CHAPTER 7
ADDENDUM E

GUIDELINES FOR THE CALCULATION OF INDIVIDUAL RESIDENTIAL TREATMENT CENTER (RTC) PER DIEM RATES

A. DATA COLLECTION FORM

1. The TMA Form 771 is designed for the collection of reimbursement data used in the calculation of prospective all-inclusive per diem rates for RTCs seeking certification under the TRICARE/CHAMPUS RTC program. The form will be sent out as part of the RTC certification package encouraging the facility to conduct a preliminary review of the reimbursement methodology prior to completion of the program certification portion of the application. Refer to attached TMA Form 771.

2. The TMA Form 771 is divided into two distinct data collection areas, one dealing with administrative information and the other with reimbursement information.

a. **Administrative Information**. Items 1 through 8 of the form identify the facility and establish the base year period over which the reimbursement data was collected. The Employer Identification Number (EIN) is of particular importance since it identifies the RTC for payment.

b. **Reimbursement Information**. Items 9 through 11 provide the reimbursement data necessary to calculate an all-inclusive prospective per diem rate for applying RTCs. The data represents those reimbursement levels that the RTC was willing to accept from other third-party payers during its base period. This allows the establishment of a per diem rate which reflects a reasonable amount consistent with rates charged by its peers nationally and with reimbursement it is accepting from other third-party payers.

B. ADMINISTRATIVE SUPPORT

1. The reviewer will provide the name and telephone number of a contact person that can provide additional help and instruction in filling out the data request form.

2. Examples of rate calculations are useful in establishing a conceptual understanding of the per diem methodology and for allowing the RTC to approximate its rates. These examples should include, but not be limited to, the following reimbursement concepts/issues:

a. 33-1/3 percent rule.

b. All-inclusive rate.

c. Charges allowed outside all-inclusive rate.

d. Rate updates.

e. Open vs. closed staffing models.

C. REVIEW AND ANALYSIS OF SUBMITTED INFORMATION

1. Conduct a preliminary review of the information/data submitted on the TMA Form 771 paying particular attention to the opening and data collection start dates. The data collection start date for RTCs which were in operation during the entire base period (July 1, 1987 thru June 30, 1988) will be July 1, 1987. The data collection start date should be the same as the opening date for facilities who began operation after June 30, 1988, or began operation before July 1, 1988, but had less than 6 months of operation by July 1, 1988, since the RTC's base period would be its first 12 months of operation. If the dates are not the same, follow the guidelines below:

a. Contact the person designated in Item #4 of TMA Form 771 for clarification regarding the discrepancy.

b. If the discrepancy resulted from a transcription error, correct the error and proceed with the review.

c. If the discrepancy did not result from a transcription error, have the RTC submit revised data encompassing the correct data collection period (i.e., data collected over the first 12 months of operation).

2. The reimbursement sections (Items 9 through 10) should be reviewed to make sure the submitted information is complete and correctly formatted. The data contained in these sections will be used to figure the RTC's prospective all-inclusive per diem rate and will be the basis for all future rates. The following are the data element requirements under each of these sections:

a. Item #9. This section requests information on all third-party payers establishing or affecting an RTC's rates during its specified base period. It includes the following reimbursement information:

(1) Name, address and telephone number of each payor for whom a rate was established/accepted. This information is important for verification of rates under Items 9 thru 11, especially in the case of state patients where there is often a negotiated contract. If the state rate represents 33-1/3 percent of total patient days, it might be advisable for the reviewer to request copies of these contracts in order to verify the negotiated rates in effect during the RTCs base period. However, the reviewer will be given discretion in setting its own review parameters for requesting supporting documentation.

(2) The rates accepted from each third-party payor during the RTC's designated base period. The accepted rates should not be confused with actual charged amounts. It is not uncommon to bill third-party payers amounts in excess of their allowed charges knowing payment will be less than the charged amounts. The allowed charge represents the amount the facility is willing to accept from a payor for RTC care. A determination will have to be made whether the listed facility rates represent total daily

charges (i.e., represent an all-inclusive rate) or only the institutional component of the accepted rate using the following guidelines:

(a) If there are no additional charges listed under Item #10, the facility rates appearing in Item #9 are to be determined as all-inclusive, and as such, represent payment in full for all mental health services provided within the RTC (both professional and institutional).

(b) If additional charges are listed under Item #10, a determination must be made on whether they apply to all of the third-party payers appearing in Item #9; i.e., whether all of the third-party payers allow payment of additional services above the facility rates listed in Item #9. The reviewer should note that where state or local agencies are involved most of their reimbursement is based on flat per diem rates. The reviewer should contact the RTC if there is any question regarding the applicability of Item #10 charges to any one of the listed third-party payers.

(3) The number of patient days provided/paid at each accepted rate. Cumulative patient days will be used in determining the rate high enough to cover at least one-third of the total patient days subject to the cap amount.

b. Item #10. This section requests information on the payment of any additional services allowed outside the facility rates recorded under item #9. The sum of these charges will be added to the facility rate in calculating the TRICARE all-inclusive per diem rate. The RTC must provide the methodology (the actual calculations) used in establishing the charge per patient day (PPD) for each of the services listed in this section.

(1) Required Data Elements.

(a) The service for which additional payment is allowed.

(b) The frequency of the service.

(c) The accepted charge/rate per service.

(d) The accepted charge/rate per patient day.

(2) The following are examples of services which might be allowed for payment outside the facility rates reflected in Item #9:

(a) Admission history and physical.

(b) Medical visits for physical illness or injury.

(c) Lab drug testing.

(d) EKG.

(e) Family therapy.

(f) Pharmaceuticals.

(g) Individual and group psychotherapy.

c. Item #11. This section pertains to the payment of educational services in an RTC. Educational charges are excluded from payment under the prospective per diem system. If the RTC indicates that educational charges are included within the facility rate, they must be removed prior to establishing the TRICARE all-inclusive rate. The educational rate/charge per patient per day reported in Item #11.b will be subtracted from the overall facility rate. Payment of educational services may be paid apart from the facility per diem as long as the services have been authorized by the reviewer. The RTC may provide educational services to its children under the following arrangements:

(1) The RTC has its own educational program whereby it bills for the entire educational component, incorporating facility and professional costs (i.e., bills for teachers, books, supplies, classroom facilities, etc.).

(2) The RTC has an agreement with its local school district to share in the education of its children. In most cases the local school district agrees to supply the teachers while the RTC provides the classrooms. The RTC only bills for the facilities charges.

(3) The local school district accepts total responsibility for educating the RTC children. No educational charges are billed since the children attend public school during the day.

3. The data collected and used to establish RTC per diem rates will be retained indefinitely.

D. BASE YEAR CALCULATIONS

1. For RTCs new to the TRICARE program, one of the following two alternative methods will be used in determining their individual rates:

a. The rates for an RTC which was in operation during the base period (July 1, 1987 through June 30, 1988) will be calculated based on the actual charging practices of the RTC during the 12 months ending July 1, 1988. The individual RTC rate will be the lower of either the TRICARE/CHAMPUS rate in effect on June 30, 1988, or the rate high enough to cover at least one-third of the total patient days of care provided by the RTC during the 12 months ending July 1, 1988 subject to a maximum cap.

b. The rates for an RTC which began operation after June 30, 1988, or began operation before July 1, 1988, but had less than 6 months of operation by July 1, 1988, will be based on the actual charging practices during its first 6 to 12 consecutive months, with 6 months being the minimum time in operation for certification under the TRICARE program. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available, the rate should be recalculated using the additional reimbursement data. The rates would be calculated the same as in paragraph a. above, except a different base period would be used.

2. The following methods are used in establishing the maximum capped per diem amounts:

a. Prior to April 6, 1995, the capped per diem amount was set at the 75th percentile of all established TRICARE RTC rates nationally and weighted by total TRICARE/CHAMPUS days provided at each rate during the base period (July 1, 1987, through June 30, 1988). The capped amount was adjusted annually (on October first of each year) by the CPI-U for medical care. The following are the capped amounts in effect since December 1, 1988:

RTC CAPPED AMOUNTS

DATES OF SERVICE		CAPPED AMOUNTS
December 1, 1989	- September 30, 1989	$355
October 1, 1989	- September 30, 1990	373
October 1, 1990	- September 30, 1991	408
October 1, 1991	- September 30, 1992	444
October 1, 1992	- September 30, 1993	477
October 1, 1993	- September 30, 1994	506
October 1, 1994	- April 5, 1995	530
April 6, 1995	- September 30, 1997	515
October 1, 1997	- September 30, 1998	515
October 1, 1998	- September 30, 1999	528

b. The 70th percentile of the day-weighted current (FY95) per diems was used in establishing a new cap amount for services rendered on or after April 6, 1995. The following methodology was used in establishing the RTC cap and floor amounts:

(1) RTC institutional claims data from the period 10/01/1993 to 03/31/1994 were used (the first half of FY94).

(2) The FY94 per diems were merged onto the claims (from the RTC per diem list in the Policy Manual) and updated by 1.046 (the CPI-U) to represent FY95 per diems.

(3) The 30th and 70th percentiles of the day-weighted FY95 per diems were calculated as $429 and $515. Any RTC per diem above $515 was cut to $515 as of April 6, 1995.

E. ADJUSTMENT OF BASE YEAR RATE

1. The base year rate is adjusted by the following annual inflation factors [Consumer Price Index - Urban Wage Earner (CPI-U) for medical care] to bring it forward to the current fiscal year (FY):

UPDATE FACTORS FOR RTC PER DIEM RATES

TIME PERIOD		CPI-U INFLATION FACTORS
July 1, 1988	- November 30, 1988	2.6%
December 1, 1988	- July 30, 1989	4.9
October 1, 1989	- September 30, 1990	9.2
October 1, 1990	- September 30, 1991	8.6
October 1, 1991	- September 30, 1992	7.4
October 1, 1992	- September 30, 1993	6.0
October 1, 1993	- September 30, 1994	4.6
October 1, 1994	- September 30, 1995	4.4
October 1, 1995	- September 30, 1996	3.6
TIME PERIOD		**MEDICARE UPDATE FACTOR**
October 1, 1996	- September 30, 1997	0.0
October 1, 1997	- September 30, 1998	2.4

2. If the RTC's base year falls within the previous year's reporting period, the inflation factor is prorated for the remaining time in that period. The updating process can best be demonstrated through the following example:

EXAMPLE: RTC E is submitting reimbursement information as a final step in its certification process. The data was collected over the facility's first 12 months of operation (April 1, 1991 thru March 31, 1992). Since the RTC's base period extended 6 months (or 180 days, based on 30-day months and a 360-day year) into the inflation reporting period, the inflation factor for the subsequent update year (October 1 thru September 30) was prorated for the remaining time period of May 1, 1992 thru September 30, 1992 (6 months or 180 days). The following are the calculations used in updating the RTC's all-inclusive base year per diem to FY96 (current year per diem amount):

ADJUSTMENT OF BASE YEAR PER DIEM RATE	
Derived rate at 33.33 percent of total patient days during base period of April 1, 1991 through March 31, 1992.	$320.00
Plus:	
Consumer Price Indices - Urban Wage Earner for medical care [CPI-U (medical)]:	
For 6-month period ending September 30, 1992 (7.4% x 6/12 = 3.7 percent)	11.84
Adjusted Rate	$331.84

ADJUSTMENT OF BASE YEAR PER DIEM RATE (CONTINUED)	
For 12-month period ending September 30, 1993 (6.0 percent)	19.91
Adjusted Rate	$351.75
For 12-month period ending September 30, 1994 (4.6 percent)	16.81
Adjusted Rate	$367.93
For 12-month period ending September 30, 1995 (4.4 percent)	16.19
Adjusted Rate	$384.12
TRICARE all-inclusive per diem rate for services on or after October 1, 1995	$385.00

3. In a final rule published in the Federal Register (60 FR 12419) on March 7, 1995, TRICARE imposed a two-year moratorium on the annual updating of RTC per diems rates subject to the following provisions:

a. TRICARE payments will remain at FY95 rates for a two-year period beginning in FY96, for any RTC whose 1995 rate was at or above the 30th percentile of all established FY95 rates ($429).

b. For any RTC whose FY95 rate was below that of the 30th percentile, the rate will be adjusted by the lesser of the CPI-U, or the amount that brings the rate up to the 30th percentile level.

c. For fiscal years after FY97, the individual facility rates and cap amount will be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system at the discretion of the Executive Director, TRICARE Management Activity (TMA) or designees.

NOTE: The above provisions will lead to aggregate expenditures which approximate average facility costs. The 4.4 percent update factor was used in the RTC rate computation since its FY95 rate ($368) was below the 30th percentile level ($429).

F. CALCULATION OF RTC PER DIEM RATE

1. Array the rates accepted by other third-party payers (Item #9) in descending order from lowest to highest in the first column of the Reimbursement Information Work Sheet (see Attachment B).

2. Place the number of days paid at each of the rates listed above in the second column of the work sheet.

a. If there is more than one rate with an individual third-party payor during the base period, the RTC must provide the total number of patient days paid by the payor at each rate. Total patient days will be used in determining the most favored rate for the facility. The

following is an example of multiple rates paid by an individual payor during the RTC's base period:

EXAMPLE: RTC F has negotiated three separate rates with a third-party payor over its base period. The three rates were reported as follows:

1. $295/day from July 1993, through October 31, 1993 - 2000 patient days;

2. $315/day from November 1, 1993, through February 29, 1994 - 3000 patient days;

3. $330/day from March 1, 1994, through June 30, 1994 - 2000 patient days.

b. Each of the above negotiated rates would be reported separately in Item #9 of the TMA Form 771 representing a blending of payments made by a particular payor over a facility's base period.

c. Patient days would be combined in those situations where third-party payers were paying the same rate for RTC care. This would represent the cumulative frequency of payments made at each reported reimbursement level in Item #9 of the data collection form.

d. The following examples represent the methodology used in calculating the TRICARE base year facility rate from data provided under Item #9 of the TMA Form 771:

EXAMPLE: RTC G provided the following third-party reimbursement data under Item #9 of the TMA Form 771 as part of the certification process:

ITEM #9 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

THIRD-PARTY PAYERS	RATE ACCEPTED	PATIENT DAYS
AA	$253	312
BB	527	207
CC	402	163
DD ***	212	198
EE	454	371
FF	603	118
GG	317	446
HH	489	538
II	552	319
JJ	503	132

***** - State or local government agency.**

STEP 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate:

(1) RATES	(2) PATIENT DAYS	(3) CUMULATIVE PATIENT DAYS	(4) PERCENT CUMULATIVE PATIENT DAYS
$212	198	198	7.1%
253	312	510	18.2
317	**446**	**956**	**34.1**
402	163	1,119	39.9
454	371	1,490	53.1
489	538	2,028	72.3
503	132	2,160	77.0
527	207	2,367	84.4
552	319	2,686	95.8
603	118	2,804	100.0
Total	**2,804 Patient Days**		

STEP 2: Sum the patient days in column 2, which in this particular example equals 2,804 patient days.

STEP 3: Calculate 33-1/3 percent of the total patient days by multiplying total patient days figured in Step #2 by .3333.

(2,804 patient days x .3333 = 934.57 patient days)

STEP 4: Go down in the cumulative patient day column (column 3) to where 33-1/3 percent of the patient days lie (934.57).

STEP 5: Go across to the rate in column 1 in which 33-1/3 of the cumulative patient days fall. This represents the base year/period facility rate. The base year/period rate in this example would be $317 (refer to table above).

EXAMPLE: RTC H provided the following third-party reimbursement data under Item #9 of the TMA Form 771 as part of the certification process:

ITEM #9 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

THIRD-PARTY PAYERS	RATE ACCEPTED	PATIENT DAYS
AA	$425	201

***** - State or local government agency.**

ITEM #9 OF TMA FORM 771 (MODIFIED FOR EXAMPLE) (CONTINUED)

THIRD-PARTY PAYERS	RATE ACCEPTED	PATIENT DAYS
BB ***	288	600
CC ***	235	63
DD ***	215	1,040
EE	365	276
FF	515	168
GG ***	288	346
HH	489	538
II	425	319
JJ	450	132

***** - State or local government agency.**

STEP 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate:

(1) RATES	(2) PATIENT DAYS	(3) CUMULATIVE PATIENT DAYS	(4) PERCENT CUMULATIVE PATIENT DAYS
$215	1,040	1,040	28.2
235	63	1,103	29.9
288	**946**	**2,049**	**55.6**
365	276	2,325	63.1
425	520	2,845	77.2
450	132	2,977	80.8
489	538	3,515	95.4
515	168	3,683	100.0
Total	**3,683 Patient Days**		

STEP 2: Sum the patient days in column 2, which in this particular example equals 3,683 patient days.

STEP 3: Calculate 33-1/3 percent of the total patient days by multiplying total patient days figured in Step #2 by .3333.

(3,683 patient days x .3333 = 1,227.54 patient days)

STEP 4: Go down in the cumulative patient day column (column 3) to where 33-1/3 percent of the patient days lie (1,227.54).

STEP 5: Go across to the rate in column 1 in which 33-1/3 of the cumulative patient days fall. This represents the base year/period facility rate. The base year/period rate in this example would be $218 (refer to table above).

3. The above methodology for deriving the rate at 33-1/3 of the total patient days would only be applicable under the following conditions:

a. If the rates in Item #9 were all-inclusive for payment of RTC care (i.e., included all payments for institutional and professional services), no additional charges would be added on to the facility rates from Item #10 of the data collection form. The rate established in Step #5 of the above examples would represent the all-inclusive base year rate prior to the inflationary adjustment.

b. If the charges for additional services listed in Item #10 applied to all of the third-party payers identified in Item #9 (i.e., all of the third-party payers listed in Item #9 allowed payment for additional services outside the facility rate -- rate derived at 33-1/3 percent of total RTC patient days during the base period -- at the charges per patient day established in Item #10), the sum of these charges are added to the facility rate prior to inflationary adjustment.

4. In cases where payment of additional services listed in Item #10 do not apply to all of the third-party payers listed in Item #9, or payments vary among the payers for the same services, the sum of the charges per patient day for additional services (reported in the last column of item #10) must be added to the facility rate prior to establishing the rate derived at 33-1/3 percent of the total patient days. The following example provides the methodology for incorporating these additional charges into the base year rate computations:

EXAMPLE: RTC I has provided a revised TMA Form 771 indicating that payments for additional services had been overlooked in completing its initial form. The following service charges per patient day were provided under Item #10 with the proviso that the additional payments were not allowed by the three state agencies and two private third-party providers. The payers were identified in Item #9 of the form.

ITEM #10 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

PATIENT SERVICE	FREQUENCY OF SERVICE	CHARGE PER SERVICE	CHARGE PER DAY (PPD)
Individual Therapy	1/wk	$120.00	$17.14
Group Therapy	2/wk	45.00	12.86
Admission History and Physical	1/stay	150.00	1.43
Pharmacy	($10,438/2,498 days)		4.18
Psych. Testing	28	650.00	7.29
			Total $42.90

NOTE: The RTC's average length-of-stay was 105 days during its base period.

ITEM #9 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

THIRD-PARTY PAYERS	RATE ACCEPTED	PATIENT DAYS
AA	$383	114
BB **	165 ***	313
CC **	268	102
DD **	204 ***	485
EE	365	232
FF	471 ***	117
GG **	265 ***	346
HH	489	338
II	425 ***	319
JJ	425	132

**** - State or local government agency.**
***** - Rates represent entire payment for RTC services. Charges for additional services reported in Item #10 not applied to these designated third-party payor rates.**

(1) RATES	(2) ADDITIONAL PAYMENTS	(3) PATIENT DAYS	(4) CUMULATIVE PATIENT DAYS	(5) PERCENT CUMULATIVE PATIENT DAYS
$165	$N.A.	313	313	12.5%
204	N.A.	485	798	31.9
265	**N.A.**	**346**	**1,144**	**45.8**
268	42.90	102	1,246	49.9
365	42.90	232	1,478	59.2
425	N.A.	319	1,797	71.9
383	42.90	114	1,911	76.5
425	42.90	132	2,043	81.8
471	N.A.	117	2,160	86.5
489	42.90	338	2,498	100.0
Total	**2,498 Patient Days**			

STEP 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate.

STEP 2: Sum the patient days in column 3, which in this particular example equals 2,498 patient days.

STEP 3: Calculate 33-1/3 percent of the total patient days by multiplying total patient days figured in Step #2 by .3333.

STEP 4: (2,498 patient days x .3333 = 832.58 patient days)

STEP 5: Go down in the cumulative patient day column (column 4) to where 33-1/3 percent of the patient days lie (832.48).

STEP 6: Go across to the rates in column 1 & 2 in which 33-1/3 of the accumulative patient days fall. This represents the TRICARE all-inclusive base year/period rate. The base year/period rate in this example would be $265 (refer to table above).

5. If the RTC answers no to Item #11.a., the educational rate/charge per patient day reported in Item #11.b must be subtracted from the overall facility base year/period rate.

6. Personal item charges must also be subtracted from the all-inclusive base year/period prior to inflationary adjustment.

EXAMPLE: RTC J checked no in Item #11.a. of the TMA Form 771 reporting an educational rate/charge per patient day in Item #11.b. The RTC also reported a $1 per patient day charge for personal items.

Accepted Rate at 1/3 of Patient Day	$350
Plus:	
Other Service Charges	45
Less:	
Personal Items	1
Education	20
All-Inclusive Base Period Rate Prior to Inflationary Adjustment	$374/day

7. The following is a detailed example of an RTC per diem calculation incorporating all of the data elements reported on the TMA Form 771 including inflationary adjustments:

EXAMPLE: RTC K submitted the following reimbursement information as part of the certification process:

DATA REVIEW & ANALYSIS

ITEM	DATA REQUESTED	DATA REPORTED
2	EIN	38-1734578

DATA REVIEW & ANALYSIS (CONTINUED)

ITEM	DATA REQUESTED	DATA REPORTED
5	Opening Date	June 1, 1990
6	JCAHO Accreditation	October 31, 1992
7	Data Collection Dates	June 1, 1990 - May 31, 1991

ITEM #9 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

THIRD-PARTY PAYORS	RATE ACCEPTED	PATIENT DAYS
AA	$285	214
BB	453	102
CC	314	371
DD	388	163
EE	502	118
FF	314	246
GG	489	138
HH	402	319

ITEM #10 OF TMA FORM 771 (MODIFIED FOR EXAMPLE)

PATIENT SERVICE	FREQUENCY OF SERVICE	CHARGE PER SERVICE	CHARGE PER DAY (PPD)
Individual Therapy	1/wk	$ 90.00	$12.86
Group Therapy	1/wk	45.00	6.43
Family Therapy	1/2wks	65.00	4.64
Admission History and Physical	1/stay	($175/120 ALOS)	1.46
Pharmacy	($5,638/1,671 days)		3.38
Psych. Testing	28	650.00	6.28
			Total $35.05

Item #11. EDUCATIONAL CHARGES:

a. Are educational charges excluded from the daily rate when billing TRICARE/CHAMPUS?

YES X NO ____

b. What is the educational rate/charge per patient per day in your facility?

$37.00 per patient day

BASE YEAR/PERIOD RATE CALCULATION

STEP 1: Array the rates in descending order from lowest to highest with corresponding patient days paid at each rate:

(1) RATES	(2) PATIENT DAYS	(3) CUMULATIVE PATIENT DAYS	(4) PERCENT CUMULATIVE PATIENT DAYS
$285	214	214	12.8%
314	**617**	**831**	**49.7**
388	163	994	59.5
402	319	1,313	78.6
453	102	1,415	84.7
489	138	1,553	92.9
502	118	1,671	100.0
Total	**1,671 Patient Days**		

STEP 2: Sum the patient days in column 2, which in this particular example equals 1,671 patient days.

STEP 3: Calculate 33-1/3 percent of the total patient days by multiplying total patient days figured in Step #2 by .3333.

STEP 4: (1,671 patient days x .3333 = 556.94 patient days)

STEP 5: Go down in the cumulative day column (column 3) to where 33-1/3 percent of the patient days lie (556.94).

STEP 6: Go across to the rate in column 1 in which 33-1/3 of the cumulative patient days fall. This represents the base year/period facility rate. The base year/period facility rate in this example would be $314 (refer to table above).

STEP 7: Add the sum of the charges per patient day reported in Item #10 of the Form 771 ($35.05/patient day) to the base year/period facility rate figured in Step #5 since additional payments are allowed for all the listed third party payers in Item #9. The base year/period all-inclusive per diem rate is $349.05.

STEP 8: Subtract any educational and/or personal item charges which are included in the all-inclusive base year/period rate calculated in Step #6. This does not apply in this particular example since there are no personal item and/or educational charges included in the base year/period facility rate.

INFLATIONARY ADJUSTMENTS

STEP 1: Adjust the base year rate by the annual inflation factors [Consumer Price Index - Urban Wage Earner (CPI-U) for medical care] to bring it forward to the current fiscal year (FY) as follows:

ADJUSTMENT OF BASE YEAR PER DIEM RATE	
Derived rate at 33.33 percent of total patient days during base period of June 1, 1990 thru May 31, 1991	$349.05
Plus:	
Consumer Price Indices - Urban Wage Earner for medical care [CPI-U (medical)]:	
For 4-month period ending September 30, 1991 (2.9 percent) (7.4% x 4/12 - 2.9%)	10.13
Adjusted Rate	$359.18
For 12-month period ending September 30, 1992 (7.4 percent)	26.58
Adjusted Rate	$385.76
For 12-month period ending September 30, 1993 (6.0 percent)	23.15
Adjusted Rate	$408.90
For 12-month period ending September 30, 1994 (4.6 percent)	18.81
Adjusted Rate	$427.71
For 12-month period ending September 30, 1995 (4.4 percent)	18.82
Adjusted Rate	$446.53***
TRICARE/CHAMPUS all-inclusive per diem rate for services on or after October 1, 1995.	$429.00

*** FY95 rate below that of the 30th percentile level ($429) will be adjusted by the lesser of the CPI-U, or the amount that brings the rate up to the 30th percentile level.

ATTACHMENT:
TMA Form 771

TMA FORM 771

INSTRUCTIONS FOR SUBMITTING REIMBURSEMENT INFORMATION FOR PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS SERVING CHILDREN AND ADOLESCENTS

This reimbursement information will be used to compute a Residential Treatment Center's (RTC) all-inclusive rate under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This rate of reimbursement will reflect a reasonable amount consistent with rates charged by RTCs nationally and with reimbursement already accepted from other third-party payors. All requested information will be subject to on-site verification by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) or its representatives. In accordance with Article 6 of the current CHAMPUS RTC participation agreement, failure to provide all the requested information may result in denial of an application for CHAMPUS certification or termination of a current agreement.

Administrative Information:

Items 1 through 8 identify the facility and establish the base period parameters for calculating the individual RTC's rate. It is important that the contact person designated in item 2 be familiar with the methodology used in collection of the data. This person may be contacted at a future date if OCHAMPUS should have any questions regarding the submitted information. In items 5 through 7, provide the most recent/current dates for the information requested. Failure to do so may result in a base period that is inconsistent with the operation of your facility.

Reimbursement Information:

Item 9: For the period July 1, 1987, through June 30, 1988, provide the name, mailing address, and telephone number of all third-party payors for whom a rate was established and what the accepted rate was, and the number of patient days actually provided at that rate. At a minimum, this is to include all federal, state or local government agencies (including CHAMPUS), and other private third-party payors. Also include the rate charged the general public and the number of days actually provided at that rate. Individual private payors do not need to be identified.

The data requirements for RTCs beginning operation after July 1, 1988, or beginning operation before July 1, 1988, but having less than 12 months of operation by July 1, 1988, are identical to the data requirements for those facilities in operation during the entire base period, with the exception of the time frame for which the data is to be provided. The data must be provided for the first 6 to 12 months of operation, with 6 months being the absolute minimum for new facilities. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available the rate shall be recalculated and applied prospectively. If the data only covers a portion of the base period, give the dates. If there is more than one rate with an individual third-party payor during the base period, provide the total number of patient days paid by that payor at each rate during the base period. Total patient days will be used in determining the most favored rate for your facility. The following is an example of how to handle multiple third-party rates over your base period:

An RTC had negotiated three separate rates with a third-party payor over its base period. The three rates would be reported as follows:

(1) $195/day from July 1, 1987, through October 31, 1987 - 2000 patient days;

(2) $215/day from November 1, 1987, through February 29, 1988 - 3000 patient days;

(3) $230/day from March 1, 1988, through June 30, 1988 - 2000 patient days.

In this example the total number of days paid by the third-party payor is 7000.

If the RTC was in operation during the base period, provide the requested data for the entire period regardless of change in ownership: for example, if your facility was in operation during the base period (July 1, 1987, through June 30, 1988), but was taken over by a national mental health corporation as of January 1, 1988, provide the requested data from July 1, 1987, through June 30, 1988, along with date of change of ownership. Failure to provide the entire base period data will result in delay in establishing your new rate.

CHAMPUS FORM 771, JUNE 1991

TMA FORM 771 (CONTINUED)

INSTRUCTIONS FOR SUBMITTING REIMBURSEMENT INFORMATION FOR PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS SERVING CHILDREN AND ADOLESCENTS

This reimbursement information will be used to compute a Residential Treatment Center's (RTC) all-inclusive rate under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This rate of reimbursement will reflect a reasonable amount consistent with rates charged by RTCs nationally and with reimbursement already accepted from other third-party payors. All requested information will be subject to on-site verification by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) or its representatives. In accordance with Article 6 of the current CHAMPUS RTC participation agreement, failure to provide all the requested information may result in denial of an application for CHAMPUS certification or termination of a current agreement.

Administrative Information:

Items 1 through 8 identify the facility and establish the base period parameters for calculating the individual RTC's rate. It is important that the contact person designated in item 2 be familiar with the methodology used in collection of the data. This person may be contacted at a future date if OCHAMPUS should have any questions regarding the submitted information. In items 5 through 7, provide the most recent/current dates for the information requested. Failure to do so may result in a base period that is inconsistent with the operation of your facility.

Reimbursement Information:

Item 9: For the period July 1, 1987, through June 30, 1988, provide the name, mailing address, and telephone number of all third-party payors for whom a rate was established and what the accepted rate was, and the number of patient days actually provided at that rate. At a minimum, this is to include all federal, state or local government agencies (including CHAMPUS), and other private third-party payors. Also include the rate charged the general public and the number of days actually provided at that rate. Individual private payors do not need to be identified.

The data requirements for RTCs beginning operation after July 1, 1988, or beginning operation before July 1, 1988, but having less than 12 months of operation by July 1, 1988, are identical to the data requirements for those facilities in operation during the entire base period, with the exception of the time frame for which the data is to be provided. The data must be provided for the first 6 to 12 months of operation, with 6 months being the absolute minimum for new facilities. A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available the rate shall be recalculated and applied prospectively. If the data only covers a portion of the base period, give the dates. If there is more than one rate with an individual third-party payor during the base period, provide the total number of patient days paid by that payor at each rate during the base period. Total patient days will be used in determining the most favored rate for your facility. The following is an example of how to handle multiple third-party rates over your base period:

An RTC had negotiated three separate rates with a third-party payor over its base period. The three rates would be reported as follows:

(1) $195/day from July 1, 1987, through October 31, 1987 - 2000 patient days;

(2) $215/day from November 1, 1987, through February 29, 1988 - 3000 patient days;

(3) $230/day from March 1, 1988, through June 30, 1988 - 2000 patient days.

In this example the total number of days paid by the third-party payor is 7000.

If the RTC was in operation during the base period, provide the requested data for the entire period regardless of change in ownership; for example, if your facility was in operation during the base period (July 1, 1987, through June 30, 1988), but was taken over by a national mental health corporation as of January 1, 1988, provide the requested data from July 1, 1987, through June 30, 1988, along with date of change of ownership. Failure to provide the entire base period data will result in delay in establishing your new rate.

CHAMPUS FORM 771, JUNE 1991

TMA FORM 771 (CONTINUED)

REIMBURSEMENT INFORMATION

OMB No: 0704-0295
Expires: 31 January 1994

PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS SERVING CHILDREN AND ADOLESCENTS

Public reporting burden for this collection of information is estimated to average 12 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0295), Washington, DC 20503.

1. FACILITY NUMBER:	2. EIN:
3. FACILITY NAME AND ADDRESS: TELEPHONE NUMBER: ( )	4. NAME OF PERSON PREPARING DATA: TITLE:

5. DATE CURRENT RTC PROGRAM OFFICIALLY OPENED FOR BUSINESS:

6. DATE OF MOST RECENT JOINT COMMISSION ON ACCREDITATION OF HEALTH ORGANIZATIONS (JCAHO) ACCREDITATION:

7. DATE OF CURRENT AUTHORIZATION AS A CHAMPUS CERTIFIED RTC:

8. DATES OVER WHICH DATA WAS COLLECTED: _____ TO _____.

9. THIRD-PARTY PAYORS ESTABLISHING OR AFFECTING RATES: Data requirements should be carefully reviewed and presented in the following format. (If additional sheets are required, copy the format and attach all completed sheets.)

NAME, ADDRESS AND TELEPHONE NUMBER OF EACH PAYOR	RATE ACCEPTED	PATIENT DAYS PROVIDED AT EACH RATE

CHAMPUS FORM 771, JUNE 1991

TMA FORM 771 (CONTINUED)

10 ADDITIONAL SERVICES: Identify each individual service not included in Item #9 (If additional sheets are required, copy the format below and attach all completed sheets.

SERVICE	FREQUENCY OF SERVICE	CHARGE PER SERVICE	CHARGE PER PATIENT DAY (PPD)

11. EDUCATIONAL CHARGES:

a. Are educational charges excluded from the daily rate when billing CHAMPUS:
YES ____ NO ____

b. What is the educational rate/charge per patient per day in your facility?
$_____ per patient day.

I declare that I have examined the above information and all attachments, and to the best of my knowledge and belief, they are true, correct and complete.

_____
Signature Date

_____
Name (Typed or Printed)

_____
Title

RETURN COMPLETED FORM TO: OCHAMPUS
PROGRAM INITIATIVES BRANCH
AURORA, COLORADO 80045-6900

CHAMPUS FORM 771, JUNE 1991