APPENDIX E COMMUNITY RESIDENCES FOR PERSONS WITH MENTAL ILLNESS Established 3/1/88
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1000 PURPOSE

The purpose of Appendix E is to identify reimbursement regulations that are specific to residential treatment facilities for persons with mental illness. The general provisions of MaineCare Benefits Manual, Chapter III, Section 97, PNMI services contain reimbursement regulations that are applicable to all categories of service under the PNMI regulations. It shall be the prerogative of the Commissioner of the Department of Health and Human Services to impose a ceiling on reimbursement for private non-medical institutions. This Appendix identifies which costs are reimbursable within Section 97, Chapter II and III, Private Non-Medical Institution Services of the MaineCare Benefits Manual. These regulations apply to reimbursement for PNMI services beginning the first day of the provider's fiscal year beginning on or after July 1, 2001.

1200 AUTHORITY

The authority of the Department of Health and Human Services to accept and administer funds that may be available from State and Federal sources for the provision of services set forth in these Principles of Reimbursement is contained in 22 M.R.S.A. §42, §3173.

1210 DEFINITIONS

The term resident as used throughout Appendix E refers to an individual who has been determined to be eligible for MaineCare by the Department of Health and Human Services and who is receiving mental health treatment and/or rehabilitative services and/or personal care services as a resident of a residential treatment facility for persons who experience mental illness, as defined in Section 97.01-1 (C) of the MaineCare Benefits Manual.

Effective 5/15/10

The term "facilities" as used throughout Appendix E refers to residential treatment facilities for persons who experience mental illness, or residences for the integrated treatment of persons with dual disorders, as defined in Section 97.01-1(C) of the MaineCare Benefits Manual. Scattered site housing is not covered under this Section of policy as of August 1, 2009.

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2400 ALLOWABILITY OF COST

2400.1 Allowable costs shall include salaries and wages for direct service staff and services listed below:

Physicians
Psychiatrists
Psychologists
Social workers
Psychiatric nurses
Psychological examiners
Occupational therapists
Other qualified mental health staff
Personal care service staff
Clinical consultants
Licensed substance abuse staff
Licensed clinical professional counselors
Licensed professional counselors
Other qualified alcohol and drug treatment staff, as defined in Chapter II, Section 97.07-2, of the MaineCare Benefits Manual.

It is the responsibility of the PNMI to provide and coordinate all covered services performed by direct care staff listed in this Section to assure that members receive the full range of services necessary to meet members' needs without duplication of services. See MaineCare Benefits Manual (MBM), Chapter II, Section 97, Sections 97.04 and 97.05 regarding covered services and non-duplication of services.

2400.11 The Department shall determine the reasonableness of the treatment costs on an annual basis.

2400.2 Allowable costs shall also include the taxes and fringe benefits, as defined in Chapter III, Section 2400.2.

2400.4 Allowable costs will also include the contract fee paid for use of exchange fellows in lieu of direct service staff as defined in the applicable appendix. Contract fees must be prior-approved by the Department. The contract fee paid cannot exceed the normal salary plus benefits and taxes for comparable direct service staff within the provider agency.

2410 As of July 1, 2004, allowable costs shall include a State-mandated service tax. The State- mandated service tax is a 5% tax on the value of PNMI services.

2450 A program allowance of 35%, expressed as a percentage of the allowable costs in Sections 2400.1 through 2410 will be allowed in lieu of indirect and/or PNMI related cost. The program allowance, as set forth in Chapter III, Section 97, is a percentage specific to this Appendix and is applicable to all facilities covered under this Appendix.

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2400 ALLOWABILITY OF COST (cont.)

2460 The total allowable costs shall be allocated to rehabilitation and to personal care.

2500 NON-ALLOWABLE COSTS

A non-allowable cost includes all costs not included in Section 2400.

3400 SETTLEMENT OF COST REPORTS

3400.1 Uniform Desk Review

3400.11 The Division of Audit shall perform a uniform desk review of each acceptable cost report submitted.

3400.12 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, and allowable costs.

3400.13 Based on the results of the uniform desk review, the Division of Audit shall:

1. Request more information
2. Issue a final settlement, or
3. Conduct a field audit and issue a final settlement.

3400.2 Calculation of Final Settlement

3400.21 The total actual costs of the facility shall be determined in accordance with Section 2400 in Chapter III and this Appendix.

3400.22 The total cost cap approved in the facility budget shall be determined in accordance with Section 6000 of this Appendix.

3400.23 The allowable cost shall be limited to the lesser of the total actual cost of the facility, which includes the State-mandated service tax, or the sum of the total cost cap approved in the facility budget plus the State-mandated service tax and program allowance on the service tax.

3400.24 To determine the allowable cost per bed day, the allowable cost shall be divided by the total actual days of care.

3400.25 The allowable cost per bed day shall be multiplied by MaineCare eligible days to determine the reimbursable MaineCare cost.

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3400 SETTLEMENT OF COST REPORTS (cont.)

3400.26 Final settlement: The reimbursable MaineCare cost, determined through the audit, shall be compared to the interim payments to determine an overpayment or underpayment.

5120 PERSONAL CARE SERVICES

PNMI services approved and funded by the Department of Health and Human Services- Adult Mental Health Services in licensed facilities may also provide personal care services necessary for the promotion of ongoing treatment and recovery. PNMIs must be receiving funds from the Department, specifically for the provision of personal care services, in order to also be reimbursed by MaineCare for such services.

6000 RATE-SETTING

6000.1 Payment rates and the total cost cap are established prospectively by the OMS and Department for each facility based on approved budgeted costs for the provider's fiscal year. The approved facility budget is based on a rate setting report submitted to the OMS and Department by the provider prior to the beginning of the provider's fiscal year. The budget shall be submitted on forms/media prescribed by the OMS and Department.

6000.2 The provider must also submit, upon request, such data, statistics, schedules, or other information that the OMS and Department requires.

6000.3 The rate for the previous period will remain in effect until a new rate is approved. Retroactive rate adjustments shall not be granted, unless approved by the OMS and Department under exceptional circumstances as determined by these two agencies.

6000.4 The new rate will be effective for services provided from the first day of the month following the OMS and budget approval from the Department.

6000.5 Providers must submit a rate setting report and any required supporting documentation for each facility at least 60 days prior to the start of the provider's fiscal year. The inclusive dates of the rate setting period shall be the inclusive dates of the cost reporting period as described by Chapter III, Section 3300.3.

6000.6 The OMS and Department may issue guidelines to assist providers in developing their budgets for the agreement period.

6000.7 The total allowable costs for the budget period, based on prior year actual allowable costs, current year costs and funding levels, and pre approved changes expected in the budget period, as reported by the provider, are used to determine the level of

6000 RATE-SETTING (cont.)

reasonable costs to be recognized in setting the prospective rate and total cost cap for the budget period. Only costs that are allowable pursuant to Section 2400 are included in calculating the prospective rate.

6000.8 Approval of the prospective rate and the total cost cap is at the discretion of the OMS and Department. The OMS and Department may make adjustments modifying the provider's proposal.

6000.9 Calculation of the prospective rate: the total cost cap shall be divided by the estimated annual occupancy.

7000 RATE ADJUSTMENTS FOR PROVIDERS UNDER APPENDIX E

Providers may request rate adjustments as necessary. The following section details the process for such requests. No retroactive rate adjustments will be granted.

7000.1 Process for Requesting Rate Adjustments for Providers Covered Under Appendix E:

7000.12 To request a rate adjustment, the provider will submit an approved and revised budget on a OMS-approved form to the OMS and to the Department. The provider will attach a narrative detailing the reasons for the requested adjustment, the new rate, and the total cost of the requested rate adjustment for the remainder of the fiscal year.

7000.13 The provider will designate a responsible individual as a primary contact for the OMS and the Department.

7000.14 The rate adjustment submittal date will be the date received by the Department or no more than seven days after the postmark date.

7000.15 The OMS and the Department will reach a decision within 30 calendar days of the rate adjustment submittal date.

7000.16 If a rate adjustment is approved, the effective date shall be the first day of the month following the rate adjustment submittal date.

7000.17 If the OMS denies the initial request, or requires additional information, the provider shall have 5 working days upon receipt to provide additional information. The OMS shall consider the additional information and make a final determination within 20 working days of receipt of the additional information.