

Requirements for Provider Type 01 – Inpatient Psych Unit, Private Psych Hospital and Out-of-State Psych Hospital

Specialty Types

Please choose your Specialty and Code.

011- Private Psychiatric Hospital (In-State and Out-of-State)

022- Private Psychiatric Unit

Provider Eligibility Program (PEPs)

Please choose the appropriate PEP(s) from the following:

- Fee-For-Service
- Non- Waiver Mental Retardation Base Programs
- Pennsylvania Department of Aging (PDA) Waiver and Bridge Program

Send your required documents to:

**DHS Provider Enrollment
PO Box 8045
Harrisburg, PA 17105-8045**

- or -

Fax: (717) 265-8284

- or -

Email: RA-ProvApp@pa.gov

INFORMATION REGARDING AND DOCUMENTATION REQUIRED FOR THE RATE SETTING PROCESS

AS PART OF THE ENROLLMENT PROCESS, THE FOLLOWING
DOCUMENTATION MUST BE RETURNED TO:

DHS DIVISION OF RATE SETTING
P.O. BOX 8047
HARRISBURG, PA 17110-3591

PLEASE NOTE: THE ENROLLMENT PROCESS CANNOT BE COMPLETED WITHOUT SUBMISSION OF THIS
DOCUMENTATION

INPATIENT PSYCHIATRIC FACILITIES ENROLLMENT REQUESTS

The Department utilizes four specific guidelines when evaluating inpatient psychiatric enrollment requests. These guidelines, along with a brief description/explanation of each follow.

1. **The Medical Assistance (MA) Program's Need for Additional Psychiatric Services**

The Department will determine whether the MA Program needs additional psychiatric beds in the applicant's primary service area (i.e., the geographic area where at least 75% of its patients originate) and, if so, whether the applicant has demonstrated to the Department's satisfaction that it will meet that MA Program need.

2. **Applicant Suitability**

The Department will consider, among other things, the record of licensure and Medicare and Medicaid Program participation of the applicant and any owner of the applicant beginning three years prior to the date of the enrollment request.

3. **Economic and Financial Feasibility Without MA Capital Payments**

If an applicant's new beds will be ineligible for capital cost reimbursement, the Department will consider whether the applicant will agree to provide written assurances that the construction of its new or additional beds will be economically and financially feasible without the receipt of MA capital components and that it is not entitled to MA capital component payments related to the new or additional beds.

4. **Employment of Welfare and MA Recipients**

The Department will consider whether an applicant will commit to employ welfare or MA recipients in its new or expanded facility.

In order to facilitate our evaluation, the following information/documentation is required:

1. Documentation Required in Support of the MA Program's Need for Additional Psychiatric Services

(Guideline #1)

- ✓ A project overview which explains how it addresses the Department's goal to develop an array of supports and services that meet the needs of its MA population and why the project meets, or is needed to meet, the inpatient psychiatric service requirements of the community
- ✓ Current and projected occupancy rates, by payer type, in the primary service area
- ✓ The psychiatric bed shortage or surplus in the primary service area
- ✓ Correspondence documenting MA need from human service agencies and provider and advocacy groups
- ✓ Identification of any transportation issues related to the proposal, such as travel time, emergency transportation, etc.
- ✓ Explanation of the design and purpose of the project and the manner in which the project will meet the needs of the population to be served. This explanation should also include a discussion of the physical design and location of the proposed building
- ✓ A staffing plan/schedule, by discipline, of the proposed program, including the relevant areas of staff specialization

**2. Documentation Required in the Support of Applicant Suitability
(Guideline #2)**

- ✓ A list of owners and related parties/entities involved in the project
- ✓ Whether the applicant or any owner is currently precluded from participating in the Medicare Program or any State Medicaid Program
- ✓ Whether the applicant or any owner possessed, operated or managed a facility during the past three years that:
 1. Was precluded from participation in the Medicare or any State Medicaid Program;
 2. Had its license to operate revoked or suspended; or
 3. Was the subject of the imposition of remedies based on the failure to meet applicable Medicare and/or Medicaid Program participation requirements, and the facility's deficiencies immediately jeopardized the health and safety of the facility's residents, or the facility was designated as a "poor performing facility."

If any of numbers one through three above apply, please provide copies of all documents relating to the applicable action, including notices, orders or sanction letters received from the Centers for Medicare and Medicaid Services (CMS) or any State Medicaid, survey or licensing agency.

**3. Documentation Required in Support of Economic and Financial Feasibility without
MA Capital Payments
(Guideline #3)**

- ✓ Copies of any feasibility or market studies and financial projections prepared for the project, including any studies or projections identifying project costs, sources of project funds, projected revenue sources by payer type, including assumptions used and expected occupancy rates by payer type
- ✓ Independent audited financial statements of the applicant and provider, and owners and parent corporation, if any, of the applicant or provider for the most recent year prior to the fiscal year in which the request is filed

**4. Documentation Required in Support of Employment of Welfare and MA Recipients
(Guideline #4)**

- ✓ A written statement indicating whether an applicant will commit to employ welfare or MA recipients in its new or expanded facility

Please submit the above information/documentation, identified in a manner that corresponds with the above guidelines, a copy of a projected MA-336 cost report, a contact person's name, address and telephone number, along with any other information you deem relevant to the following address:

**DHS DIVISION OF RATE SETTING
P.O. BOX 8047
HARRISBURG, PA 17110-3591**

Upon receipt of the information, the Department will contact the facility to acknowledge receipt. The Department will conduct its review and make a final decision as soon as possible.

If your request is approved, the Division of Rate Setting will notify the Department's Enrollment Unit and you will receive written notification that will reflect your new rate.

**DOCUMENTS REQUIRED FOR THE ENROLLMENT OF
INPATIENT PSYCHIATRIC UNIT, PRIVATE PSYCHIATRIC HOSPITAL AND
OUT-OF-STATE PSYCHIATRIC HOSPITAL**

DOCUMENT REQUIRED	PROVIDER TYPE TO BE ENROLLED		
	Inpatient Psychiatric Unit	Private Psychiatric Hospital	Out-of-State Psychiatric Hospital
A copy of an acceptable utilization review plan, written according to the requirements in State Regulations at §1151.72 and Federal Regulations at 42 CFR 456.100. The utilization review plan must be signed by an executive officer	X	X	
A copy of your transfer agreement with a skilled nursing facility, general hospital, and rehabilitation hospital.	X	X	
A signed copy of the Office of Medical Assistance Programs' Provider Enrollment Base Application and Provider Agreement for Inpatient Hospitals and Residential Treatment Facilities. Copy must be signed by an executive officer.	X	X	X
A copy of certification from a deemed accrediting agency: The Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association or Det Norske Veritas Healthcare, Inc.	X	X	X
A copy of the Ownership/Control Interest Form		X	X
A copy of the projected cost report (MA 336).	X	X	X
A copy of your current Medicare certification.		X	X
A copy of the Provider Participation Approval Letter from the Bureau of Fee-for-Service Programs or Letter of Nonreviewability.	X	X	
A copy of the Certificate of Compliance issued by the Office of Mental Health and Substance Abuse Services.	X		
A copy of your home state Medicaid rate letter.			X
A copy of the license as issued by the appropriate state agency.			X
A copy of the ownership or control interest form.		X	X

Contact Person: _____

Title: _____

Telephone Number: _____