August 1, 2009

TO: Interested Parties

FROM: Anthony Marple, Director, MaineCare Services

SUBJECT: Emergency Rule: MaineCare Benefits Manual, Chapter III, and Appendix D and E, Section 97, Private Non-Medical Institutions

This letter gives notice of rules that the Department has determined immediate adoption of is necessary to assure that initiatives directed by the Maine State Legislature are immediately implemented to achieve required savings in the approved budget. The Legislature, in Public Law chapter 213, authorizes emergency rulemaking on or before 12/31/09 for provisions over which the Department has subject matter jurisdiction without demonstrating that emergency rule implementation of this rule is necessary to avoid a threat to public health, safety or general welfare. These emergency rules specifically address budget initiatives for children’s Private Non-Medical Institution (PNMI) services and for adults with mental illness.

In this rulemaking, the Department is setting standard rates for children’s PNMI services and is removing language about cost settlement for facilities reimbursed under Appendix D, Child Care Facilities. All child care providers will need to bill new codes for reimbursement. The Department has also made changes to Appendix E, Community Residences for Persons with Mental Illness to clarify that “scattered site” services are no longer reimbursed under this Section. The Department will require prior authorization for these behavioral health PNMI services for both children and adults to assure cost savings are met and that services are medically necessary.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at, [http://www.maine.gov/dhhs/bms/rules/provider_rules_policies.htm](http://www.maine.gov/dhhs/bms/rules/provider_rules_policies.htm) or for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

A concise summary of the proposed rule is provided in the Notice of Agency Rule-making Proposal. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Proposal.
Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapter III, Section 97, and Appendix D and E, Private Non-Medical Institutions

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The Department has determined that the immediate adoption of these rules is necessary to assure that initiatives directed by the Maine State Legislature are immediately implemented to achieve required savings in the approved budget. The Legislature, in Public Law chapter 213, authorizes emergency rulemaking on or before 12/31/09 for provisions over which the Department has subject matter jurisdiction without demonstrating that emergency rule implementation of this rule is necessary to avoid a threat to public health, safety or general welfare. These emergency rules specifically address budget initiatives for children’s Private Non-Medical Institution (PNMI) services and for adults with mental illness.

In this rulemaking, the Department is setting standard rates for children’s PNMI services and is removing language about cost settlement for facilities reimbursed under Appendix D, as the Department will no longer cost settle these services. The Department has also made changes to Appendix E, Community Residences for Persons with Mental Illness to clarify that “scattered site” services are no longer reimbursed under this Section. Those services will still be provided to members in their apartments, but instead will be reimbursed through Community Support Services under Section 17 of the MaineCare Benefits Manual. The Department has sent a notice to those affected members to inform them of this change in services. Prior authorization will be required for all behavioral health PNMI services for children and adults to assure that required savings are met and that services are medically necessary. All child care providers will need to bill new codes for reimbursement.

The Maine State Legislature has directed the Department to achieve $6.5 million savings per State fiscal year in this rulemaking for children’s services. Another $1.6 million of savings is expected through the scattered site housing changes. Because these rules are major substantive, the emergency rules will remain in effect for one year or until the legislature approves them. The Department will propose rules through the regular Administrative Procedures Act (APA) process to provisionally adopt these rules. A public hearing will be held as part of that process.

AGENCY CONTACT PERSON: Patricia Dushuttle
AGENCY NAME: Office of MaineCare Services
ADDRESS: 442 Civic Center Drive
11 State House Station
Augusta, Maine 04333-0011


EFFECTIVE DATE: August 1, 2009
**EMG EFF. 8/1/09**

*** Child Care Facility Codes are effective by Emergency Rule on 8/1/09.

* OTHER CODE UPDATES WILL NOT BE EFFECTIVE UNTIL FURTHER NOTICE*

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1000 PURPOSE

The purpose of Appendix D is to identify reimbursement regulations that are specific to residential child care facilities, child placing agencies, treatment foster care providers, or Intensive Temporary Out of Home Treatment Services providers under Section 97, Chapter III, Private Non-Medical Institutions (PNMI) services of the MaineCare Benefits Manual. The general provisions of Chapter III for 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 capitated rates for Child Care Facilities, which costs are reimbursable within Section 97, Chapters II and III and Appendix D, 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. As of August 1, 2009, Child Care Facilities under this appendix are reimbursed a capitated fee for services, and are not subject to establishment of interim rates or auditing, as detailed in Section 97, Chapter III.

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 the services set forth in this Appendix of Reimbursement is contained in 22 MRSA Sec. 42 and Sec. 3173.

1210 DEFINITIONS

The term “member” as used throughout this Appendix 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 as a resident of a child care facility as defined in Section 97.01-1(B) of the MaineCare Benefits Manual.

The term “facility” as used throughout these Principles of Reimbursement refers to a child care facility, as defined by Section 97.01-1(B) of the MaineCare Benefits Manual. Also, as stated in Section 97.01-1(B) for MaineCare reimbursement purposes, this term also includes child placing agencies and treatment foster care providers.

2400 ALLOWABILITY OF COST

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

Physicians
Psychiatrists
Psychologists
Psychological examiners
Licensed clinical professional counselors
Licensed professional counselors
Dentists
Providers must follow all State of Maine Licensing guidelines for staffing levels and must maintain specific staffing listed below sufficient to serve the individual needs of each child as identified in the child’s individual service plan (as defined in Chapter II) and approved by the Department. Staffing is also detailed in MBM, Chapter II, Section 97. Services may only be provided within scope of licensure for the respective professional.

The following PNMI services are included in the capitated rate for each Appendix D level of care:

a. Psychiatrist services
b. Psychologist services – treatment/not testing
c. Social worker services
d. Licensed clinical professional counselor services
e. Licensed professional counselor services
f. Licensed practical nurse services
g. Psychiatric nurse services
h. Licensed alcohol and drug counselor services
i. Behavioral Health Professional
j. Pediatric Neurologist
k. Other Qualified Mental Health Professional
l. Behavioral Health Professional
2400 ALLOWABILITY OF COST (cont.)

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 resident 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.

EMG 8/1/09

2400.11 The Department shall determine the reasonableness of the treatment costs on an annual basis. Providers must submit any requested data to the Department including but not limited to utilization data and cost reports.

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

2400.3 Other qualified treatment foster care providers (Chapter 2, Section 97.07-2 of the MaineCare Benefits Manual). Reimbursement to foster parents for care of children in placement shall be limited to 60% of the wages and taxes/fringe benefits (as defined under Sections 2400.1 and 2400.2 of this Appendix) or 60% of the stipend amounts as determined by the Department.

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. The rates in this Section shall include a State-mandated service tax. The State-mandated service tax is a 5% tax on the value of PNMI services. Since providers will no longer receive Rate letters detailing this information, they will need to calculate the service tax at 5% of reimbursed 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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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 report of findings, or
3. Conduct a field audit and issue a final-settlement report of findings.

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

a. 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.

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.
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.

The following capitated rates apply to Appendix D services:

- Mental Retardation and Pervasive Developmental Disorder- Level I- $397.12 per diem
- Mental Retardation and Pervasive Developmental Disorder- Level II- $595.62 per diem
- Child Mental Health Condition- Level I- $336.49 per diem
- Child Mental Health Condition – Level II- $441.20 per diem
- Intensive Mental Health for Infants and/or Toddlers- $696.43 per diem
- Crisis Stabilization Residential Services- $542.94 per diem
- Therapeutic Foster Care- $105.75 per diem

Children are assessed by the Department, as described in Chapter II, and will be assigned into one of the categories of level of care described above. Providers bill the Department on a per diem basis for each child. The capitated rate includes all PNMI services required by a child for his/her category of level of care including all staffing required pursuant to State of Maine licensing guidelines, and as identified in the child’s individual service plan. There is no cost settlement for Appendix D PNMI services.

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.

6000.4 The new rate will be effective for services provided on August 1, 2009 or after the effective date of these rules and approved individually for each child from the first day of the month following the budget approval from OMS and 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 prescribed by Chapter III, Section 3300.3. Providers and child/guardians shall receive a written prior authorization letter which indicates the model level of care that the child is eligible for, and the date of the eligibility.

6000.6 The OMS 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 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 the Department. The OMS 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 D:

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 D:

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 RATE ADJUSTMENTS FOR PROVIDERS UNDER APPENDIX D: (cont.)

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.
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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.

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.

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.
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.
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
3400 SETTLEMENT OF COST REPORTS (cont.)

MaineCare eligible days to determine the reimbursable MaineCare cost.

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. PNMI services 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.