plans to pay for the inpatient psychiatric facility benefit. Traditionally, many states make a direct payment to the facility through either an all-inclusive per diem rate or a base per diem rate with add-on payments. Under this direct payment method, if the facility obtains services under arrangement with outside providers, the facility would be responsible for paying the providers of the arranged services.

An option that may be more flexible, and has been approved in State Plan amendments, 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. States electing this option would pay 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. This option would allow states greater ability to capture potential efficiencies, and monitor the quality of care, through the use of existing delivery and billing processes. States electing to make separate payments under this option will need to assure there is no duplication of payment between the inpatient facility rate and the items paid for separately using existing State plan fees. It is important to note that while the state may directly reimburse individual providers, CMS will require expenditures for all services provided to individuals receiving services through the inpatient psychiatric facility benefit to be reported and claimed on the Mental Health Facility Services line item of the CMS 64 form, and not under the line item applicable to the furnished Medicaid service.

We are ready to work with states to provide assistance in implementing this benefit, and we look forward to our continuing collaboration. If you have questions, please contact Ms. Barbara Edwards, Director, Disabled and Elderly Health Programs Group, at 410-786-7089, or at Barbara.Edwards@cms.hhs.gov.

(r) DISREGARDING PAYMENTS FOR CERTAIN MEDICAL EXPENSES BY INSTITUTIONALIZED INDIVIDUALS

(1)

(A) For purposes of sections 1396a(a)(17) and 1396r–5(d)(1)(D) of this title and for purposes of a waiver under section 1396n of this title, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation payments made by the Federal Republic of Germany, and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this subchapter, subject to reasonable limits the State may establish on the amount of these expenses.

(B)

(i) In the case of a veteran who does not have a spouse or a child, if the veteran—

(I) receives, after the veteran has been determined to be eligible for medical assistance under the State plan under this subchapter, a veteran's pension in excess of $90 per month, and

(II) resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to section 1741(a) of title 38,

any such pension payment, including any payment made due to the need for aid and attendance, or for unreimbursed medical expenses, that is in excess of $90 per month shall be counted as income only for the purpose of applying such excess payment to the State veterans home's cost of providing nursing home care to the veteran.

(ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a veteran who does not have a child in the same manner as they apply to a veteran described in such clause.

(2)

(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1396d(p) of this title may be less restrictive, and shall be no more restrictive, than the methodology—

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under subchapter XVI, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.