DATE: 10/03/2018

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Adopted Rule: 10-144, C.M.R. ch. 101, MaineCare Benefits Manual:

   Ch. II, Section 107 Psychiatric Residential Treatment Facility Services

   Ch. III, Section 107 Principles of Reimbursement for Psychiatric Residential Treatment Facility Services

This rulemaking adopts a new section of policy describing Psychiatric Residential Treatment Facilities (PRTF) services and reimbursement for such services. PRTFs are Medicaid services authorized and governed under: 42 U.S.C. § 1396d(a)(16) and (h) and 42 C.F.R. 441 Subpart D and 42 C.F.R.483 Subpart G. The services are offered only to members under the age of 21.

NOTE: The Department will seek approval from CMS for the PRTF service. The service will not be offered, and this rule will not become effective, until CMS has approved. Upon CMS approval, the Department will issue notice to the Secretary of State and Interested Parties informing of CMS approval pursuant to Title 5 §8052(6).

The rule describes the PRTFs’ covered services, policies and procedures, standards, and reimbursement methodology. This service is intended to address a current gap in Maine’s offering of behavioral health services to youth under the age of 21. The PRTF is being created to specifically support Maine’s most vulnerable youth, including: youth in out of state placement, youth stranded in psychiatric hospitalization with no safe discharge option, youth stranded in emergency rooms with no safe placement, and incarcerated youth in need of mental health treatment. This rule was developed by a multidisciplinary team including members from the Office of Child and Family Services, the Department of Education, the Department of Corrections, Maine Centers for Disease Control and Prevention, and the Office of MaineCare services. The development of this policy included stakeholder input. A public hearing was held on May 21, 2018, and, in addition, public comments were received.

This service will be reimbursed using a statewide per diem rate for medical, clinical and direct care costs (direct care services) and using a facility-specific rate for routine and fixed costs (room and board costs). The routine and fixed costs facility rate is informed by annual cost reporting performed by providers using a state-developed cost report form. The medical, clinical and direct care per diem rate is not cost settled. The routine and fixed cost rate is cost settled by the Department based on allowable fixed and routine costs.

The Department has issued notice to the Legislature prior to rulemaking adoption and complies with 34-B M.R.S. §§15002 (Children’s Mental Health Services).
As a result of public comments and review by the Office of the Attorney General, the Department has deleted the utilization of chemical restraints in this service. The Department added language for Medication Pro Re Nata (PRN), which clarifies that PRN medication may not be utilized as a chemical restraint.

The Department added language to clarify that this rulemaking complies with the following regulations: the Rights of Recipients of Mental Health Services who are Children in Need of Treatment by a Provider, 14-172 C.M.R. ch. 1, and also the Rights of Recipients of Mental Health Services, 14-193 C.M.R. ch. 1. These changes were adapted to ensure compliance with all state and federal regulation and to ensure members are afforded the highest level of protections.

At the same time it is adopting this rulemaking, the Department is also adopting new licensing rules, which will govern the licensing of PRTFs. Those rules are the Children’s Residential Care Facilities Licensing Rule, 10-144 C.M.R. ch. 36.

Rules and related rulemaking documents may be reviewed at, or printed from, the Office of MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/index.shtml or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050 or call Maine Relay at 711.

A concise summary of the adopted rule is provided in the Notice of Agency Rulemaking Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rulemaking process.
Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, Office of MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R. Chapter 101, MaineCare Benefits Manual, Ch. II Section 107 Psychiatric Residential Treatment Facility Services
Ch. III. Section 107 Principles of Reimbursement for Psychiatric Residential Treatment Facility Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY:

This rulemaking adopts a new section of policy describing Psychiatric Residential Treatment Facilities (PRTF) services and reimbursement for such services. PRTFs are Medicaid services authorized and governed under: 42 U.S.C. § 1396d(a)(16) and (h) and 42 C.F.R. 441 Subpart D and 42 C.F.R.483 Subpart G. The services are offered only to members under the age of 21.

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At the same time it is adopting this rulemaking, the Department is also adopting new licensing rules, which will govern the licensing of PRTFs. Those rules are the Children’s Residential Care Facilities Licensing Rule, 10-144 C.M.R. ch. 36.


EFFECTIVE DATE: The rule will become effective upon CMS approval

AGENCY CONTACT PERSON: Dean Bugaj, Comprehensive Health Planner
Dean.Bugaj@maine.gov

AGENCY NAME: Division of Policy

ADDRESS: 242 State Street, 11 State House Station
Augusta, Maine 04333-0011

TELEPHONE: (207)-624-4045  FAX: (207) 287-1864
TTY users call Maine relay 711
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>SECTION</th>
<th>LEGAL AUTHORITY</th>
<th>DEFINITIONS</th>
<th>INTRODUCTION</th>
<th>MEMBER ELIGIBILITY</th>
<th>COVERED SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>107.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-01</td>
<td>Abuse or Neglect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-02</td>
<td>Caregiver</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-03</td>
<td>Child and Adolescent Needs &amp; Strengths Assessment (CANS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-04</td>
<td>Clinical Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-05</td>
<td>Emergency Safety Intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-06</td>
<td>Emergency Safety Situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-07</td>
<td>Functional Behavior Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-08</td>
<td>Individual Certification of Need</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-09</td>
<td>Mechanical Restraint</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-10</td>
<td>Minor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-11</td>
<td>Natural Supports</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-12</td>
<td>Personal Restraint</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-13</td>
<td>Positive Behavioral Support Strategies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-14</td>
<td>Psychiatric Residential Treatment Facility (PRTF)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-15</td>
<td>Restraint</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-16</td>
<td>Seclusion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-17</td>
<td>Serious Injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-18</td>
<td>Serious Occurrence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-19</td>
<td>Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-20</td>
<td>Time Out</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.02-21</td>
<td>Treatment Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.03</td>
<td>INTRODUCTION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.04</td>
<td>MEMBER ELIGIBILITY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.04-01</td>
<td>General Eligibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.04-02</td>
<td>Clinical Certification of Need for PRTF Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.05</td>
<td>COVERED SERVICES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.05-01</td>
<td>Active Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.05-02</td>
<td>Development and Periodic Revision of the Treatment Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.05-03</td>
<td>Ancillary Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>107.05-04</td>
<td>Discharge Planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

107.06 NON-COVERED SERVICES .................................................................11

107.07 POLICIES AND PROCEDURES .........................................................11

107.07-01 Licensing, Certification, and Accreditation ..............................11
107.07-02 Enrollment .............................................................................11
107.07-03 Qualified Providers ...............................................................11
107.07-04 Treatment Planning Team .....................................................13
107.07-05 Supervision Requirements ....................................................14
107.07-06 Required Disclosures and Informed Consents .......................15
107.07-07 Provider Documentation Requirements and Member Record ....17
107.07-08 Additional Treatment Standards .........................................22
107.07-09 Education, Training, and Background Checks .....................24
107.07-10 Reporting of Serious Occurrences ......................................26

107.08 MEDICATION PRO RE NATA (PRN) .............................................27

107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION ....28

107.09-01 General Requirements .........................................................28
107.09-02 Orders for Restraint or Seclusion .........................................29
107.09-03 Monitoring of the Member ...................................................30
107.09-04 Examination Following Use of Restraint or Seclusion ..........30
107.09-05 Use of Timeouts ..................................................................32
107.09-06 Documentation of Restraint and Seclusion .........................33
107.09-07 Postintervention Debriefings ...............................................34
107.09-08 Medical Treatment for Injuries Resulting from an Emergency Safety Intervention .................................................................35

107.10 WAIVERS ...................................................................................36

107.11 REIMBURSEMENT .................................................................36

107.10-01 Principles of Reimbursement ..............................................36

107.12 BILLING ..................................................................................37

Appendix A Qualifying Diagnoses .......................................................38
Appendix B CANS Domains ...............................................................39
Appendix C Staffing Requirements .....................................................40
107.01 **LEGAL AUTHORITY**

The following federal statutory and regulatory authorities govern these services:

Section 1905 (a)(16) and (h) of the Social Security Act
42 CFR §441.150 through §441.184
42 CFR §483.350 through §483.376

107.02 **DEFINITIONS**

107.02-01 **Abuse or Neglect** is a threat to a child’s health or welfare as defined in 22 M.R.S. § 4002(1); or Abuse, Neglect, or Exploitation of an adult means those terms as defined in 22 M.R.S. §3472.

107.02-02 **Caregiver** is an individual who is responsible for the custodial care, and protective oversight and supervision of a youth. Caregivers may include but are not limited to a member’s parents, babysitter, immediate or extended family, other natural supports fulfilling this role, or professional staff providing protective oversight and supervision in a variety of settings.

107.02-03 **Child and Adolescent Needs & Strengths (CANS)** assessment is a multipurpose tool that assesses the needs and strengths of children and adolescents with mental illness, developmental disabilities/intellectual disabilities, and autism spectrum disorders. The CANS may be used to support decision making (including level of care and service planning), to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

107.02-04 **Clinical Staff** means licensed staff, to include the following:

1. Physicians, including psychiatrists
2. Psychiatric Mental Health Nurse Practitioners
3. Registered Nurses (RNs)
4. Licensed Clinical Social Workers (LCSWs)
5. Licensed Clinical Professional Counselors (LCPCs)
6. Licensed Marriage and Family Therapists (LMFTs), and
7. Licensed Psychologists

107.02-05 **Emergency Safety Intervention** means the use of restraint or seclusion as an immediate response to an emergency safety situation.
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107.02 DEFINITIONS (cont.)

107.02-06 **Emergency Safety Situation** means unanticipated member behavior that places the member or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention.

107.02-07 **Functional Behavior Assessment** means a problem-solving process that identifies the individual and environmental variables contributing to occurrences of challenging behaviors for the purpose of designing individualized behavioral interventions.

107.02-08 **Clinical Certification of Need** is the process by which a member demonstrates the medical necessity for treatment in a Psychiatric Residential Treatment Facility (PRTF) setting.

107.02-09 **Mechanical Restraint** means any device attached or adjacent to the member’s body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

107.02-10 **Minor** means an individual under 18 years of age.

107.02-11 **Natural Supports** are individuals who do not share a common residence with the family, who include the relatives, friends, neighbors, and community resources that a family goes to for support.

107.02-12 **Personal Restraint (Physical Restraint)** means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. Briefly holding a resident, without undue force, in order to calm or comfort him or her, holding a resident's hand to safely escort a resident from one area to another, or physical cueing in accordance with the member’s treatment plan are not considered a personal restraint.

107.02-13 **Positive Behavioral Support Strategies** means a strengths-based strategy based on individualized assessment that emphasizes teaching a person productive and self-determined skills or alternate strategies and behaviors without the use of restrictive Interventions.

107.02-14 **Psychiatric Residential Treatment Facility (PRTF)** means a facility other than a hospital that provides psychiatric services to individuals under age 21, in an inpatient setting, and which meets the requirements of this policy. Psychiatric Residential Treatment Facility means a facility licensed in Maine by the Maine Department of Health and Human Services.
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107.02 DEFINITIONS (cont.)

107.02-15 **Restraint** means a “personal restraint,” or “mechanical restraint” as defined in this section.

107.02-16 **Seclusion** means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.

107.02-17 **Serious Injury** means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

107.02-18 **Serious Occurrence** means a member’s death, a Serious Injury to a member, or a suicide attempt by a member.

107.02-19 **Staff** means those individuals with responsibility for managing a resident’s health or participating in an emergency safety intervention and who are employed by the facility on a full-time, part-time, or contract basis.

107.02-20 **Time Out** is intended to remove the resident from positive reinforcement of a particular behavior that has negatively impacted him or herself and/or others. Time out may include the loss of access to positive reinforcement within a particular setting and/or the restriction of a resident to a designated area for a period of time for the purpose of providing the resident an opportunity to regain self-control. During a time out, a resident must not be physically prevented from leaving the designated area.

107.02-21 **Treatment Plan** means an active plan of care developed for each member in accordance with the standards of this policy and intended to improve the member’s condition to the extent that inpatient care is no longer medically necessary.

107.03 INTRODUCTION

This rule describes the standards for the provision of Psychiatric Residential Treatment Facility (PRTF) services. PRTFs are jointly federally and state regulated, and providers must follow all federal and state requirements to provide this service. This includes standards for staffing of PRTFs, as described in this policy.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

107.03 INTRODUCTION (cont.)

The purpose of a PRTF is to provide comprehensive mental health treatment and/or substance abuse treatment to children and adolescents who, due to mental illness, substance abuse, or severe emotional disturbance, meet level of care requirements for a PRTF.

For members who have co-occurring intellectual or developmental disability, all applicable state and federal laws, including Title 34-B of the Maine Revised Statutes must be followed.

In order for a member to qualify for PRTF services, all other community based resources must have been determined to be inadequate to meet the member’s needs. PRTF services are designed to be short term and intensive in nature, with the goal of successfully transitioning the member back to his or her community. The PRTF is expected to actively engage the member’s natural supports to offer culturally competent, medically appropriate treatment designed to meet the individual needs of the member.

107.04 MEMBER ELIGIBILITY

107.04-01 General Eligibility

To access PRTF services, members must meet all the following criteria:

A. Be under the age of 21.

B. Meets Clinical Certification of Need (CCON) requirements, as set forth in 107.04-02.

C. The parent or legal guardian, when applicable has approved of this level of service; and

D. The member meets all other MaineCare eligibility requirements.

107.04-02 Clinical Certification of Need (CCON) for PRTF Services

A. CCON Team

1. An independent team consisting of the following individuals must complete the CCON for each member seeking care in a PRTF. No member of the team may be employed by or have a consultant relationship with the admitting PRTF. The team must consist of the following individuals:
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107.04 MEMBER ELIGIBILITY (cont.)

a. A physician;

b. A licensed master’s level clinician with clinical experience in child psychiatry. Eligible provider types include:

   i. LCSW;
   ii. LCPC;
   iii. Psychiatric Mental Health Nurse Practitioner;
   iv. Physician’s Assistant;

c. An individual with specific knowledge of the member’s situation. The parent/guardian (when applicable) or designee must fill this role. This individual may be a current provider, family or community member, case manager, or other individual with relevant knowledge. In the event of multiple providers, only one individual may be designated to serve this role. The parent/guardian will have the opportunity to select this individual to serve on their behalf; and


B. Certification Requirements

1. The CCON team must unanimously certify all the following:

   a. The member has an active psychiatric condition and functional deficits qualifying as a Serious Emotional Disturbance (SED) meeting the criteria below. The member must be reassessed annually at minimum (within twelve (12) months of the last determination) by licensed mental health professional acting within the scope of their licensure to determine if the member continues to qualify as having an SED:

      i. Have a primary diagnosis listed in Appendix A with a severity specifier of moderate to severe (when applicable) when applied to the current condition of the youth, as determined by a licensed mental health professional acting within the scope of their licensure, for the previous six (6) month period or must be reasonably predicted to last six (6) months; and
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107.04 MEMBER ELIGIBILITY (cont.)

ii. The member must also consistently and persistently demonstrate behavioral abnormalities to a significant degree, well outside the normative developmental expectations for the previous six (6) month period or must be reasonably predicted to last six (6) months. Behavioral abnormalities cannot be attributed to intellectual, sensory, or health factors.

iii. The member must additionally display at a minimum, four (4) of the following conditions:

a. failure to establish or maintain developmentally and culturally appropriate relationships with adult caregivers or authority figures;

b. failure to demonstrate or maintain developmentally and culturally appropriate peer relationships;

c. failure to demonstrate a developmentally appropriate range and expression of emotion or mood;

d. disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic, or recreation settings;

e. behavior that is seriously detrimental to the youth's growth, development, safety, or welfare, or to the safety or welfare of others; or

f. behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

b. Ambulatory (community-based) resources available in the community, including Private Non-Medical Institutions (PNMI), do not meet the treatment needs of the member, as evidenced by one of the following:

i. The youth has behavior that puts the youth at substantial documented risk of harm to self;
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

107.04 MEMBER ELIGIBILITY (cont.)

ii. The youth has persistent, pervasive, and frequently occurring oppositional defiant behavior, aggression, or impulsive behavior related to the SED diagnosis which represents a disregard for the wellbeing or safety of self or others; or

iii. There is a need for continued treatment beyond the reasonable duration of an acute care hospital and documented evidence that appropriate intensity of treatment cannot be provided in a community setting.

The member need not have accessed or exhausted all other available services; however, the team must make a determination that these other services are inadequate to meet the member’s needs.

c. Treatment of the member’s psychiatric condition requires medical supervision seven days per week and 24 hours per day, on an inpatient basis and under the direction of a physician.

d. Services can reasonably be expected to improve the member’s condition or prevent further regression so that the services will no longer be needed.

2. Additionally, the CCON team must provide documentation of the following:

a. Member’s diagnosis or diagnoses;

b. Summary of present medical finding;

c. Relevant medical, psychiatric, and behavioral history;

d. Mental and physical functional capacity;

e. Prognoses, to the extent determinable;

f. The member’s created or updated CANS assessment; and

g. Documentation describing any community based services previously accessed by the member as well as their efficacy and challenges faced.
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107.04 MEMBER ELIGIBILITY (cont.)

3. Prior Authorization
   a. The CCON documentation must contain relevant information as described in Sections 107.04-02.B (1-2) above, which must be submitted for Prior Authorization (PA) to the Department or the Department’s third-party administrator. Prior Authorization is required for all PRTF services.

4. Copies of the CCON documentation must be submitted to the PRTF upon the member’s admission, and every 60 days thereafter in accordance with the CCON process.

C. Duration of Care

1. PRTF services may continue to be provided as long as medically necessary as determined by the Treatment Plan and described in the CCON.

2. The CCON process must be completed every 60 days to meet federal utilization control requirements.

3. A continued stay Prior Authorization (PA) must be completed every 60 days.

107.05 COVERED SERVICES

107.05-01 Active Treatment: PRTFs must provide active psychiatric treatment, including all the following:

A. Assessment and evaluation, including review of CCON team documents, to be completed in accordance with Section 107.07-07.A.;

B. Medical supervision seven days per week and 24 hours per day;

C. Intensive psychiatric monitoring and intervention, to include medication management and medication administration:
   1. Medication Management sessions must occur at least once per week;

D. Behavioral and/or rehabilitative therapies, the specific modality to be described in the member’s Treatment Plan. Therapy must include at a minimum, the following:
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

107.05 COVERED SERVICES (cont.)

1. Individual Therapy, at least two (2) hours weekly;

2. Group Therapy, at least one (1) hour daily; and

3. Family Therapy, at least two (2) hours weekly;

E. Comprehensive and individualized discharge planning, to be commenced upon admission to the PRTF and meeting the requirements described in Sections 107.05-04 and 107.07-07 below;

F. Crisis planning and intervention;

G. Development of a Positive Behavioral Support Plan (PBSP) as described in 107.07-08.B;

H. Case management;

I. All transportation services;

J. Personal care, activities of daily living services, and instrumental activities of daily living services, and;

K. Room and board.

107.05-02 Development and Periodic Revision of the Treatment Plan as described in Section 107.07-07 of this policy.

107.05-03 Ancillary Services: When medically necessary, PRTFs must assure the provision of ancillary services to members enrolled in the PRTF. Ancillary services as described below are billed pursuant to their appropriate section of policy and are as follows:

A. Occupational Therapy Services are covered pursuant to regulations outlined in MaineCare Benefits Manual, Section 68, Occupational Therapy Services and provided by or under the direction of providers who meet the qualifications in accordance with MaineCare Benefits Manual, Section 68, Occupational Therapy Services and acting within his or her scope of practice under Maine State Law.

B. Physical Therapy Services are covered pursuant to regulations outlined in MaineCare Benefits Manual, Section 85, Physical Therapy Services and provided by or under the direction of providers who meet the qualifications in
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

107.05 COVERED SERVICES (cont.)

C. **Speech and Hearing Services** are covered pursuant to regulations outlined in *MaineCare Benefits Manual*, Section 109, Speech and Hearing Services and provided by or under the direction of providers who meet the qualifications in accordance *MaineCare Benefits Manual*, Section 109, Speech and Hearing Services and acting within his or her scope of practice under Maine State Law.

D. **Interpreter Services** are covered pursuant to regulations outlined in Chapter I, Section 1.06-3 of the *MaineCare Benefits Manual*.

E. **Medical Services**: to address any existing or newly diagnosed physical health conditions when medically necessary.

F. Board Certified Behavior Analyst consultation with Prior Authorization.

107.05-04 **Discharge Planning**

A. Discharge planning must be included in the Treatment Plan and be considered a vital component of the member’s care.

B. The member and the member’s natural supports, including school personnel, and community providers must be considered in the development of the discharge plan. The member’s family or guardian must be involved in the development of the discharge plan.

C. As part of the discharge planning requirements, PRTFs must ensure the member has a minimum of a seven-day supply of prescribed medication and a written prescription for medication to last through the first outpatient visit in the community with a prescribing provider.

D. Prior to discharge, the PRTF must identify a prescribing provider in the community and schedule an outpatient visit. Documentation of the medication plan and arrangements for the outpatient visit must be included in the medical record for the member.

E. If medication has been used during the PRTF treatment of the member, but is not needed following discharge, the reason the medication is being discontinued must be documented in the medical record for the member.
107.06 **NON-COVERED SERVICES**


Duplicative services are non-covered services. A listing of duplicative and allowable concurrent services are described in detail in Appendix E.

107.07 **POLICIES AND PROCEDURES**

107.07-01 **Licensing, Certification, and Accreditation**

A. All PRTFs must maintain current CMS certification and state licensure as administered by the Department of Health and Human Services.

B. All PRTFs must maintain current accreditation by one of the following entities:

1. The Joint Commission on Accreditation of Healthcare Organizations, or
2. The Commission on Accreditation of Rehabilitation Facilities, or
3. The Council on Accreditation

C. All accreditation reports, with findings & remediation, must be submitted to the Maine Center for Disease Control and Prevention (CDC).

107.07-02 **Enrollment**

A. All PRTFs must maintain enrollment with MaineCare according to the terms of Chapter I Section 1 of the MaineCare Benefits Manual.

B. All PRTFs, upon enrollment with MaineCare, must attest, in writing, that the facility is in compliance with CMS’s standards governing the use of restraint and seclusion. This attestation must be signed by the facility medical director.

107.07-03 **Qualified Providers**

PRTF Programs must have appropriately credentialed staff, as described in the roles below, to satisfy the minimum staffing requirement for covered services described in Appendix D. Roles and qualified providers are described as follows:
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107.07 POLICIES AND PROCEDURES (cont.)

A. Medical Director – is responsible for overall program implementation, individualized treatment planning, interventions, and key decision-making regarding an individual’s treatment. The medical director must be licensed to practice in the State of Maine and be held by at least one of the following:

1. Board-eligible or board-certified psychiatrist, or
2. Licensed Psychologist AND a physician licensed to practice medicine or osteopathy practicing as co-directors to fulfill the above medical director duties.

B. Administrator– is responsible for business oriented decisions regarding the PRTF. The Program Administrator must be at least 21 years of age, have a Bachelor’s Degree from an accredited school and two years of experience in the management and supervision of personnel and children’s care facilities, or comparable training or experience. Duties include, but are not limited to: oversight of day-to-day operations, scheduling, ensuring staff training, and maintaining the physical plant.

C. Clinical Coordinator – is responsible for the oversight of the implementation of a member’s clinical interventions. The Clinical Coordinator will provide supervision, training, and clinical support staff clinician(s). Additionally, the Clinical Coordinator must serve on the member’s team to develop the ITP and must facilitate the member’s discharge and transition to aid in ensuring a successful transition from the PRTF. A clinical coordinator must be held by one of the following:

1. A LCSW with at least two years of experience in the diagnosis and treatment of children with serious behavioral health conditions (experience may include experience gained while obtaining clinical licensure status as an LMSW-CC), or
2. A Licensed Psychologist by the State of Maine.

D. Staff Clinician – is responsible for the implementation of the clinical services offered by the PRTF. The clinical services include at minimum a mixture of individual, group, and family therapy provided at the levels outlined in Section.

A Staff Clinician may be any of the following:
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

107.07 POLICIES AND PROCEDURES (cont.)

1. A fully Licensed Clinical Social Worker (LCSW);

2. A fully Licensed Clinical Professional Counselor (LCPC); or

3. A fully Licensed Marriage and Family Therapist (LMFT).

E. Nurse – is responsible for the support of the behavioral health, wellness, and medical needs of a member receiving PRTF services. There must be a nurse present in the PRTF 24 hours per day, 365 days per year. The Nurse must be either:

1. A psychiatric mental health nurse practitioner or

2. A registered nurse with at least two years experience in the treatment of children with serious behavioral health conditions.

F. Nurse Support – is responsible for supporting the Nurse in duties allowable by the scope of their licensure including the administration of medications as well as assistance with personal care activities. The Nurse Support must be either:

1. A Certified Nursing Assistant-Medication Aide (C.N.A.-M) listed on the Maine C.N.A. Registry with no disqualifying annotations and two years of experience as a C.N.A.-M. responsible for the administration of medications as well as assistance with personal care activities; or

2. A Licensed Practical Nurse (LPN) with at least two years experience in the treatment of children with serious behavioral health conditions.

G. Direct Care Staff – is responsible for the daily implementation of the direct program. Direct support staff must be present 24 hours per day, 365 days per year. Direct care staff are critical staff required to maintain structure and safety within the program, and to implement a member’s individualized programming. A Direct Care Staff must hold current Behavioral Health Professional certification (BHPs) with at least two years’ experience working as a BHP with a related population.

107.07-04 Treatment Planning Team

The Treatment Plan must be developed by an interdisciplinary team within the PRTF. This team may also include any Ancillary service providers as medically indicated.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

107.07 POLICIES AND PROCEDURES (cont.)

The member must be involved in the planning process to the greatest degree possible. The member’s parent or guardian (when applicable) must be involved in the planning process. The team, based on education and experience (including competence in child psychiatry) must be capable of:

A. Assessing the member’s immediate and long-term therapeutic needs, developmental priorities, and personal strengths and liabilities;

B. Assessing the potential resources of the member’s family;

C. Setting treatment objectives; and

D. Prescribing therapeutic modalities to achieve the plan’s objectives.

E. The team must include:

1. The Medical Director;

2. Clinical Coordinator; and

3. One of the following:

   a. Registered Nurse with specialized training or one year’s experience in treating mentally ill individuals; OR

   b. A psychologist who has a master’s degree in clinical psychology or who has been certified by the State or by the State psychological association.

107.07-05 Supervision Requirements

A. The facility must assign a supervisor to each staff member based on the staff member’s roles and responsibilities.

1. BHPs must be supervised by a Staff Clinician (LCSW, LCPC or LMFT) for the purposes of treatment plan implementation.

2. RNs must be supervised by a physician or nurse practitioner.

3. LPNs and CNA-Ms must be supervised by RNs or nurse practitioners.
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107.07 POLICIES AND PROCEDURES (cont.)

4. Staff Clinicians will be supervised by the Clinical Coordinator.

5. The facility Administrator will provide supervision regarding any administrative or operational issues.

B. Supervisors must meet with assigned staff at least one hour per week, either individually or in a group format. The supervisory sessions must be documented. At least one hour per month must be individual supervision.

107.07-06 Required Disclosures and Informed Consents

A. At the time of admission, the facility must:

1. Inform the incoming member and, in the case of a minor, the member’s parents or legal guardians, of the facility’s policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the member is in the program;

2. Communicate its restraint and seclusion policy in a language that the member and his or her parents or legal guardians understand and when necessary, the facility must provide interpreters or translators;

3. Obtain an acknowledgement, in writing, from the member, or in the case of a minor, from the parent or legal guardian that he or she (or they) have been informed of and have received the facility’s policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgement in the member’s record;

4. Provide a copy of the facility policy on the use of restraint or seclusion during an emergency situation to the member and in the case of a minor, to the member’s parents or legal guardians; and

5. Provide contact information, including the phone number and mailing address, for the State Protection and Advocacy Organization.

6. Advise the member and the member’s parent or legal guardians (as applicable) in understandable terms of the member’s rights pursuant to the Rights of Recipients of Mental Health Services Who are Children in Need of Treatment, 14-172 C.M.R. ch. 1, and provide a copy of these rights to the member and the member’s parents or legal guardians (as applicable).
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

107.07 POLICIES AND PROCEDURES (cont.)

For members 18 years of age and older or who are emancipated minors, also advise the member and the member’s legal guardian (as applicable) in understandable terms of the member’s rights pursuant to the Rights of Recipients of Mental Health Services, 14-193 C.M.R. ch. 1, and provide a copy of these rights to the member and the member’s legal guardian (as applicable). The member’s parent/guardian must sign acknowledgement that the member’s rights have been reviewed and the publication has been received.

7. Acquire informed consent for services from the member and his or her parent/guardian, when applicable. Informed consent means sharing, in writing, a description of the services being provided, service goals, service expectations, disclosure of risks and benefits and the roles and the responsibilities of the Provider and the family toward meeting service goals and expectations. Proof of Informed Consent will be documented, and signed by the Provider and the parent/guardian. Additional requirements are as follows:

a. The Provider shall document in the member’s plan the treatment or service delivery method or model for each service provided to a client, indicating full disclosure to the child, youth, parent and guardian of the risks and benefits of the method or model and alternative methods or models.

b. The Provider shall review with the member and his or her parent/guardian, when applicable upon intake, its role and responsibility as a mandated reporter of abuse and/or neglect pursuant to 22 M.R.S. § 3477 and 22 M.R.S. §4011-A and document this disclosure within the client record.

c. The Provider shall secure consent from the member and his or her parent/guardian, when applicable, to use the disclosed methods of intervention to treat the identified areas of need in the member’s Individualized Treatment Plan. The Provider shall document the consent within the member’s service record.

d. The Provider shall consider available Evidence-Based Practices and consider using such practices when clinically appropriate for the member’s condition. Provider staff shall understand and consider empirical evidence, clinical expertise, and the values and preferences of families and youth in implementing treatments.
107.07 POLICIES AND PROCEDURES (cont.)

e. The Provider shall clearly document the target symptoms of the treatment, how they will be measured and improvement determined.

107.07-07 Provider Documentation Requirements and Member Record

A. Assessment and Evaluation

1. The Provider shall conduct an initial assessment and evaluation in accordance with § 107.5-1.A within seventy-two (72) hours of admission, with a full comprehensive assessment and evaluation completed within fourteen (14) days of admission to the facility.

2. The assessment and evaluation must consist of direct and indirect encounters. Direct encounter shall include a psychological assessment and medical evaluation (to include medication review) directly with the member. Indirect encounters consist of record review and may include conversations with the member’s parent/guardian (as applicable), teachers, other professionals involved, and natural supports (as applicable). Direct and indirect encounters must inform the medical, psychological, social, behavioral and developmental aspects of the member’s situation, and reflects the need for inpatient psychiatric care. Assessment and evaluation will be conducted to the extent necessary to determine the member’s current disposition and treatment recommendations.

3. Documents submitted to the PRTF by the CCON team in accordance with 107.04-02.B may be used to satisfy parts of the documentation requirements for the initial and/or full comprehensive assessment.

4. The assessment must contain documentation of the member’s current status, the reason for referral to the service, history, strengths and needs in the following domains: personal, family, social, emotional, psychiatric, psychological, medical, drug and alcohol (including screening for co-occurring services), legal, permanency/housing, financial, vocational, educational, leisure/recreation, transition needs (when applicable), potential need for crisis intervention, physical/sexual and emotional abuse (including trauma history). The assessment must review cultural needs including issues of literacy and English and language barriers, and the need for interpretation and other needed services. The assessment should also take into consideration the member’s expressed desires.
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107.07 POLICIES AND PROCEDURES (cont.)

5. The assessment shall contain documentation of developmental history, sources of support that may assist the member to sustain treatment outcomes including natural and community resources and state and federal entitlement programs. The assessment shall address physical and environmental barriers to treatment and current medications. Domains addressed must be clinically pertinent to the service being provided.

6. For a member with substance abuse, the documentation must also contain age of onset of alcohol and drug use, duration, patterns and consequences of use, family usage, types and response to previous treatment.

7. The provider will review the member’s CANS assessment as a part of the full comprehensive assessment and will review the CANS ongoing in coordination with the member’s treatment plan intervals described below in 107.07-07.B.2.

8. The assessment must be summarized to include a clinical formulation that summarizes the strengths and needs of the member and family (when applicable) that informs treatment, service intensity, and recommendations for service. The formulation will include intended intervention modalities. The assessment must include a diagnosis using the most recent version of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) or the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC 0-5), as appropriate. The assessment must be signed, credentialed and dated by the appropriate personnel conducting the assessment.

B. Treatment Plan

1. All members must have an active Treatment Plan, which must:

   a. Be developed and implemented in a timely manner; an initial treatment plan must be developed and implemented within 72 hours of admission while a more comprehensive treatment plan must be developed and implemented within 14 days of admission.

   b. Be developed by the Treatment Planning Team as described in Section 107.07-04 of this policy;
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107.07 POLICIES AND PROCEDURES (cont.)

c. Be developed based on the Assessment completed in accordance with Section 107.07-07.A;

d. Reflect the needs and strengths identified in the member’s CANS assessment;

e. Be designed to achieve the member’s discharge from inpatient status at the earliest possible time;

f. Describe the functional level of the member;

g. Prescribe an integrated program of therapies, activities, and experiences designed to meet the member’s treatment objectives, and include any orders for:

   i. Medications; and

   ii. Treatments and Therapy; and

   iii. Social services; and

   iv. Special procedures recommended for the health and safety of the member.

h. Include plans for continuing care, including review and modification of the Treatment Plan;

i. Include clear short and long-term goals and treatment objectives that are specific, measurable and are time limited to include target dates, and include the frequency, intensity, and duration of each described intervention;

j. Describe the rationale for utilizing the prescribed treatment and services;

k. Specify treatment and service responsibility, including both staff and member responsibilities in meeting the member’s treatment objectives;
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107.07 POLICIES AND PROCEDURES (cont.)

1. Be developed in consultation with the member, the member’s parents or legal guardians (where appropriate), or others who will be caring for the member following discharge from the PRTF, including but not limited to family, school officials, and community service providers; and

m. Include a list of needs identified in the assessment process that are not addressed in the Treatment Plan and an explanation of why the identified needs are not addressed;

n. Include a discharge plan which must:
   i. Identify individualized discharge criteria that are related to the goals and objectives described in the Treatment Plan;
   ii. Identify the individuals responsible for implementing the plan, including staff who can assist the member in making referrals for other resources;
   iii. Identify natural and other supports necessary for the member and family to maintain the safety and well-being of the member, and to sustain progress made during the course of treatment;
   iv. Be reviewed by the treatment planning team every review meeting and no less than every thirty (30) days;
   v. Identify any service recommendations and reasons for recommending that service;
   vi. Address behavior planning, including interventions and resources necessary to carry out the plan without supports; and
   vii. Contain a list of resources tailored to the member’s individualized needs and situation necessary for parents, guardians, and natural supports to increase the likelihood of a successful and sustainable discharge.

2. The Treatment Plan must:
   a. Be entered in the member’s medical record upon initial completion and upon any alteration;
B. Consider any additional assessments in the development of the Treatment Plan;

c. Be reviewed every 30 days, or sooner as clinically indicated by the treatment planning team to:

   i. Determine that services being provided are required on an inpatient basis and

   ii. Recommend changes in the plan as indicated by the member’s overall adjustment as an inpatient;

d. Document plan approval as shown by the signature of the member (when applicable), parent/guardian (when applicable), any staff with credential(s) involved in creating the treatment plan, and the medical director with credential(s). All signatures will be dated at the time of signature. In extenuating circumstances, verbal approval by the parent/guardian may be obtained in lieu of signature which must be documented in the member record with the staff member who received the approval (and signature/date), and the reason why signature could not be obtained;

e. Be provided to the member and the member’s parent/guardian (if applicable) within five (5) working days from the date of final plan approval.

C. Results of any assessments conducted must be included in the member record.

D. Progress Notes:

1. Providers must maintain written progress notes for each service discipline provided by the PRTF, in chronological order. There must be one milieu note per shift and all medication/therapy services (as defined under covered services Section 107.05-01.D) must be documented individually.

2. All entries in the progress note must include the service provided, the provider’s signature and credentials, the date on which the service was provided, the duration of the service, and the progress the member is
107.07 POLICIES AND PROCEDURES (cont.)

making toward attaining the goals or outcomes identified in the Treatment Plan.

107.07-08 Additional Treatment Standards

In addition to the requirements detailed above, providers must follow all the Treatment Standards described below:

A. Family Centered Practice

1. The treatment shall be tailored to return the member to a family when possible and to a community. The Provider shall include and support family members as extensively as possible from the beginning of the admissions process through discharge, transition and aftercare. Families shall be full partners in all aspects of the member’s treatment, barring any limitations on participation. The focus of treatment shall be on helping families acquire the skills necessary to solve problems, meet needs, and attain desired goals. Individualized Family Therapy goals shall be included in the Treatment Plan.

2. It is the responsibility of the PRTF Provider to work with the member and his or her family to continually pursue effective levels of engagement with families, which include extended family members and natural/informal supports.

3. Planning with families shall make every effort to mobilize both informal and formal resources in support of families. Informal/natural supports include identification of the member and family’s personal resources including their specific skills, capacities or attributes. The PRTF staff shall work as a part of the team in exploring these resources for families.

4. The Treatment Planning Team shall address family readiness and the specific supports needed to ensure placement stability and success.

5. The PRTF Provider will have a family-centered policy including the following components, and will maintain records documenting training of all staff in the policy. The family-centered policy shall:
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107.07 POLICIES AND PROCEDURES (cont.)

a. Ensure family involvement in all aspects of the program (medical appointments, school communication, daily living, daily programming, etc.);

b. Illustrate family’s right to visitation and treatment participation in the PRTF setting;

c. Expectations of family treatment & daily living participation; and

d. Define exceptions when limits are placed on family participation, including but not limited to protect the member’s welfare, as a result of a protection from abuse or other court order, or a member age 18 years and older or an emancipated minor who does not consent to family participation.

6. The PRTF Provider will provide parent with supports and treatment interventions including psycho-educational, preventive, and supportive services as indicated by assessments. The focus will be on enhancing the parents’ coping mechanisms and providing them with the tools to move towards self-sufficiency through involvement in normal parenting activities and participating in positive behavioral supports and management techniques. The program will actively engage parental involvement and provide ongoing opportunities for parent to engage within the daily life activities of the member in the PRTF setting. Sibling involvement in treatment, visitation, and shared activities should be a part of the family treatment.

7. Documentation of parental presence and participation in treatment and typical daily parenting activities, as well as sibling involvement shall be maintained in the member’s record. It is the responsibility of the PRTF Provider to document its attempts and strategies for family engagement and to overcome barriers to family participation in treatment.

B. Behavioral Support and Management Standards

The PRTF shall practice positive behavior support strategies. Interventions are designed to modify member behavior should be individualized, respectful, developmentally appropriate, related to the issue at hand, flexibly applied, and designed to help the child master age and developmentally appropriate skills.
107.07 POLICIES AND PROCEDURES (cont.)

1. All individualized positive behavior support plans shall be based on a Functional Behavioral Assessment (FBA) by a qualified clinician or Board Certified Behavioral Analyst, with specific training in FBAs.

2. All individual positive behavioral support plans shall be monitored, reviewed, and adjusted on an ongoing basis based on the member’s behavior and response to treatment. Review shall not be limited solely to the required 30-day Treatment Plan review.

   a. Each behavioral plan shall include strategies that encourage the use of adaptive and pro-social behaviors with the goal of preventing aggressive behavior and de-escalating behavior before it becomes necessary to use more restrictive measures. The member’s trauma history shall be considered in determining the most effective means to de-escalate behavior.

3. Behavioral interventions shall not be used as punishment, a form of discipline, or for the convenience of staff.

4. All staff will be trained in appropriate de-escalation techniques. Staff shall be provided ongoing trainings and supervision around their use to ensure fidelity to the model chosen by the provider.

C. Any use of outside resources to intervene with psychiatric or behavioral occurrences must be reviewed and approved by the Medical Director prior to the intervention. The approval, including rationale, must be documented in the member record. This includes, but is not limited to referring a member to psychiatric hospitalization and requesting police intervention.

107.07-09 Education, Training Requirements and Background Checks

A. Required Background checks:

   The following is required for all staff working in a PRTF:

   1. Background checks must be completed in accordance with the facility’s licensing requirement 10-144 C.M.R Ch. 36;
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107.07 POLICIES AND PROCEDURES (cont.)

2. Additionally, all background checks must be performed at hire and every two years, at minimum, thereafter;

3. Any potentially adverse findings must be vetted by the provider and documented in the staff’s personnel record.

B. The facility must require staff to have initial and ongoing training, education and demonstrated knowledge of:

1. Techniques to identify staff and member behaviors, events, and environmental factors that may trigger emergency safety situations;

2. The use of non-physical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and

3. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in members who are restrained or in seclusion.

C. Certification in the use of cardiopulmonary resuscitation (CPR), including periodic recertification, is required. Certification and staff competency in the use of CPR must be reviewed on an annual basis.

D. First aid certification is required. Certification must be reviewed on an annual basis.

E. Staff trainings must be provided by individuals who are qualified by education, training and experience to provide such training.

F. Staff training must include training exercises in which staff members successfully demonstrate, in practice, the techniques they have learned for managing emergency safety situations.

G. Staff must be trained and demonstrate competency before participating in an emergency safety intervention.

H. Staff must demonstrate their competencies and proficiencies in the skills described in subsection (B) above every six months.
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107.07 POLICIES AND PROCEDURES (cont.)

I. The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.

J. All training programs and materials used by the facility must be available for review by CMS, the Office of MaineCare Services, Maine CDC, and the Office for Child and Family Services.

107.07-10 Reporting of Serious Occurrences

A. PRTFs must report each Serious Occurrence to:

1. The Office of MaineCare Services;

2. The Office of Child and Family Services (OCFS);

3. Maine CDC; and

4. The Department’s State Protection and Advocacy Agency.

B. Reports must be made by the close of business the next business day following a Serious Occurrence.

C. The report must include the name of the member involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility.

D. If the member involved is a minor, the facility must notify the member’s parents or legal guardians as soon as possible, and in no case no later than 24 hours after a Serious Occurrence.

E. Staff must document in the member’s record that the serious occurrence was reported to the agencies as required in this provision, including the name of the person to whom the incident was reported.

F. A copy of the report must be maintained in the member’s record, as well as in the incident and accident report logs maintained by the facility.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

107.07 POLICIES AND PROCEDURES (cont.)

G. In the event of a member death, the following additional reporting and documentation must be made:

1. Facilities must report the death of any member to the Centers for Medicare and Medicaid Services (CMS) regional office no later than close of business the next business day after the member’s death; and

2. Staff must document in the member’s record that the death was reported to the CMS regional office.

H. In certain circumstances, additional reports must be made to Child Protective services for youth under 18 years old per 22 M.R.S. § 4011-A, or Adult Protective Services for individuals 18 years and older per 22 M.R.S. § 3477.

107.08 MEDICATION PRO RE NATA (PRN)

A. PRN medication orders are written on an “as needed” basis for the treatment of a member’s medical or psychiatric condition;

B. PRN medication orders can only be issued if developed as part of the member’s Treatment Plan;

C. PRN medication orders must be signed and dated by authorized licensed practitioners and must include detailed behavior-specific written instructions, including symptoms that might require use of such medication, exact dosage, exact time frames between dosages, and the maximum dosage to be given in a 24-hour period;

D. The PRTF may only administer a PRN medication order for antipsychotic-type psychotropic medication when the PRTF also has an order prescribing routine scheduled and administered doses of the antipsychotic-type psychotropic medication for the member;

E. PRN medication orders shall not be used as a form of restraint and shall not be written in anticipation of an emergency safety situation. PRN medication cannot be given in response to a member’s aggressive behavior, in order to restrict a member’s movement or given to prevent the resident from acting out violently;
107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION

107.09-01 General Requirements

Restraint and Seclusion may be utilized by the provider and must be done in adherence with 42 C.F.R. part 483 Subpart G, the Maine Rights of Recipients of Mental Health Services, and the Rights of Recipients of Mental Health Services who are Children in Need of Treatment. Restraints or Seclusion. When there are conflicting provisions in these sources, the provision that provides the member the most protection applies. Restraint and seclusion may only be employed under the following circumstances:

A. When the intervention is absolutely necessary to protect the member from causing serious physical harm to self or others. Restraint or seclusion must not be utilized solely to address the comfort, convenience, or anxiety of staff, or as a form of coercion, discipline, or retaliation;

B. The intervention is the least restrictive emergency safety intervention necessary to resolve the emergency safety situation after other methods have been proven ineffective or inappropriate;

C. The restraint or seclusion is performed only by staff with specific training in these interventions. These interventions are applied in a manner that is safe, proportionate, and appropriate to the severity of behavior, and the member’s chronological and developmental age, size, gender, physical conditions, psychiatric conditions, medical conditions, and personal history. The restraint or seclusion must not result in harm or injury to the member and must be used only:

1. To ensure the safety of the member or others during an emergency safety situation; and

2. Until the emergency situation has ceased and the member’s safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired; and

D. Restraint (including physical and mechanical restraints) and seclusion must not be used simultaneously; and

E. Locked seclusion is prohibited. The member may not be confined alone to any area with the door locked, barred, or held shut by staff.
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107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)

F. For minor members, the Treatment Planning Team must decide and document in the Treatment Plan whether to allow restraints to be employed on a particular member in the event of an emergency safety situation and where the requirements of this section are met.

107.09-02 Orders for Restraint or Seclusion

A. The restraint or seclusion must be ordered by a physician or a nurse practitioner who is acting under the guidance of the team physician. When the team physician is available, only he or she may order restraint or seclusion. In the event that the provider ordering restraint or seclusion is not the treatment planning team physician, the ordering provider must consult with the member’s treatment planning team physician as soon as possible and inform him or her of the emergency safety situation that required the member to be restrained or placed in seclusion and document in the member’s record the date and time the team physician was consulted. The order must be the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

B. An order for restraint or seclusion may be given after an examination by a physician or nurse practitioner. In the event neither are available, a registered nurse, acting in consultation with and in accordance with protocol approved by the Medical Director, may conduct the examination and approve the emergency safety intervention.

C. An order for restraint or seclusion must not be written as a standing order or on an as-needed (PRN) basis. An order for restraint or seclusion may be given only during or immediately after the emergency safety situation arises.

D. The order must include:

1. The name of the ordering physician, or nurse practitioner permitted to order restraint or seclusion;

2. The date and time the order was obtained;

3. The reason for the restraint or seclusion;
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107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)

4. The emergency safety intervention ordered, including the authorized length of time for the intervention and the conditions under which the member may be sooner released; and

E. Each order for restraint or seclusion must adhere to the following:

1. Be limited to no longer than the duration of the emergency safety situation;

2. Under no circumstances exceed four (4) hours for members ages 18-21; two (2) hours for members ages 9-17; or one (1) hour for members up to age 9; and

3. The order must be signed by the ordering physician, or nurse practitioner in the member’s record as soon as possible.

F. If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse, while the emergency safety intervention is being initiated by staff, or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted to order restraint or seclusion must verify the verbal order in a signed written form in the member’s record. The physician or other licensed practitioner permitted to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention;

G. Under no circumstances may prone restraints be ordered or used. Additionally, providers must not initiate or sustain any restraint that may hinder chest and abdomen movement.

107.09-03 Monitoring of the Member

A. Monitoring of the Member During and Immediately Following Restraint

1. Clinical staff trained in the use of restraints must be physically present, continually assessing and monitoring the physical and psychological well-being of the member and the safe use of restraint throughout the duration of the emergency safety intervention.

2. Every member placed in restraint shall be released as necessary to eat, drink, bathe, toilet and to meet any special medical orders. Members in restraint shall have each extremity examined and the restraint loosened, sequentially,
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107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)

no less frequently than every fifteen (15) minutes. In instances in which blanket wraps are utilized for restraint, the member will be released and examined no less frequently than every hour.

3. A special progress/check sheet shall be maintained for each use of restraint. In addition to documenting the requirements of this provision, a description of the member’s behavior as observed shall be noted on the special progress/check sheet every fifteen (15) minutes.

4. If the emergency safety situation continues beyond the time limit of the order for the use of restraint, a registered nurse must immediately speak with the ordering physician or nurse practitioner permitted to order restraint or seclusion to receive further instructions.

5. A physician, nurse practitioner, RN or LPN trained in the use of emergency safety interventions must evaluate the member’s well-being immediately after the restraint is removed.

B. Monitoring of the Member During and Immediately After Seclusion

1. Clinical staff trained in the use of seclusion must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the member in seclusion. Video monitoring does not meet this requirement.

2. Every member placed in seclusion shall be released, unless clinically contraindicated, at least every two (2) hours to eat, drink, bathe, toilet and to meet any special medical orders.

3. A special progress/check sheet shall be maintained for each use of seclusion. In addition to documenting the requirements of 107-09.03.B.2 above, a description of the member’s behavior as observed shall be noted on the special progress/check sheet every fifteen (15) minutes.

4. A room used for seclusion must:

   a. Allow staff full view of the member in all areas of the room; and
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107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)

b. Be free of potentially hazardous materials, objects, or conditions such as unprotected light fixtures, phone cords, and electrical outlets.

5. If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse must immediately speak with the ordering physician or nurse practitioner permitted to order restraint or seclusion to receive further instructions; and

6. A physician, nurse practitioner, RN, or LPN trained in the use of emergency safety interventions must evaluate the member’s well-being immediately after member is removed from seclusion.

107.09-04 Examination Following Use of Restraint or Seclusion

A. Within thirty (30) minutes of the initiation of the emergency safety intervention, the team physician, or nurse practitioner must conduct a face-to-face of the physical and psychological well-being of the member. If the examination is not able to occur within thirty (30) minutes, the reason why must be documented in the member’s record. The examination may be in person, or by phone in consult with a registered nurse. Documentation of the physician’s or nurse practitioner’s examination must be entered into the member’s record. When a telephonic consult occurs, the physician, or nurse practitioner must examine the member in person within the following time constraints:

1. Within one (1) hour of when the registered nurse requests an examination;

2. Within one (1) hour of when information relayed is suggestive of causes leading to physical harm to the member;

3. Within one (1) hour if an examination has not yet occurred during the member’s stay; or

4. Within six (6) hours in all other circumstances.

B. Thereafter, the need for a member’s continuation in the emergency safety intervention shall be re-evaluated every two hours by a nurse. The nurse shall examine the member in person. For a member subject to an order of seclusion, the examination may be conducted outside the seclusion area; the nurse shall note the clinical reasons for selection of the examination site. For a member subject to
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107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)

an order of restraint, the examination may be conducted with the member free of restraints; the nurse shall note the clinical reasons for selecting whether the member is examined in or free or restraints. The nurse shall assess the member to determine whether the intervention is absolutely necessary to protect the member from causing serious harm to self or others. If the nurse finds these conditions are still met, then the emergency safety intervention may be continued if the physician’s or nurse practitioner’s order has not yet lapsed. Should the member not need continued seclusion or restraint, the nurse shall release the member even if the time frame of the original order has not yet lapsed. Documentation of the nurse’s examination must be entered into the member’s record.

C. In addition to the above criteria, examinations conducted under this section include, but are not limited to:

1. The member’s physical and psychological status, including vital signs;

2. The member’s behavior;

3. The appropriateness of the intervention measures; and

4. Any complications resulting from the intervention.

107.09-05 Use of Time Outs

A. A member in time out must never be physically prevented from leaving the time out area;

B. Time out may take place away from an activity or from other members, such as in the member’s room (exclusionary), or in the area of activity of other members (inclusionary);

C. Staff must monitor the member while he or she is in time out.

107.09-06 Documentation of Restraint and Seclusion

A. Documentation regarding the use of restraint and seclusion must be kept within the member record; and must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation of the restraint or seclusion must include all the following:
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107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)

1. Each order for restraint or seclusion as required in Section 107.09-02 above;

2. The time the emergency safety intervention actually began and ended;

3. The time and results of the examinations as required in Section 107.09-04 above;

4. The emergency safety situation that required the member to be restrained or put into seclusion;

5. The name(s) of the staff involved in the emergency safety intervention;

6. The outcome of the situation; and

7. The member’s vital signs.

B. If the member is a minor or has a legal guardian:

1. The facility must notify the parents or legal guardians of the member who has been restrained or placed in seclusion as soon as possible after the initiation of the restraint or seclusion. Families or guardians may not waive this requirement.

2. The facility must document in member’s record that the parents or legal guardians have been notified of the emergency safety intervention, including the date and time of notification and the name of the staff providing the notification.

107.09-07 Post-intervention Debriefings

A. Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the member must have a face to face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the member. Other staff may participate in the discussion when it is deemed appropriate by the facility. The member’s parents or legal guardians, as applicable, must be given the opportunity to participate in the discussion, unless clinical staff have determined that participation would be detrimental to the member. The facility must conduct such discussion in a language that is understood by the member’s parents or legal guardians. The discussion must
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107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)

provide both the member and the staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the member, or others that could prevent the future use of restraint or seclusion.

B. Within 24 hours after the use of restraint or seclusion, all staff involved (including any clinical staff involved) in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a separate debriefing session (to not include the member) that includes, at a minimum, a review and discussion of:

1. The emergency situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention; and

2. Alternative techniques that might have prevented the use of restraint or seclusion; and

3. The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and

4. The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

C. Staff must document in the member’s record that both debriefing sessions took place and must include in that documentation the names and signatures of staff who were present for the debriefing, the names of staff that were excused from the debriefing (and the reason for the non-presence of the staff), and any changes to the member’s treatment plan that result from the debriefings.

107.09-08 Medical Treatment for Injuries Resulting from an Emergency Safety Intervention

Members requiring Third Party Treatment of Medical and Psychological Conditions are subject to the following requirements:

1. Staff must immediately obtain medical treatment from qualified medical personnel for a member injured as a result of use of a restraint or seclusion.

2. The PRTF must have affiliations or written transfer agreements in effect with one or more hospitals enrolled with MaineCare that reasonably ensure that:
107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)

1. A member will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

2. Medical and other information needed for care of the member in light of such a transfer will be exchanged between the institutions in accordance with state medical privacy law (including 22 M.R.S. §1711-C and 34-B M.R.S. §1207), including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

3. Services are available to each member twenty-four hours a day, seven days a week.

3. Staff must document in the member’s record all injuries that occur as a result of the use of restraints or seclusion, including injuries to staff resulting from the intervention.

4. Staff involved in the use of restraint or seclusion that results in injury to a member or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

107.10 WAIVERS

107.10-01 Waiver Criteria. In certain circumstances, DHHS may authorize waivers of Specific PRTF Requirements. All waiver requests must be submitted to the Office of Child and Family Services, and approvals must be obtained in writing prior to initiating any waiver request. Federally mandated requirements are not waivable under any circumstance. Any approved waiver request must be clearly documented in the member’s record.

107.11 REIMBURSEMENT


For each MaineCare provider enrolled as a participating Psychiatric Residential Treatment Facility, the Department will determine a prospective per diem rate for routine and fixed costs, as determined under Chapter III, Section 107, Principles of Reimbursement for Psychiatric Residential Treatment Facilities. Medical, clinical,
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107.11 REIMBURSEMENT (cont.)

and direct care services are reimbursed per diem as described in Chapter III, Section 107, Principles of Reimbursement for Psychiatric Residential Treatment Facilities. Providers are required to obtain separate MaineCare provider number(s) for each PRTF. Upon completion of the provider’s fiscal year, the providers shall submit to the Department, a cost report for each PRTF that has been assigned a provider number(s) in accordance with Chapter III of the Principles of Reimbursement.

A. In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek from any other sources payment for the rendered service prior to billing the MaineCare Program.

B. Psychiatric Residential Treatment Facilities may not accept or receive payment for covered services in addition to the MaineCare payment.

107.12 BILLING INFORMATION

Providers must bill in accordance with the Department’s billing Instructions for the UB-04 Claim Form. Billing instructions are available at: http://www.maine.gov/bms/provider.htm.
### Appendix A

#### Qualifying Diagnoses

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia Spectrum</td>
<td>Schizophrenia</td>
<td>F20.9</td>
</tr>
<tr>
<td>Moderate and Severe Modifier</td>
<td>Paranoic schizophrenia</td>
<td>F20.0</td>
</tr>
<tr>
<td></td>
<td>Disorganized schizophrenia</td>
<td>F20.1</td>
</tr>
<tr>
<td></td>
<td>Catatonic schizophrenia</td>
<td>F20.2</td>
</tr>
<tr>
<td></td>
<td>Undifferentiated schizophrenia</td>
<td>F20.3</td>
</tr>
<tr>
<td></td>
<td>Residual schizophrenia</td>
<td>F20.5</td>
</tr>
<tr>
<td></td>
<td>Schizophreniform disorder</td>
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</tr>
<tr>
<td></td>
<td>Schizoaffective disorder, bi-polar type</td>
<td>F25.0</td>
</tr>
<tr>
<td></td>
<td>Schizoaffective disorder, depressive type</td>
<td>F25.1</td>
</tr>
<tr>
<td></td>
<td>Other Schizoaffective disorders</td>
<td>F25.8</td>
</tr>
<tr>
<td>Bipolar and Related Disorders</td>
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</tr>
<tr>
<td></td>
<td>Bipolar I disorder, current episode manic w/out psychotic features, severe</td>
<td>F31.13</td>
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<tr>
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<td>Bipolar I disorder, current episode manic, severe with psychotic features</td>
<td>F31.2</td>
</tr>
<tr>
<td></td>
<td>Bipolar I disorder, current episode depressed, moderate</td>
<td>F31.32</td>
</tr>
<tr>
<td></td>
<td>Bipolar I disorder, current episode depressed, severe, w/out psychotic features</td>
<td>F31.4</td>
</tr>
<tr>
<td></td>
<td>Bipolar I disorder, current episode depressed, severe, with psychotic features</td>
<td>F31.5</td>
</tr>
<tr>
<td></td>
<td>Bipolar I disorder, current episode mixed, moderate</td>
<td>F31.62</td>
</tr>
<tr>
<td></td>
<td>Bipolar I disorder, current episode mixed, severe, w/out psychotic features</td>
<td>F31.63</td>
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</tr>
<tr>
<td></td>
<td>Bipolar I disorder in partial remission, most recent episode manic</td>
<td>F31.73</td>
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<td></td>
<td>Bipolar I disorder, in partial remission, most recent episode depressed</td>
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</tr>
<tr>
<td></td>
<td>Bipolar II disorder</td>
<td>F31.81</td>
</tr>
<tr>
<td></td>
<td>Other bipolar disorder</td>
<td>F31.89</td>
</tr>
<tr>
<td></td>
<td>Cyclothymic Disorder</td>
<td>F34.0</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>Major depressive disorder, single episode, moderate</td>
<td>F32.1</td>
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<td>F32.4</td>
</tr>
<tr>
<td></td>
<td>Major depressive disorder, recurrent, moderate</td>
<td>F33.1</td>
</tr>
<tr>
<td></td>
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<td>F33.2</td>
</tr>
<tr>
<td></td>
<td>Major depressive disorder, recurrent, severe, with psychotic symptoms</td>
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<tr>
<td></td>
<td>Major depressive disorder, recurrent, in partial remission</td>
<td>F33.41</td>
</tr>
<tr>
<td></td>
<td>Disruptive mood dysregulation disorder</td>
<td>F34.8</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>Panic Disorder</td>
<td>F41.0</td>
</tr>
<tr>
<td></td>
<td>Generalized anxiety disorder</td>
<td>F41.1</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>Borderline Personality Disorder</td>
<td></td>
</tr>
<tr>
<td>Trauma and Stressor Related Disorders</td>
<td>Posttraumatic stress disorder</td>
<td>F43.10</td>
</tr>
<tr>
<td></td>
<td>Posttraumatic stress disorder, acute</td>
<td>F43.11</td>
</tr>
<tr>
<td></td>
<td>Posttraumatic stress disorder, chronic</td>
<td>F43.12</td>
</tr>
<tr>
<td>Dissociative Disorder</td>
<td>Dissociative identity disorder</td>
<td>F44.81</td>
</tr>
<tr>
<td>Disruptive, Impulse-Control, and Conduct Disorders</td>
<td>Oppositional defiant disorder</td>
<td>F91.3</td>
</tr>
<tr>
<td></td>
<td>Intermittent Explosive Disorder</td>
<td>F63.81</td>
</tr>
<tr>
<td>NeuroDevelopmental Disorders</td>
<td>Attention Deficit Hyperactivity Disorders</td>
<td>F90-F90.9</td>
</tr>
</tbody>
</table>
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Appendix B

CANS Domains

1. Child Behavioral / Emotional Needs:
   Two or more ratings of ‘3’ or;
   Three or more ratings of at least a ‘2’ on the following:
   - Psychosis / Thought Disturbances
   - Depression
   - Anxiety
   - Impulse/Hyperactivity
   - Oppositional Behavior
   - Conduct
   - Anger Control
   - Substance Use

2. Child Risk Factors:
   Two or more ratings of ‘3’ or;
   Three or more ratings of at least a ‘2’ on any of the following:
   - Self-Injurious Behavior
   - Suicide Risk
   - Reckless Behavior (other Self Harm)
   - Danger to Others
   - Sexual Aggression
   - Runaway
   - Delinquent Behavior
   - Fire Setting
   - Intentional misbehavior
   - Bullying Others

3. Caregiver Needs:
   Two or more ratings of ‘3’ or;
   Three or more ratings of ‘2’ on any of the following:
   - Supervision
   - Involvement with Care
   - Knowledge of Child’s Needs
   - Organizational Skills
   - Social Resources
   - Residential Stability
   - Physical
   - Mental Health
   - Substance Abuse
   - Developmental
   - Family Stress
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Appendix C
Required Minimum Staffing Requirement

The PRTF must employ staffing to adequately meet the needs of the program, and must minimally meet the following staffing requirements:

Medical Director – on site: 1 Full Time Equivalent (FTE)
Facility Administrator – on site: 1 FTE
Clinical Coordinator – on site: 1 FTE
Clinician – on site: 1 FTE per 5 members
Nurse – on site: 1 FTE per 10 members awake, 1 FTE per 20 members asleep
Nurse Support – on site: 1 FTE per 20 members awake
Direct Care – on site: 1 FTE per 2 members awake, 1 FTE per 4 members asleep
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<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 COST COMPONENTS</td>
<td>17</td>
</tr>
<tr>
<td>16 ROUTINE COST COMPONENT</td>
<td>18</td>
</tr>
<tr>
<td>17 FIXED COSTS COMPONENT</td>
<td>23</td>
</tr>
<tr>
<td>18 MEDICAL CLINICAL AND DIRECT CARE COSTS</td>
<td>40</td>
</tr>
<tr>
<td>19 WAIVER</td>
<td>41</td>
</tr>
<tr>
<td>20 SPECIAL SERVICE ALLOWANCE</td>
<td>41</td>
</tr>
<tr>
<td>21 MEDICAL LEAVE AND THERAPEUTIC LEAVE ALLOWANCES</td>
<td>41</td>
</tr>
<tr>
<td>22 ESTABLISHMENT OF INTERIM RATE</td>
<td>42</td>
</tr>
<tr>
<td>23 INTERIM AND SUBSEQUENT RATES</td>
<td>42</td>
</tr>
<tr>
<td>24 FINAL RATES</td>
<td>43</td>
</tr>
<tr>
<td>25 FINAL AUDIT OF INTERIM RATES</td>
<td>43</td>
</tr>
<tr>
<td>26 SETTLEMENT OF ROUTINE AND FIXED COSTS</td>
<td>44</td>
</tr>
<tr>
<td>27 CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS</td>
<td>44</td>
</tr>
<tr>
<td>28 ADJUSTMENTS</td>
<td>45</td>
</tr>
<tr>
<td>29 APPEAL PROCEDURES-START UP COSTS-DEFICIENCY RATE</td>
<td>45</td>
</tr>
<tr>
<td>30 DEFICIENCY ROUTINE AND FIXED COSTS RATE</td>
<td>46</td>
</tr>
<tr>
<td>31 APPENDIX</td>
<td>48</td>
</tr>
</tbody>
</table>
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

LEGAL AUTHORITY

The following federal statutory and regulatory authorities govern these services:

42 U.S.C. §§ 1396d(a)(16) and (h) 42 CFR §441.150 through §441.184
42 CFR §483.350 through §483.376

1 GENERAL PROVISIONS

1.1 PURPOSE

The purpose of these principles is to comply with 42 U.S.C. §§ 1396d(a)(16) and (h) 42 CFR §441.150 through §441.184 and 42 CFR §483.350 through §483.376. These principles provide reimbursement methodology for Psychiatric Residential Treatment Facility (PRTF) services (provided under the MaineCare Program in accordance with Title XIX of the Social Security Act) through the use of rates which are reasonable and adequate to meet the costs of the facility. These costs must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Accordingly, these rates take into account the costs of services required to attain or maintain the highest practicable physical, psychological, and psychosocial well-being of each MaineCare resident.

1.2 AUTHORITY

The Authority of the Department to accept and administer any funds which may be available from private, local, State or Federal sources for the provision of the services set forth in the Principles of Reimbursement is established in Title 22 of the Maine Revised Statutes Annotated. The regulations themselves are issued pursuant to authority granted to the Department by Title 22 of the Maine Revised Statutes Annotated §§ 41-B and 42(1).

1.3 GENERAL DESCRIPTION OF THE RATE SETTING SYSTEM

Providers of PRTF services are paid a statewide per diem rate for medical, clinical and direct care costs (direct care services), and paid a facility-specific rate for routine and fixed costs (room and board costs). The routine and fixed costs facility rate is informed by annual cost reporting performed by the providers using a state-developed cost report. The medical, clinical and direct care per diem rate is not cost settled. The routine and fixed cost rate is cost settled by the Department.

(A) Routine and Fixed Costs: An interim payment system for psychiatric residential treatment facilities (PRTF) is established by these rules in which
1 GENERAL PROVISIONS (cont.)

the payment rate for services is set in advance of the actual provision of those services. A facility's cost report is reviewed to extract those costs that are allowable costs. A facility's costs may fall into an allowable cost category, but be determined unallowable because they exceed certain limitations. Once allowable costs have been determined they will be separated into two (2) components - routine and fixed costs, resulting in one cost settled interim rate for room and board.

(B) **Medical, Clinical, and Direct Care Costs:** Medical, Clinical, and Direct Care costs are reimbursed at a Per Diem rate. The per diem rate is a statewide rate and it is not subject to cost settlement.

1.4 DEFINITIONS

**Department** as used throughout these principles is the State of Maine Department of Health and Human Services.

**State Licensing and Federal Certification** as used throughout these principles is the "Regulations Governing the Licensing and Functioning of Children’s Residential Care Facilities with Secure Capacity and Psychiatric Treatment Level 2" and the Federal Certification requirements for psychiatric residential treatment facility services that are in effect at the time the cost is incurred. Secure Capacity Level 2 means Psychiatric Residential Treatment Facility (PRTF).

**Accrual Method of Accounting** means that revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

**AICPA** is the American Institute of Certified Public Accountants.

**Allowable Costs** are costs that MaineCare will reimburse under these Principles of Reimbursement and that are below the caps.

**Ancillary Services** are medical services identifiable to a specific resident furnished at the direction of a physician and for which charges are customarily paid separately from the direct care per diem charge.

**Capital Asset** is defined as services, equipment, supplies or purchases which have a value of $500 or greater.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

1 GENERAL PROVISIONS (cont.)

Cash Method of Accounting means that revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

Centers for Medicare and Medicaid Services (CMS) is the agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

Common Ownership exists when an individual possesses significant ownership or equity in the provider and the institution or organization serving the provider.

Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

Cost Finding is the process of segregating costs by cost centers and allocating indirect cost to determine the cost of services provided.

Days of Care are the total number of days of care provided whether or not payment is received and the number of any other days for which payment is made. (Note: Bed hold days and discharge days are included only if payment is received for these days.)

Direct Costs are costs that are directly identifiable with a specific activity, service or product of the program.

Discrete Costing is the specific costing methodology that calculates the costs associated with new additions/renovations of psychiatric residential treatment facilities. None of the historical basis of costs from the original building are allocated to the addition/renovation.

Donated Asset is an asset acquired without making any payment in the form of cash, property or services.

Experience Modifier is the rating number given to PRTFs based on worker’s compensation claims submitted for the previous three (3) years. The lower the rating number, the better the worker’s compensation claims ratio.

Fair Market Value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been communicated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

Fixed Cost Component shall be determined based upon actual allowable costs incurred by an economically and efficiently operated facility.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

1 GENERAL PROVISIONS (cont.)

Fringe Benefits include payroll taxes, qualified retirement plan contributions, group health, dental, and life insurance, cafeteria plans and flexible spending plans.

Generally Accepted Accounting Principles (GAAP) are accounting principles approved by the American Institute of Certified Public Accountants: those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB technical Bulletins, (7) FASB Concepts statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

Historical Cost is the cost incurred by the present owner in acquiring the asset. The historical cost shall not exceed the lower of:

(a) current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase;

(b) fair market value at the time of the purchase;

(c) the allowable historical cost of the first owner of record on or after September 1, 2018.

In computing the historical cost three (3) categories of assets will be evaluated: Land, Building, and Equipment. Each category will be evaluated based on the methods listed above.

Land (non-depreciable) includes the land owned and used in provider operations. Included in the cost of the land are costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider and other land expenditures of a non-depreciable nature.

Land Improvements (depreciable) include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the provider).

Leasehold Improvements include betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessee after the expiration of the lease.

Medical Leave Days are defined as days PRTFs are reimbursed at the routine and fixed costs rate when a member is hospitalized for an acute medical or psychiatric condition that cannot be treated at the PRTF.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

1 GENERAL PROVISIONS (cont.)

Necessary and Proper Costs are for services and items that are essential to provide appropriate resident care and activities at an efficient and economically operated facility. They are costs for services and items that are commonly provided and are commonly accepted as essential for the type of facility in question.

Net Book Value of an asset is the depreciable basis used under the program by the asset's last participation owner less the depreciation recognized under the program.

Owners include any individual or organization with ten percent (10%) equity interest in the provider's operation and any members of such individual's family or his or her spouse's family. Owners also include all partners and all stockholders in the provider's operation and all partners and stockholders or organizations that have an equity interest in the provider's operation.

Policy Planning Function includes the policy-making, planning and decision-making activities necessary for the general and long-term management of the affairs of the facility, including, but not limited to the following:

(a) the financial management of the facility;
(b) the establishment of personnel policies;
(c) the planning of resident admission policies; and
(d) the planning of expansion and financing thereof.

Psychiatric Residential Treatment Facility (PRTF) means a facility other than a hospital, that provides psychiatric services to individuals under age 21, in an inpatient setting, and which meets the requirements set forth in Chapter II, Section 107, Psychiatric Residential Treatment Facility Services.

Reasonable Costs are those services and items for which a prudent and cost-conscious buyer would pay and which are essential for resident care and activities at the facility as determined by the Division of Audit. If any of a provider's costs are determined to exceed by a significant amount, those that a prudent and cost-conscious buyer would have paid, those costs of the provider will be considered unreasonable in the absence of a showing by the provider that those costs were unavoidable.

Related to Provider means that the provider to a significant extent is associated or affiliated by common ownership with or has control of or is controlled by the organization furnishing the services, facilities, and supplies.

State Fiscal Year is defined as July 1st of the first year through June 30th of the second year. Example: State fiscal year 2019 begins July 1st of 2018 and ends June 30th of 2019.
SECTION 107 PRINCIPLES OF REIMBURSEMENT FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES

THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

1 GENERAL PROVISIONS (cont.)

Straight-line Method is a method of depreciation whereby the cost or other basis (e.g., fair market value in the case of a donated asset) of an asset, less its estimated salvage value, if any, is determined first. This amount is then distributed in equal amounts over the period of the estimated useful life of the asset.

Therapeutic Leave Days are defined as days when PRTFs are reimbursed at the routine and fixed costs rate when a member is on a leave of absence for therapeutic reasons as directed by the team physician as indicated in the member’s treatment plan.

2 REQUIREMENTS FOR PARTICIPATION IN MAINECARE PROGRAM

2.1 Psychiatric Residential Treatment Facilities (PRTFs) must satisfy all of the following prerequisites in order to be reimbursed for care provided to MaineCare members:

2.1.1 be licensed and certified by the Maine Department of Health and Human Services-Center for Disease Control and Prevention, pursuant to 22 M.R.S. §8101(4-B) and 42 CFR, Part 441, Subpart D, and 107.2-1.2 have a MaineCare Provider Agreement with the Department of Health and Human Services.

2.1.2 MaineCare payments shall not be made to any facility that fails to meet all the requirements of Principle 2.1.

2.1.3 Medical, Clinical, and Direct Care Services means services provided by a qualified provider directly to a member in a PRTF as outlined in Chapter II, Section 107 in accordance with covered services described in Chapter II Section 107.

3 RESPONSIBILITIES OF OWNERS OR OPERATORS

3.1 The owners or operators of a psychiatric residential treatment facility shall prudently manage and operate PRTF services of adequate quality to meet its members’ needs. Neither the issuance of an interim rate, nor final orders made by the Commissioner or a duly authorized representative shall in any way relieve the owner or operator of a PRTF from full responsibility for compliance with the requirements and standards of the Department of Health and Human Services or Federal requirements and standards.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

4 DUTIES OF THE OWNER OR OPERATOR

In order to qualify for MaineCare reimbursement the owner or operator of a PRTF, or a duly authorized representative shall:

4.1 Comply with the provisions of Principles 3 and 4 setting forth the requirements for participation in the MaineCare Program.

4.2 Submit master file documents and cost reports in accordance with the provisions of Principles 12.1 and 12.2 of these Principles.

4.3 Maintain adequate financial and statistical records and make them available when requested for inspection by an authorized representative of the Department of Health and Human Services, the state, or the Federal government.

4.4 Assure that annual records are prepared in conformance with Generally Accepted Accounting Principles (GAAP), except where otherwise required.

4.5 Assure that the construction of buildings and the maintenance and operation of premises and services comply with all applicable health and safety standards.

4.6 Submit such data, statistics, schedules or other information that the Department requires in order to carry out its functions. Failure to supply the required documentation may result in the Department imposing the deficiency routine and fixed costs rate described in Principle 30 of these Principles.

5 ACCOUNTING REQUIREMENTS

5.1 ACCOUNTING PRINCIPLES

5.1.1 All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules require specific variations in such principles and Medicare Provider Reimbursement Regulations HIM-15.

5.1.2 The provider shall establish and maintain a financial management system that provides for adequate internal control assuring the accuracy of financial data, safeguarding of assets and operation efficiency.

5.1.3 The provider shall report on an accrual basis, unless it is a state or municipal institution that operates on a cash basis. The provider whose records are not maintained on an accrual basis shall develop accrual data for reports on the
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

5 ACCOUNTING REQUIREMENTS (cont.)

basis of an analysis of the available documentation. The provider shall retain all such documentation for audit purposes.

6 PROCUREMENT STANDARDS

6.1 Providers shall establish and maintain a code of standards to govern the performance of its employees engaged in purchasing Capital Assets. Such standards shall provide, and providers shall implement to the maximum extent practical, open and free competition among vendors. Providers are encouraged to participate in group purchasing plans when feasible.

6.2 If a provider does not accept the lowest bid for a Capital Asset, the amount over the lower bid that cannot be demonstrated to be a reasonable and necessary expenditure is an unallowable cost. In situations not competitively bid, providers must act as a prudent buyer as referenced in Principle 9.2 in these Principles.

7 COST ALLOCATION PLANS AND CHANGES IN ACCOUNTING METHODS

With respect to the allocation of costs to the PRTF and within the PRTF, the following rules shall apply:

7.1 Providers that have costs allocated from related entities included in their cost reports shall include as a part of their cost report submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements which must also be submitted with the MaineCare cost report. In the case of a home office, related management company, or real estate management company, this would include a completed Home Office Cost Statement that shows the costs that are removed which are unallowable. The provider shall submit this reconciliation with the MaineCare cost report.

7.2 No change in accounting methods or basis of cost allocation may be made without written prior approval from the Division of Audit.

7.3 Any application for a change in accounting method or basis of cost allocation, which has an effect on the amount of allowable costs or computation of the interim rate of payment, shall be made within the first ninety (90) days of the reporting year. The application shall specify:

7.3.1 the nature of the change;

7.3.2 the reason for the change;
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

7 COST ALLOCATION PLANS AND CHANGES IN ACCOUNTING METHODS (cont.)

7.3.3 the effect of the change on the interim rate of payment; and

7.3.4 the likely effect of the change on future rates of payment.

7.4 The Department shall review each application and within sixty (60) days of the receipt of the application approve, deny or propose modification of the requested change. If no action is taken within the specified period, the application will be deemed to have been approved.

7.5 Each provider shall notify the Department of changes in statistical allocations or record keeping required by the Medicare Intermediary.

7.6 The capital component (any element of fixed cost that is included in the price charged by a supplier of goods or services) of purchased goods or services, such as plant operation and maintenance, utilities, dietary, laundry, housekeeping, and all others, whether or not acquired from a related party, shall be considered as costs for the particular good or service and not classified as Property and Related costs (fixed costs) of the PRTF.

7.7 Costs allocated to the PRTF shall be reasonable and necessary, as determined by the Department pursuant to these rules.

7.8 It is the duty of the provider to notify the Division of Audit within five (5) days of any change in its customary charges to the general public. A rate schedule may be submitted to the Department by the PRTF to satisfy this requirement if the schedule allows the Department the ability to determine with certainty the charge structure of the PRTF.

7.9 All year-end accruals must be paid by the PRTF within six (6) months after the end of the fiscal year in which the amounts are accrued. If the accruals are not paid within such time, these amounts will be deducted from allowable costs incurred in the first field or desk audit conducted following that six-month period.

7.10 The unit of output for cost finding shall be the costs of routine services per resident day. The same cost finding method shall be used for all PRTFs. Total allowable costs shall be divided by the actual days of care to determine the cost per bed day.

Total allowable costs shall be allocated based on the occupancy data reported and the following statistical bases:

7.10.1 Plant operation and maintenance. Square feet serviced.

7.10.2 Housekeeping. Square feet serviced.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

7 COST ALLOCATION PLANS AND CHANGES IN ACCOUNTING METHODS (cont.)

7.10.3 Laundry. Resident days, or pounds of laundry, whichever is most appropriate.

7.10.4 Dietary. Number of meals served.

7.10.5 General and Administrative and Financial and Other Expenses. Total accumulated costs not including General and Administrative and Financial Expense.

8 ALLOWABILITY OF COST

8.1 If these principles do not set forth a determination of whether or not a cost is allowable or sufficiently define a term used, reference will be made first, to the Medicare Provider Reimbursement Manual (HIM-15) guidelines, followed by the Internal Revenue Service Guidelines in effect at the time of such determination if the HIM-15 is silent on the issues.

9 GENERAL COST PRINCIPLES

9.1 Principle. Federal law requires that payment for PRTF services provided under MaineCare shall be provided through the use of rates which are reasonable and adequate to meet costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Costs incurred by the PRTF must be reasonable, necessary, and related to resident care, subject to principles relating to specific items of revenue and cost.

9.2 Costs must be ordinary and necessary and related to resident care. They must be of the nature and magnitude that prudent and cost conscious management would pay for a specific item or service.

9.3 Costs must not be of the type conceived for the purpose of circumventing the regulations. Such costs will be disallowed under Principle 9.

9.4 Costs that relate to inefficient, unnecessary or luxurious care or unnecessary or luxurious facilities or to activities not common and accepted in the PRTF field are not allowable.

9.5 Wages, to be allowable, must be reasonable and related to resident care and pertinent to the operation of the facility. The services must actually be performed and must be paid in full. The wages must be reported to all appropriate state and federal tax authorities to the extent required by law for income tax, social security, and unemployment insurance purposes.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

9 GENERAL COST PRINCIPLES (cont.)

9.6 Costs incurred for resident services that are rendered in common to MaineCare residents as well as to non-MaineCare residents, will be allowed on a pro rata basis, unless there is a specific allocation defined elsewhere in these Principles.

9.7 Cost to Related Organizations Principle. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable costs of the provider at the cost to the related organization. However, such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. Providers should reference Principle 6 of these Principles.

10 UPPER PAYMENT LIMITS

10.1 Aggregate payments to PRTFs pursuant to these rules may not exceed the limits established for such payments in 42 CFR 447.272, using Medicare principles of reimbursement.

10.2 If the Division of Audit projects that MaineCare payments to PRTFs in the aggregate will exceed the Medicare upper limit, the Division of Audit shall limit some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit as set forth in Principle 10.4.

10.3 In computing the projections that MaineCare payments in the aggregate are within the Medicare Upper Limit, any facility exceeding one hundred-twelve percent (112%) of the State mean allowance routine service costs may be notified that additional information is required to determine allowable costs under the Medicare Principles of Reimbursement, including any exceptions as stated in 42 CFR §413.30(f). This information may be requested within thirty (30) days of the effective date of these regulations, and thereafter at the time the interim rates are set.

10.4 Facility Rate Limitations if Aggregate Limit is exceeded. If the Department projects that the MaineCare payments to PRTFs in the aggregate exceed the Medicare upper limit, the Department shall limit payments to those facilities whose projected MaineCare payments exceed what would have been paid using Medicare Principles of Reimbursement. The Department will notify the facilities when the Department projects that the MaineCare payments to PRTFs in the aggregate exceed the Medicare upper limit and that the Department must limit payments to those facilities to the level that would reduce the aggregate payments to the Medicare upper limit.
SECTION 107 PRINCIPLES OF REIMBURSEMENT FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY SERVICES

THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

11 SUBSTANCE OVER FORM

11.1 The cost effect of transactions that have the effect of circumventing these rules may be adjusted by the Department on the principle that the substance of the transaction shall prevail over the form.

12 RECORD KEEPING AND RETENTION OF RECORDS

12.1 Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the cost report, and must, upon request, make these records available to the Department, or the U.S. Department of Health and Human Services, and the authorized representatives of either agency.

12.2 Complete documentation means clear evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service charge schedule and amounts of income received by service, or any other record which is necessary to provide the Commissioner with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

12.3 The provider shall maintain all such records for at least five (5) years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later. The Division of Audit shall keep all cost reports, supporting documentation submitted by the provider, correspondence, work papers and other analysis supporting audits for a period of three (3) years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division of Audit shall retain all records that are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

12.4 When the Department of Health and Human Services determines that a provider is not maintaining records as outlined above for the determination of reasonable cost under the program, the Department, upon determination of just cause, shall send a written notice to the provider that in thirty (30) days the Department intends to reduce payments, unless otherwise specified, to a ninety percent (90%) level of reimbursement as set forth in Principle 30 of these Principles. The notice shall contain an explanation of the deficiencies. Payments shall remain reduced until the Department is assured that adequate records are maintained, at which time reimbursement will be reinstated at the full rate.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

12 RECORD KEEPING AND RETENTION OF RECORDS (cont.)

from that time forward. If, upon appeal, the provider documents that there was not just cause for the reduction in payment, all withheld amounts will be restored to the provider.

13 FINANCIAL REPORTING

13.1 MASTER FILE

The following documents concerning the provider or, where relevant, any entity related to the Provider, will be submitted to the Department at the time that the cost report is filed. Such documents will be updated to reflect any changes on a yearly basis with the filing of a cost report. Such documents shall be used to establish a Master file for each facility in the MaineCare Program:

13.1.1 Copies of the articles of incorporation and bylaws, of partnership agreements of any provider or any entity related to the provider;

13.1.2 Chart of accounts and procedures manual, including procurement standards established pursuant to Principle 6;

13.1.3 Plant layout;

13.1.4 Terms of capital stock and bond issues;

13.1.5 Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing and bonus agreements;

13.1.6 Schedules for amortization of long-term debt and depreciation of plant assets;

13.1.7 Summary of accounting principles, cost allocation plans, and step-down statistics used by the provider;

13.1.8 Related party information on affiliations, and contractual arrangements;

13.1.9 Tax returns of the PRTF; and

13.1.10 Any other documentation requested by the Department for purposes of establishing a rate or conducting an audit.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

13 FINANCIAL REPORTING (cont.)

If any of the items listed in Principle 13.1.1 – 13.1.10 are not submitted in a timely fashion the Department may impose the deficiency routine and fixed costs rate described in Principle 30 of these Principles.

13.2 UNIFORM COST REPORTS

13.2.1 All PRTFs are required to submit cost reports as prescribed herein to the State of Maine Department of Health and Human Services, Division of Audit, State House Station 11, Augusta, ME, 04333. Such cost reports shall be based on the fiscal year of the facility. If a PRTF determines from the as filed cost report that the PRTF owes moneys to the Department, a check equal to one hundred percent (100%) of the amount owed to the Department will accompany the cost report. If a check is not received with the cost report the Department may elect to offset the current payments to the facility until the entire amount is collected from the provider.

13.2.2 Forms. Annual report forms shall be provided or approved for use by PRTFs in the State of Maine by the Department of Health and Human Services.

13.2.3 Each PRTF in Maine must submit an annual cost report within five (5) months of the end of each fiscal year on forms prescribed by the Division of Audit. If available, the PRTF can electronically submit a copy of the cost report. The inclusive dates of the reporting year shall be the twelve-month period of each provider's fiscal year, unless advance authorization to submit a report for a lesser period has been granted by the Director of the Division of Audit. Failure to submit a cost report in the time prescribed above may result in the Department imposing the deficiency routine and fixed costs rate described in Principle 30.

13.2.4 Certification by operator. The cost report is to be certified by the owner and administrator of the facility. If the return is prepared by someone other than staff of the facility, the preparer must also sign the report.

13.2.5 The original and one (1) copy of the cost report must be submitted to the Division of Audit. All documents must bear original signatures.

13.2.6 The following supporting documentation is required to be submitted with the cost report:
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

13 FINANCIAL REPORTING (cont.)

13.2.6.1 Financial statements;

13.2.6.2 Reconciliation of the financial statements to the cost report;

13.2.6.3 Any other financial information requested by the Department; and

13.2.6.4 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.

13.3 ADEQUACY AND TIMELINESS OF FILING

13.3.1 The cost report and financial statements for each facility shall be filed not later than five (5) months after the fiscal year end of the provider. When a provider fails to file an acceptable cost report by the due date, the Department may send the provider a notice by certified mail, return receipt requested, advising the provider that all payments are suspended on receipt of the notice until an acceptable cost report is filed. Reimbursement will then be reinstated at the full rate from that time forward but, reimbursement for the suspension period shall be made at the deficiency rate of ninety percent (90%).

13.3.2 The Division of Audit may reject any filing that does not comply with these regulations. In such case, the report shall be deemed not filed, until refilled and in compliance.

13.3.3 Extensions to the filing deadline will only be granted under the regulations stated in the Medicare Provider Reimbursement Manual (HIM-15).

13.4 REVIEW OF COST REPORTS BY THE DIVISION OF AUDIT

13.4.1 Uniform Desk Review

13.4.1.1 The Division of Audit shall perform a uniform desk review on each cost report submitted.

13.4.1.2 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, allowable costs and a summary of the results of the review. The Division of Audit will schedule an on-site audit or will prepare a settlement based on the findings determined by the uniform desk review.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

13 **FINANCIAL REPORTING** (cont.)

13.4.1.3 Unless the Division of Audit intends to schedule an on-site audit or requests additional information from the provider, it shall issue a written summary report of its findings and adjustments upon completion of the uniform desk review.

13.4.2 **On-site Audit**

13.4.2.1 The Division of Audit will perform on-site audits, as considered appropriate, of the provider's financial and statistical records and systems.

13.4.2.2 The Division of Audit will base its selection of a facility for an on-site audit on factors such as but not limited to: length of time since last audit, changes in facility ownership, management, or organizational structure, random sampling evidence or official complaints of financial irregularities, questions raised in the uniform desk review, failure to file a timely cost report without a satisfactory explanation, and prior experience.

13.4.2.3 The audit scope will be limited so as to avoid duplication of work performed by a facility's independent public accountant, provided such work is adequate to meet the Division of Audit’s requirements.

13.4.2.4 Upon completion of an audit, the Division of Audit shall review its draft findings and adjustments with the provider and issue a written summary of such findings.

13.5 **SETTLEMENT OF COST REPORTS**

13.5.1 Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division of Audit’s decision to reopen shall be based on: (1) new and material evidence submitted by the provider or discovered by the Department; or, (2) evidence of a clear and obvious material error.

13.5.2 Reopening means an affirmative action taken by the Division of Audit to re-examine the correctness of a determination or decision otherwise final. Such action may only be taken:

13.5.2.1 At the request of either the Department, or a provider within the applicable time period set out in paragraph 13.5.4; and,
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

13 FINANCIAL REPORTING (cont.)

13.5.2.2 When the reopening may have a material effect (more than one percent (1%) on the provider's MaineCare rate payments.)

13.5.3 A correction is a revision (adjustment) in the Division of Audit’s determination, otherwise final, which is made after a proper re-opening. A correction may be made by the Division of Audit, or the provider may be required to file an amended cost report.

13.5.4 A determination or decision may only be re-opened within three (3) years from the date of notice containing the Division of Audit’s determination, or the date of a decision by the Commissioner or a court, except that no time limit shall apply in the event of fraud or misrepresentation.

13.5.5 The Division of Audit may also require or allow an amended cost report any time prior to a final audit settlement to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, however, the provider is bound by its elections. The Division of Audit shall not accept an amended cost report to avail the provider of an option it did not originally elect.

14 REIMBURSEMENT METHOD

14.1 Principle. PRTFs will be reimbursed for services provided to members based on a rate which the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards.

15 COST COMPONENTS

15.1 As regards to the interim payment system of reimbursement, allowable costs are grouped into cost categories. The nature of the expenses dictates which costs are allowable under these Principles of Reimbursement. The costs shall be grouped into the following two (2) cost categories:

15.1.1 Routine Costs; and

15.1.2 Fixed Costs.

Principles 16-17 describe the cost centers in each of these categories, the limitations and allowable costs placed on each of these cost centers.
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16  ROUTINE COST COMPONENT

All allowable costs not specified for inclusion in another cost category pursuant to these rules shall be included in the routine cost component subject to the limitations set forth in these Principles. The costs for the routine cost component shall be the routine costs defined in Principle 1.4 for these costs listed in Principle 16, except for facilities whose MaineCare rates are based on pro forma cost reports in accordance with Principle 23. Subsequent years will be based on the most recently audited fiscal year. The routine cost component is determined by adjusting routine costs pursuant to Principles 23.

16.1  Principle. All expenses which providers must incur to meet state licensing and federal certification standards are allowable.

16.2  Inventory Items. All inventory items used in the provision of routine services to residents are required to be expensed in the year used. Inventory items shall include, but are not limited to: linen and disposable items.

16.3  Allowable Costs. Allowable costs shall also include all items of expense efficient and economical providers incur for the provision of routine services. Routine services mean the regular room, dietary services, and the use of equipment and facilities.

16.4  Allowable costs for the routine component of the rate.

16.4.1  The rate shall include but not be limited to costs reported in the following functional cost centers on the facility's cost report.

(a)  fiscal services;
(b)  administrative services and professional fees, including administrative functions;
(c)  plant operation and maintenance including utilities;
(d)  laundry and linen;
(e)  housekeeping;
(f)  medical records;
(g)  subscriptions related to resident care;
(h)  dietary;
(i)  clerical;
(j)  office supplies/telephone;
(k)  conventions and meetings within the state of Maine;
(l)  EDP bookkeeping/payroll;
(m)  fringe benefits, to include:
   (1)  payroll taxes;
   (2)  qualified retirement plan contributions;
   (3)  group health, dental, and life insurance;
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16 ROUTINE COST COMPONENT (cont.)

(n) payroll taxes;
(o) one (1) association dues, the portion of which is not related to lobbying; and
(p) food, vitamins and food supplements.

For a more complete description of allowable costs in each cost center, see the explanations in Principles 16.4.1 - 16.4.2.10.

16.4.2 Administration Functions. The administration functions include those duties that are necessary to the general supervision and direction of the current operations of the facility, including, but not limited to, the following:

16.4.2.1 Central Office operational costs for business managers, controllers, reimbursement managers, office managers, personnel directors and purchasing agents are to be according to an allocation of those costs on the basis of all licensed beds operated by the parent company.

16.4.2.2 Policy Planning Function. The policy planning function includes the policy-making, planning and decision-making activities necessary for the general and long-term management of the affairs of the facility, including, but not limited to the following:

a) financial management, including accounting fees,
b) establishment of personnel policies,
c) planning of resident admission policies,
d) planning of expansion and financing.

16.4.2.3 Compliance. Compliance with all other regulations specific to administrative functions in PRTFs that are included in State Licensing Regulations and all other State and Federal regulations.

16.4.2.4 Dividends and Bonuses. Bonuses, dividends, or accruals for the express purpose of giving additional funds to the administrator or owners of the facility will not be recognized as allowable costs by the Department.
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16 ROYUTINE COST COMPONENT (cont.)

16.4.2.5 Management fees. Management fees charged by a parent company or by an unrelated organization or individual are not allowable costs.

16.4.2.6 Corporate Officers and Directors. Salaries paid to corporate officers and directors are not allowable costs unless they are paid for direct services provided to the facility such as those provided by an administrator or other position required by licensing regulations and included in the staffing pattern which are necessary for that facility's operation.

16.4.2.7 Central Office Operational Costs. Central office bookkeeping costs and related clerical functions may be allocated to each facility on the basis of total resident census limited to the reasonable cost of bookkeeping services if they were performed by the individual facility.

(1) All other central office operational costs other than those listed above in this principle are considered unallowable costs.

16.4.2.8 Laundry services including personal clothing for MaineCare residents.

16.4.2.9 Net Cost. The net cost means the cost of an activity less any reimbursement for them from grants, tuition and specific donations. These costs may include: registration fees, salary of the staff member if replaced, and meals and lodging as appropriate.

16.4.2.10 Dues. Dues are allowed only if the PRTF is able to provide auditable data that demonstrates what portion of the dues is not used for lobbying efforts by the agency receiving the dues payments.

16.4.2.11 Reimbursement for a facility administrator is capped at $80,170 per year including salary, employment taxes, paid time off, and benefits.
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16 ROUTINE COST COMPONENT (cont.)

16.5 Principle. Research Costs are not includable as allowable costs.

16.6 Grants, Gifts, and Income from Endowments

16.6.1 Principle. Unrestricted grants, gifts and income from endowments should not be deducted from operating costs in computing reimbursable costs. However, unrestricted Federal or State grants or gifts received by a facility will be used to reduce the operating costs of that facility. Grants, gifts, or endowment income designated by a donor for paying specific operating costs should be deducted from the operating costs or group of costs.

(1) Unrestricted grants, gifts, income from endowment. Unrestricted grants, gifts, and income from endowments are funds, cash or otherwise, given to a provider without restriction by the donor as to their use.

(2) Designated or restricted grants, gifts and income from endowments. Designated or restricted grants, gifts and income from endowments are funds, cash or otherwise, which must be used only for the specific purpose designated by the donor. This does not refer to grants, gifts or income from endowments which have been restricted for a specific purpose by the provider.

16.6.2 Donations of Produce or Other Supplies. Donations of produce or supplies are restricted gifts. The provider may not impute a cost for the value of such donations and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's costs, the amount included is deleted in determining allowable costs.

16.6.3 Donations of Use of Space. A provider may receive a donation of the use of space owned by another organization. In such case, the provider may not impute a cost for the value of the use for the space and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's cost, the amount included is deleted in determining allowable costs.

16.7 Purchase Discounts and Allowances and Refunds of Expenses

16.7.1 Principle. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.
16.7.2 Reduction of Costs. All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

16.7.3 Application of Discounts. Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase, but rather from a sale or an exchange, and the purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

16.7.4 Discounts, Allowances, and Rebates. All discounts, allowances, and rebates received from the purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party organizations paying on the basis of costs.

16.8 Principle. Advertising Expenses. The reasonable and necessary expense of newspaper or other public media advertisements for the purpose of securing necessary employees is an allowable cost. No other advertising expenses are allowed.
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16 **Routine Cost Components** (cont.)

16.9 **Legal Fees.** Legal fees to be allowable costs must be directly related to resident care. Fees paid to the attorneys for representation against the Department of Health and Human Services are not allowable costs. Retainers paid to lawyers are not allowable costs. Legal fees paid for organizational expenses, are to be amortized over a sixty-month period.

16.10 **Costs Attributable to Asset Sales.** Costs attributable to the negotiation or settlement of a sale or purchase of any capital asset (by acquisition or merger) are not allowable costs. Included among such unallowable costs are: legal fees, accounting and administrative costs, appraisal fees, costs of preparing a certificate of need, banking and broker fees, goodwill or other intangibles, travel costs and the costs of feasibility studies.

16.11 **Bad debts, charity, and courtesy allowances** are deductions from revenue and are not to be included in allowable cost.

17 **Fixed Costs Component**

17.1 The costs for the fixed cost component shall be the costs incurred by the facility in the most recently audited fiscal year. Fixed costs include:

17.1.1 depreciation on buildings, fixed and movable equipment.

17.1.2 depreciation on land improvements and amortization of leasehold improvements,

17.1.3 real estate and personal property taxes,

17.1.4 real estate insurance, including liability and fire insurance,

17.1.5 interest on long term debt,

17.1.6 rental expenses,

17.1.7 amortization of finance costs,

17.1.8 amortization of start-up costs and organizational costs,

17.1.9 facility's liability insurance, including malpractice costs and Workers compensation,

17.1.10 water & sewer fees necessary for the initial connection to a sewer system/water system,
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17  FIXED COSTS COMPONENT (cont.)

For a more complete description of allowable costs in each of these cost centers, see the explanations in Principle 17.2.

17.2 Principle. An appropriate allowance for depreciation on buildings and equipment is an allowable costs.

17.2.1 Allowance for Depreciation Based on Asset Costs. The depreciation must be:

17.2.1.1 Identified and recorded in the provider's accounting records.

17.2.2 Based on historical cost and prorated over the estimated useful life of the asset using the straight-line method.

17.2.3 The total historical cost of a building constructed or purchased becomes the basis for the straight-line depreciation method. Component depreciation is not allowed except on those items listed below with their minimum useful lives:

<table>
<thead>
<tr>
<th>Component</th>
<th>Useful Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electric Components</td>
<td>20 years</td>
</tr>
<tr>
<td>Plumbing and Heating Components</td>
<td>25 years</td>
</tr>
<tr>
<td>Central Air Conditioning Unit</td>
<td>15 years</td>
</tr>
<tr>
<td>Elevator</td>
<td>20 years</td>
</tr>
<tr>
<td>Escalator</td>
<td>20 years</td>
</tr>
<tr>
<td>Central Vacuum Cleaning System</td>
<td>15 years</td>
</tr>
<tr>
<td>Generator</td>
<td>20 years</td>
</tr>
</tbody>
</table>

17.2.3.1 Any provider using the component depreciation method that has been audited and accepted for cost reporting purposes prior to July 1, 2018, will be allowed to continue using this depreciation mechanism.

17.2.3.2 Where an asset that has been used or depreciated under the program is donated to a provider, or where a provider acquires such assets through testate or in testate distribution, (e.g., a widow inherits a PTRF upon the death of her husband and becomes a newly certified provider;) the basis of depreciation for the asset is the lesser of the fair market value, or the net book value of the asset in the hands of the owner last participating in the program. The basis of depreciation shall be determined as of the date of donation or the date of death, whichever is applicable.
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17 FIXED COSTS COMPONENT (cont.)

17.2.3.3 Special Reimbursement Provisions for Energy Efficient Improvements

(1) For the Energy Efficient Improvements listed below which are made to existing facilities, depreciation will be allowed based on a useful life equal to the higher of the term of the loan received (only if the acquisition is financed) or the period by the limitations listed below:

CAPITAL EXPENDITURE

Up to $5,000.00 - Minimum depreciable period three (3) years

From $5,001.00-$10,000.00 - Minimum depreciable period five (5) years

$10,000.00 and over - Minimum depreciable period seven (7) years

(2) The above limitations are minima and if a loan is obtained for a period of time in excess of these minima the depreciable period becomes the length of the loan, provided that in no case shall the depreciable period exceed the useful life as spelled out in the American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets".

(3) If the total expenditures exceeds $25,000.00, then prior approval for such an expenditure must be received in writing from the Department. A request for prior approval will be evaluated by the Department on the basis of whether such a large expenditure would decrease the actual energy costs to such an extent as to render this expenditure reasonable. The age and condition of the facility requesting approval will also be considered in determining whether or not such an expenditure would be approvable.

(4) The reasonable Energy Efficient Improvements are listed below:

1. Insulation (fiberglass, cellulose, etc.)
2. Energy Efficient Windows or Doors for the outside of the facility, including insulating shades and shutters.
3. Caulking or Weather stripping for windows or doors for the outside of the facility.
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17 FIXED COSTS COMPONENT (cont.)

4. Fans specially designed for circulation of heat inside the building.
5. Wood and Coal burning furnaces or boilers (not fireplaces).
6. Furnace Replacement burners that reduce the amount of fuel used.
7. Enetrol or other devices connected to furnaces to control heat usage.
8. A Device or Capital Expenditures for modifying an existing furnace that reduces the consumption of fuel.
9. Solar active systems for water and space heating.
10. Retrofitting structures for the purpose of creating or enhancing passive solar gain, if prior approved by the Department regardless of amount of expenditure. A request for prior approval will be evaluated by the Department on the basis of whether energy costs would be decreased to such an extent as to render the expenditure reasonable. The age and condition of the facility requesting approval will be also considered.
11. Any other energy saving devices that might qualify as Energy Efficient other than those listed above must be prior approved by the Department for this Special Reimbursement provision. The Department will evaluate a request for prior approval under recommendations from the Division of Energy Programs on what other items will qualify as an energy efficient device and that the energy savings device is a reliable product and the device would decrease the energy costs of the facility making the expenditure reasonable in nature.

(5) In the event of a sale of the facility the principle payments as listed above will be recaptured in lieu of depreciation.

17.2.3.4 Recording of depreciation. Appropriate recording of depreciation encompasses the identification of the depreciable assets in use, the assets' historical costs, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation. The American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets" 1983 edition is to be used as a guide for the estimation of the useful life of assets.
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17 FIXED COSTS COMPONENT (cont.)

(1) For new buildings constructed after April 1, 1980 the minimum useful life to be assigned is listed below:

- Wood Frame, Wood Exterior: 30 years
- Wood Frame, Masonry Exterior: 35 years
- Steel Frame, or Reinforced Concrete Masonry Exterior: 40 years
- Concrete Masonry Exterior: 40 years

If a mortgage obtained on the property exceeds the minimum life as listed above, then the terms of the mortgage will be used as the minimum useful life.

17.2.3.5 Depreciation method. Proration of the cost of an asset over its useful life is allowed on the straight-line method.

17.2.3.6 Funding of depreciation. Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciation assets, and coordinate their planning of capital expenditures with area wide planning of activities of community and state agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

17.2.3.7 Replacement reserves. Some lending institutions require funds to be set aside periodically for replacement of fixed assets. The periodic amounts set aside for this purpose are not allowable costs in the period expended, but will be allowed when withdrawn and utilized either through depreciation or expense after considering the usage of these funds. Since the replacement reserves are essentially the same as funded depreciation the same regulations regarding interest and equity will apply.

(1) If a facility is leased from an unrelated party and the ownership of the reserve rests with the lessor, then the replacement reserve payment becomes part of the lease payment and is considered an allowable cost in the year expended. If for any reason the lessee is allowed to use this replacement reserve for the replacement of the lessee's assets then during that year the allowable lease payment will be reduced by that amount. The Lessee will be allowed to depreciate the assets purchased in this situation.
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17 FIXED COSTS COMPONENT (cont.)

(2) If a rebate of a replacement reserve is returned to the lessee for any reason, it will be treated as a reduction of the allowable lease expense in the year review.

17.2.3.8 Gains and Losses on disposal of assets. Gains and losses realized from the disposal of depreciable assets are to be included in the determination of allowable costs. The extent to which such gains and losses are includable is calculated on a proration basis recognizing the amount of depreciation charged under the program in relation to the amount of depreciation, if any, charged or assumed in a period prior to the provider's participation in the program, and in the current period. For sales of PRTFs that occur on or after October 1, 2018, the Department shall either:

(1) At the time of the sale, recapture depreciation paid by the Department under the MaineCare program, from the proceeds of the sale using the procedures outlined below:

(a) The recapture will be made in cash from the seller. During the first eight (8) years of operation, all depreciation allowed on buildings and fixed equipment by the Department will be recaptured from the seller in cash at the time of the sale. From the ninth (9th) to the fifteenth (15th) year all but three percent (3%) per year will be recaptured and from the sixteenth (16th) to the twenty-fifth (25th) year, all but eight percent (8%) per year will be recaptured, not to exceed one hundred percent (100%). Recaptured accumulated depreciation, in any case, shall not exceed the extent of the gain on the sale. For sales of PRTFs on or after January 1, 2019, the calculation of credits for buildings and fixed equipment will be from the date the owner began operating the facility with the original license.

(b) For sales of PRTFs that occur on or after January 1, 2019, moveable equipment will accumulate credits as follows: for the first four years the asset is placed into service, all but ten percent (10%) per year will be recaptured and from the fifth (5th) and sixth (6th) year, all but thirty percent (30%) per year will be recaptured, not to exceed one hundred percent (100%).
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17. FIXED COSTS COMPONENT (cont.)

The calculation of credits for moveable equipment will be from the date the asset is placed into service by the provider.

(c) The buyer must demonstrate how the purchase price is allocated between depreciable and non-depreciable assets. The cost of land, building and equipment must be clearly documented. Unless there is a sales agreement specifically detailing each piece of moveable equipment, the gain on the sale will be determined by the total selling price of all moveable equipment compared to the book value at the time of the sale.

(d) In calculating the gain on the sale, the entire purchase price will be compared to net book value unless the buyer demonstrates by an independent appraisal that a specific portion of the purchase price reflects the cost of non-depreciable assets.

(e) Depreciation will not be recaptured if depreciable assets are sold to a purchaser who will not use the assets for a health care service for which future Medicare, MaineCare, or State payments will be received. The purchaser must use the assets acquired within five (5) years of the purchase. The purchaser will be liable for recapture if the purchaser violates the provisions of this rule; OR

(2) At the election of the buyer and seller, waive the recapture of depreciation at the time of the sale and allow the asset to transfer at the historical cost of the seller, less depreciation allowed under the MaineCare program, to the buyer for reimbursement purposes.

17.2.3.9 Limitation on the participation of capital expenditures. Depreciation, interest, and other costs are not allowable with respect to any capital expenditure in plant and property, and equipment related to resident care, which has not been submitted to the designated planning agency as required, or has been determined to be consistent with health facility planning requirements.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

17  FIXED COSTS COMPONENT (cont.)

17.3  Purchase, Rental, Donation and Lease of Capital Assets

17.3.1  Purchase of facilities from related individuals and/or organization where a facility, through purchase, converts from a proprietary to a nonprofit status and the buyer and seller are entities related by common and/or ownership, the purchaser's basis for depreciation shall not exceed the seller's basis under the program, less accumulated depreciation if the following requirements are met:

(A)  Where a facility is purchased from an individual or organization related to the purchaser by common control and/or ownership; or

(B)  Where a facility is purchased after July 1, 2018 by an individual related to the seller as:

(1)  a child
(2)  a grandchild
(3)  a brother or sister
(4)  a spouse of a child, grandchild, or brother or sister, or
(5)  an entity controlled by a child, grandchild, brother, sister or spouse of child, grandchild or combination brother or sister thereof; or

17.3.1.1  Accumulated depreciation of the seller under the program shall be considered as incurred by the purchaser for purposes of computing gains and applying the depreciation recapture rules in Principle 17.2.3.8 to subsequent sales by the buyer. There will be no recapture of depreciation from the seller on a sale between stipulated related parties since no set-up in the basis of depreciable assets is permitted to the buyer.

17.3.1.2  One-time exception to Principle 17.3.1.1. At the election of the seller, Principle 17.3.1 will not apply to a sale made to a buyer defined in Principle 17.3.1.1 if:

(a)  the seller is an individual or any entity owned or controlled by individuals or related individuals who were selling assets to a "related party" as defined in Principle 17.3.1 or 17.3.1.1, and

(b)  the seller has attained the age of fifty-five (55) before the date of such sale or exchange; and
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17 FIXED COSTS COMPONENT (cont.)

(c) during the twenty-year period ending on the day of the sale, the seller has owned and operated the facility for periods aggregating ten (10) years or more; and

(d) the seller has inherited the facility as property of a deceased spouse to satisfy the holding requirements under Principle 17.3.1.2(c)

(e) if the seller makes a valid election to be exempted from the application of 17.3.1.1 the allowable basis of depreciable assets for reimbursement of interest and depreciation expense to the buyer will be determined in accordance with the historical cost as though the parties were not related. This transaction is subject to depreciation recapture if there is a gain on the sale.

17.3.1.3 The one (1) exception to Principle 17.3.1.1 applies to individual owners and not to each facility. If an individual owns more than one (1) facility he must make the election as to which facility he wished to apply this exception.

17.3.1.4 Limitation in the application of Principle 17.3.1.3

17.3.1.4.1 Principle 17.3.1.2 shall not apply to any sale or exchange by the seller if an election by the seller under Principle 17.3.1.2 with respect to any other sale or exchange has taken place.

17.3.1.4.2 Principle 17.3.1.2 shall not apply to any sale or exchange by the seller unless the seller:

17.3.1.4.2.1 immediately after the sale has no interest in the PRTF (including an interest as officer, director, manager or employee) other than as a creditor, and

17.3.1.4.2.2 does not acquire any such interest within ten (10) years after the sale of this or any other facility; and

17.3.1.4.2.3 agrees to file an agreement with the Department of Health and Human Services to notify the
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17 FIXED COSTS COMPONENT (cont.)

Department that any acquisition as defined by the Principle 17.3.1.4.2.2 has occurred.

17.3.1.4.2.4 If Principle 17.3.1.4.2 is satisfied, Principle 17.3.1 and Principle 17.3.11 will also be satisfied.

17.3.1.4.2.5 If the seller acquires any interest defined by Principle 17.3.1.4.2.2 then pursuant to the agreement the basis will revert to what the seller's basis would be if the seller had continued to own the facility, the amounts paid by the Title XIX program for depreciation, interest and return of owner's equity from the increase in basis will be immediately recaptured, and an interest rate of nine percent (9%) per annum on recaptured moneys will be paid to the Department for sellers' use of Title XIX moneys. A credit against this, of the original amount of depreciation recapture from the seller, will be allowed, with any remaining amount of the original depreciation recapture becoming the property of the Department.

17.3.2 Basis of assets used under the program and donated to a provider. Where an asset that has been used or depreciated under the program is donated to a provider, the basis of depreciation for the asset shall be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program.

The net book value of the asset is defined as the depreciable basis used under the program by the asset's last participating owner less the depreciation recognized under the program.

17.3.3 Allowances for depreciation on assets financed with Federal or Public Funds. Depreciation is allowed on assets financed with Hill Burton or other Federal or Public Funds.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

17   FIXED COSTS COMPONENT (cont.)

17.4   Leases and Operations of Limited Partnerships

17.4.1   Information and Agreements Required for Leases. If a provider wishes to have costs associated with leases included in reimbursement:

17.4.1.1   A copy of the signed lease agreement is required.

17.4.1.2   An annual copy of the federal income tax return of the lessee will be made available to Representatives of the Department and of the U.S. Department of Health and Human Services in accordance with Principle 13.

17.4.1.3   If the lease is for the use of a building and/or fixed equipment, the articles and bylaws of the corporation, trust indenture partnership agreement, or limited partnership agreement of the lessor is required.

17.4.1.4   If the lease is for the use of a building and/or fixed equipment, the annual federal income tax return of the lessor will be made available to representatives of the Department and the U.S. Department of Health and Human Services in accordance with Principle 13.

17.4.1.5   A copy of the mortgage or other debt instrument of the lessor will be made available to representatives of the Department and the U.S. Department of Health and Human Services. The lessor will furnish the Department of Health and Human Services a copy of the bank computer printout sheet on the lessor’s mortgage showing the monthly principle and interest payments.

17.4.1.6   The lease must be for a minimum period of five (5) years if an unrelated organization is involved. If the lessor was to sell the property within the five (5) year period to a PRTF operator or the lessee, the historical cost for the new owner would be determined in accordance with the definition of historical costs, and the portion of the lease payment made in lieu of straight line depreciation will be recaptured in accordance with Principle 17.2.3.8. This change will become effective when and if CMS approves this new language in the state plan.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

17 FIXED COSTS COMPONENT (cont.)

17.4.2 Lease Arrangements between Individuals or Organizations Related by Common Control and/or Ownership. A provider may lease a facility from a related organization within the meaning of the Principles of Reimbursement. In such case, the rent paid to the lessor by the provider is not allowed as a cost. The provider, however, would include in its costs the costs of ownership of the facility. Generally, these would be costs of the lessor such as depreciation, interest on the mortgage, real estate taxes and other expenses attributable to the leased facility. The effect is to treat the facility as though it were owned by the provider.

17.4.3 Leased Arrangement Between Individuals or Organizations Not Related by Common Control or Ownership. A provider may lease a facility from an unrelated organization within the meaning of the Principles of Reimbursement.

The allowable cost between two (2) unrelated organizations is the lesser of:
Principles 17.4.3.1 or 17.4.3.2.

17.4.3.1 The actual costs calculated under the assumption that the lessee and the lessor are related parties; or

17.4.3.2 The actual lease payments made by the lessee to the lessor.

17.4.3.3 If the cost as defined in Principle 17.4.3.2 are less than the costs as defined in Principle 17.4.3.1, then the difference can be deferred to a subsequent fiscal period. If in a later fiscal period, costs as defined in Principle 17.4.3.2 exceed costs as defined in Principle 17.4.3.1, the deferred costs may begin to be amortized.

Amortization will increase allowable costs up to the level of the actual lease payments for any given year. These deferred costs are not assets of the provider for purposes of calculating allowable costs of interest or return of owner’s equity and, except as specified, do not represent assets that a provider or creditor of a provider may claim is a monetary obligation from the Title XIX program.

17.4.3.4 A lease payment to an unrelated party for moveable furnishings and equipment is an allowable cost.
17 FIXED COSTS COMPONENT (cont.)

17.4.4 Sale and Leaseback Agreements-Rental Charges. Rental costs specified in sale and leaseback agreements incurred by providers through selling physical plant facilities or equipment to a purchaser not connected with or related to the provider, and concurrently leasing back the same facilities or equipment, are includable in allowable cost.

However, the rental charge cannot exceed the amount that the provider would have included in reimbursable costs had the retained legal title to the facilities or equipment, such as interest on mortgage, taxes, depreciation, insurance and maintenance costs.

17.5 Interest Cost

17.5.1 Allowable interest costs on both current and capital indebtedness will be reimbursed.

17.5.2 Interest. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the costs incurred for funds borrowed for a relatively short term, usually one (1) year or less, but in no event more than fifteen (15) months. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans. Except as provided in Principle 17.5.4.6, interest does not include interest and penalties charged for failure to pay accounts when due.

17.5.3 In order to be allowable, interest must:

17.5.3.1 Be incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments would be considered unnecessary; and

17.5.3.2 Be reduced by investment income except where such income is from gifts, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation is not used to reduce interest expense.

17.5.3.3 Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

17 FIXED COSTS COMPONENT (cont.)

17.5.3.3.4 Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization.

17.5.3.5 Refinancing. Any refinancing of property mortgages or loans on fixed assets must be written prior approved by the Department’s Division of Licensing and Certification, prior to the closing of the loan. If written prior approval is not obtained the Department will pay the lowest of the following:

a. The actual interest paid; or

b. The amount of interest the provider would have paid under the terms of the original loan. Original loan means the last Department approved loan.

17.5.4 Borrower-lender relationship

17.5.4.1 To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement with higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arm's-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowed. Where the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, where interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans shall be treated as invested funds in the computation of the provider's equity capital.

17.5.4.2 Exceptions to the general rule regarding interest on loans from controlled sources of funds. Where the general fund of a provider borrows from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money borrowed from the
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

17 FIXED COSTS COMPONENT (cont.)

funded depreciation account of the provider. In addition, if a provider of a facility operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost. Interest paid by the provider cannot exceed interest earned by the above subject funds.

17.5.4.3 Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to resident care, or payment of long-term debt principle once the principle payment exceeds the straight-line depreciation allowed under the Principles of Reimbursement, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation.

17.5.4.4 Loans not reasonably related to resident care. Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost are not considered to be for a purpose reasonably related to resident care.

17.5.4.5 Interest expense of related organizations. Where a provider leases facilities from a related organization and the rental expense paid to related organization is not allowable as a cost, costs of ownership of the leased facility are allowable as in interest cost to the provider. Therefore, in such cases, mortgage interest paid by the related organization is allowable as an interest cost to the provider.

17.5.4.6 Interest on Property Taxes. Interest charged by a municipality for late payment of property taxes is an allowable cost when the following conditions have been met:

17.5.4.6.1 The rate of interest charged by the municipality is less than the interest which a prudent borrower would have had to pay in the money market existing at the time the loan was made;

17.5.4.6.2 The payment of property taxes is deferred under an arrangement acceptable to the municipality;

17.5.4.6.3 The late payment of property taxes results from the financial needs of the provider and does not result in excess funds; and
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

17 FIXED COSTS COMPONENT (cont.)

17.5.4.6.4 Approval in writing has been given by the Department prior to the time period in which the interest is incurred. Any requests for written prior approval must be received by the Department at least two (2) weeks prior to the desired effective date of the approval.

17.5.4.7 Limitation on the participation of capital expenditures. Interest is not allowable with respect to any capital expenditure in plant and property, and equipment related to resident care, which did not receive a required Certificate of Need Review approval.

17.5.5 Adjustments. The Department will make adjustments to the PRTF fixed cost portion of the interim rate to reflect the effect of refinancing which results in lower interest payments.

17.6 Insurance

Reasonable and necessary costs of insurance involved in operating a facility are considered allowable costs (real estate insurance including liability and fire insurance are included as fixed costs - see Principle 17.1.4). Premiums paid on property not used for resident care are not allowed. Life insurance’s premiums related to insurance on the lives of key employees where the provider is a direct or indirect beneficiary are not allowable costs. A provider is a direct beneficiary where, upon the death of the insured officer or key employee the insurance proceeds are payable directly to the provider. An example of a provider as an indirect beneficiary is the case where insurance on the lives of officers is required as part of a mortgage loan agreement entered into for a building program, and, upon the death of an insured officer the proceeds are payable to the lending institution as a credit against the loan balance. In this case, the provider is not a direct beneficiary because it does not receive the proceeds directly, but is, nevertheless, an indirect beneficiary since its liability on the loan is reduced.

17.6.1 Workers’ Compensation Insurance premiums paid to an admitted carrier; application fees, assessments and premiums paid to an authorized fully-funded trust; and premiums paid to an individual self-insured program approved by the State of Maine for facility fiscal years that began on or after October 1, 2018, and deductibles paid by facilities related to such cost are allowable fixed costs. Estimated amounts for workers compensation insurance audit premiums will not be accepted as an allowable cost. The Department will require the facility to be a prudent and cost conscious buyer of Workers’ Compensation Insurance. In those instances where the Department finds that a facility pays more than the usual and customary rate or does not try to minimize costs, in the absence of clear
justification, the Department may exclude excess costs in determining allowable costs under MaineCare. Allowable costs are subject to an experience modifier of 1.4; that is, cost associated with an experience modifier of 1.4 or under are allowable. Workers’ Compensation costs incurred above the experience modifier of 1.4 shall be considered unallowable and will be settled at time of audit.

17.6.2 The costs of Loss-Prevention and Safety Services are allowable costs to a maximum of $40.00 per covered employee per year for PRTFs with an experience modifier greater than .9. The costs of Loss-Prevention and Safety Services are allowable costs to a maximum of $70.00 per covered employee per year for PRTFs with an experience modifier equal to or less than .9. Allowable costs shall include the cost of educational programs and training classes, transportation to and from those classes, lodging when necessary to attend the classes, materials needed in the preparation and presentation of the classes (when held at the PRTF), and equipment (e.g.: lifts) which lead towards accomplishing the established goals and objectives of the facility’s safety program. Non-allowable costs include salaries paid to individuals attending the safety classes and personal gifts such as bonuses, free passes to events or meals, and gift baskets.

17.7 Start Up Costs Applicability

Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof, to the time the first resident is admitted for treatment. In the case where the start-up costs apply only to nonrevenue-producing resident care functions or unallowable functions, the startup costs are applicable only to the time the areas are used for their intended purposes. Start-up costs are charged to operations. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility will be accumulated in a single deferred charge account and will be amortized when the first resident is admitted for treatment. If a provider intends to prepare portions of its facility on a piecemeal basis (e.g., preparation of a floor or wing of a provider's facility is delayed), start-up costs would be capitalized and amortized separately for the portion(s) of the provider's facility prepared during different time periods. Moreover, if a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas.

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the Department need not be capitalized, but rather will be charges to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

17 FIXED COSTS COMPONENT (cont.)

immaterial by the Department, these costs need not be capitalized, but will be charged to operations in the periods incurred.

For program reimbursement purposes, costs of the provider's facility and building equipment should be depreciated over the lives of these assets starting with the month the first resident is admitted for treatment, subject to the provider's method of determining depreciation in the year of acquisition or construction. Where portions of the provider's facility are prepared for resident care services after the initial start-up period, these asset costs applicable to each portion should be depreciated over the remaining lives of the applicable assets. If the portion of the facility is a resident care area, depreciation should start with the month the first resident is admitted for treatment. If the portion of the facility is a non-revenue-producing resident care area or unallowable area, depreciation should begin when the area is opened for its intended purpose. Costs of major movable equipment, however, should be depreciated over the useful life or each item starting with the month the item is placed into operation.

Where a provider prepares all portions of its facility for resident care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratable over a period of sixty (60) consecutive months beginning with the month in which the first resident is admitted for treatment. Where a provider prorates portions of its facility for resident care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for resident care services during different periods of time.

18 MEDICAL, CLINICAL, AND DIRECT CARE COSTS

18.1 Medical, Clinical, and Direct Care costs will be reimbursed at a per diem rate per member per day which is not subject to cost settlement. The per diem member per day price includes services provided by the medical, clinical, and direct care services staff listed below. Allowable costs include salaries, wages, and benefits for medical, clinical, and direct care staff and the services listed below:

Medical Director
Clinical Coordinator
Registered Nurses
Licensed Practical Nurses
Certified Nurses Aide-Medication
Licensed Clinical Social Workers
Behavioral Health Professional.
Licensed Clinical Professional Counselors
Licensed Marriage and Family Therapists
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

18 MEDICAL, CLINICAL, AND DIRECT CARE COSTS (cont.)

18.2 The per diem rate (per member per day) for Medical, Clinical, and Direct Care costs is $485.72. This rate includes the salary and benefit costs of the staff listed in principle 18.1.

19 WAIVER

The failure of the Department to insist, in any one (1) or more instances, upon the performance of any of the terms or conditions of these Principles, or to exercise any right under these principles, or to disapprove of any practice, accounting procedure, or item of account in any audit, shall not be construed as a waiver of future performance of the right. The obligation of the Provider with respect to future performance shall continue, and the Department shall not be stopped from requiring such future performance.

20 SPECIAL SERVICE ALLOWANCE

20.1 Principle. A special ancillary service is to be distinguished from a service generally provided in the PRTF.

20.1.1 A special ancillary service is that of an individual nature required in the case of a specific resident. This type of service includes, but not limited to professional services such as physical therapy, occupational therapy, and speech and hearing services. Special services of this nature must be billed through the appropriate Section of the MaineCare Members Benefit Manual required for the care of individual members.


20.1.3 Interpreter Services to address any existing or newly diagnosed physical health conditions when medically necessary as outlined in Chapter 1 of the MaineCare Members Benefits Manual.

20.1.4 Medical Services to address any existing or newly diagnosed physical health conditions when medically necessary and can not be provided at the PRTF.

21 MEDICAL LEAVE AND THERAPEUTIC LEAVE ALLOWANCES

21.1 Principle for Medical Leave. For members requiring physician ordered hospitalization for treatment of an acute condition that cannot be treated in the PRTF, up to four (4) consecutive days. The PRTF must maintain a physician’s order for the hospitalization in the member’s file. Should a member be hospitalized for longer than four (4) consecutive...
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

21 MEDICAL LEAVE AND THERAPEUTIC LEAVE ALLOWANCES (cont.)

days, the PRTF must discharge the member. Documentation is subject to retrospective review.

21.2 Principle for Therapeutic Leave. A member’s leave of absence from the PRTF must be for therapeutic reasons as directed by the team physician and as indicated in the member’s treatment plan. The facility must maintain a physician’s order for the therapeutic leave in the member’s file. Therapeutic leave days are limited to seven (7) days per admission. Therapeutic leave days do not have to be consecutive. Documentation is subject to retrospective review.

For billing purposes PRTFs are expected to follow the midnight to midnight method when reporting days of leave for members, even if the facility uses a different definition of a day for statistical or other purposes. PRTFs will be reimbursed their routine and fixed costs rate, as stated on their rate letter, for medical leave and therapeutic leave days. Medical leave days will be billed using revenue code: 0185 and therapeutic leave days will be billed using revenue code 0184. Medical and Therapeutic Leave days are cost settled.

22 ESTABLISHMENT OF INTERIM RATE

22.1 Initial Rate. For a PRTF’s first year of operation, the Department will establish an initial prospective routine and fixed cost interim rate, based on the facility’s pro-forma. This rate is subject to cost settlement.

22.2 Subsequent Interim Rate. For subsequent years of operation, the interim rate will be based on the most recent cost settlement. If a cost settlement has not yet been calculated, the interim rate will be based on the facility’s pro-forma.

23 INTERIM AND SUBSEQUENT RATES

23.1 Interim Rate and Subsequent Year Rates. Fifteen (15) days prior to the beginning of the State fiscal year, an interim rate will be established by using the fixed and routine cost component of the latest audited cost report. The interim rate in subsequent fiscal years will be determined in the same manner as outlined above.

23.2 Fixed costs may be adjusted upon request of the provider when sufficient documentation (determined by the DHHS) has been provided to the Department. These adjustments will be effective with the next issuance of an interim rate.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

24 FINAL RATE

Upon final audit of each PRTF’s cost report, the Department will determine a final rate of each PRTF, which cannot be greater than one hundred percent (100%) of all the calculated and allowable fixed cost and routine cost components for that PRTF.

24.2 A cost report is settled if there is no request for reconsideration of the Division of Audit’s findings made within the required time frame or, if such request for reconsideration was made and the Division of Audit has issued a final revised audit report.

25 FINAL AUDIT OF INTERIM RATES

25.1 Principle. All facilities will be required to submit a cost report in accordance with Principle 13.2 at the end of their fiscal year on cost report forms approved by the Department. The Department will conduct a final audit of each facility’s cost report, which may consist of a full scope examination by Department personnel and which will be conducted on an annual basis.

25.2 Upon final audit of the facility’s cost report for the first and subsequent years prospective years, the Department will:

25.2.1 Determine the actual allowable fixed costs incurred by the facility during the cost reporting period;

25.2.2 Determine the actual allowable routine costs incurred by the facility during the cost reporting period;

25.2.3 Determine the occupancy levels of the PRTF;

25.2.4 Calculate a final rate; and

25.2.5 Determine final settlement by calculating the difference between the audited final rate and the interim rate(s) paid to the provider times the MaineCare utilization. PRTFs that transfer a cost center from one (1) cost component to another cost component resulting in increased MaineCare costs will have the affected cost components adjusted at time of audit.

Upon final audit of a facility’s cost report, the Department will calculate a final prospective rate and determine the lump sum settlement amount either due to or from the PRTF.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL

26 SETTLEMENT OF ROUTINE AND FIXED COSTS

26.1 The Department will reimburse facilities for the allowable and actually incurred routine and fixed costs which are incurred during a fiscal year. Upon final audit of a facility's cost report, if the Department's share of the allowable routine and fixed costs actually incurred by the facility is greater than the amount paid by the Department (the fixed cost component of the final prospective rate multiplied by the number of days of care provided to MaineCare beneficiaries), the difference will be paid to the facility by the Department. If the Department's appropriate share of the allowable fixed costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.

27 CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS

Upon determination of the final rate as outlined in Principle 24 above, the Department will calculate the net amount of any overpayments or underpayments made to the facility.

If the Department determines that it has underpaid a facility, the Department will calculate the exact amount due and forward the result to the facility within thirty (30) days. If the Department determines that it has overpaid a facility, the Department will so notify the facility. Facilities will pay the total overpayment within sixty (60) days of the notice of overpayment or request the Department to reduce facility payments during the balance of its fiscal year by the amount of the overpayment. Facilities that do not notify the Department of the method by which they intend to repay the overpayment will, beginning sixty (60) days after their receipt of the notice of overpayment, have their subsequent payments from the Department reduced by the amount of overpayment.

If a facility appeals a determination of overpayment, the facility must repay within sixty (60) days of the notice of overpayment all portions of the determined overpayment except those that are expressly disputed and for which specific dollar values are identified. Repayment of each such specifically disputed portion and identified amount shall be stayed pending resolution of the dispute with respect thereto. The amount of money in dispute must be identified in the manner outlined in Principle 27.

The net amount of any over or underpayment made to the facility will be based on 1) the calculation of actual fixed expenses incurred in the prior year and 2) the estimated difference in amount due or paid based on the interim versus final prospective rate.
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

28 ADJUSTMENTS

28.1 Adjustment for Appeal Decisions. The Department will adjust any interim or final prospective rate to reflect appeal decisions made subsequent to the establishment of those rates.

28.2 Adjustments for Capital Costs. The Department will adjust the fixed cost component of an interim or final prospective rate to reflect increases or decreases in capital costs.

29 APPEAL PROCEDURES-START UP COSTS-DEFICIENCY RATE - RATE LIMITATION

29.1 Appeal Procedures

29.1.1 A facility may administratively appeal any of the following types of Division of Audit determinations:

(1) Audit Adjustment
(2) Calculation of final prospective rate
(3) Adjustment of final prospective rate or a refusal to make such an adjustment pursuant to these Principles.

29.1.2 An administrative appeal will proceed in the following manner:

(1) Within thirty (30) days of receipt of an audit or other appealable determination, the facility must request, in writing, an informal review before the Director of the Division of Audit or his/her designee. The facility must forward, with the request, any and all specific information it has relative to the issues in dispute, note the monetary amount each issue represents and identify the appropriate principle supporting the request. Only issues presented in this manner and timeframe will be considered at an informal review or at a subsequent administrative hearing.

(2) The Director or his/her designee shall notify the facility in writing of the decision made as a result of the informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer designated by the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within thirty
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

29 APPEAL PROCEDURES – START UP COSTS – DEFICIENCY RATE – RATE LIMITATIONS (cont.)

(3) days of receipt of the decision made as a result of the informal review.

(3) To the extent the Department rules in favor of the facility, the audit report or prospective rate will be corrected.

(4) To the extent the Department upholds the original determination of the Division of Audit, review of the results of the administrative hearing is available in conformity with the Administrative Procedure Act, 5 M.R.S.A. §11001 et seq.

30 DEFICIENCY ROUTINE AND FIXED COSTS RATE

When a facility is found not to have provided the quality of service or level of care required, reimbursement will be made on ninety percent (90%) of the provider's per diem rate, unless otherwise specified. This "deficiency rate" will be applied following written notification to the facility of the effective date of the reduced rate for any of the following service deficiencies:

30.1 Specific, documented evidence that the care provided does not meet the Federal Certification and State Licensing requirements. Such penalty to be effective no sooner than thirty (30) days from written notification that such deficiencies exist;

30.2 Failure to correct, within the time frames of an accepted Plan of Remediation or Correction, deficiencies in meeting the Federal Certification, Accreditation and State Licensing requirements, which cause a threat to the health and safety of residents in a facility or the surrounding community;

30.3 Failure to submit a cost report, financial statements, and other schedules as requested by the Division of Audit and to maintain auditable records as required by these Principles and other relevant regulations may result in application of the deficiency routine and fixed costs rate. The deficiency routine and fixed costs rate for these items will go into effect immediately upon receipt of written notification from the Department.

A reduction in rate because of deficiencies shall remain in effect until the deficiencies have been corrected, as verified by representatives of the Department, following written notification by the provider that the deficiencies no longer exist. No retroactive adjustments to the full rate shall be made for the
THE DEPARTMENT WILL SEEK CMS APPROVAL FOR THESE NEW SERVICES. THE SERVICES WILL BE OFFERED, AND THIS RULE WILL BECOME EFFECTIVE, UPON CMS APPROVAL.

30 DEFICIENCY ROUTINE AND FIXED COSTS RATE (cont.)

period that the deficiency rate is in effect unless the provider demonstrates to the satisfaction of the Department that there was no just cause for the reduction in payment.
APPENDIX I

<table>
<thead>
<tr>
<th>REVENUE CODE</th>
<th>DESCRIPTION</th>
<th>MAXIMUM ALLOWANCE</th>
<th>UNIT</th>
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<td>1001</td>
<td>Medical, Clinical, &amp; Direct Care Services provided in a Psychiatric Residential Treatment Facility (Per Diem)</td>
<td>$485.72</td>
<td>Per day</td>
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<td>0169</td>
<td>Room and Board</td>
<td>Routine and Fixed Costs allowance as determined by the Facility’s rate letter</td>
<td>Per day</td>
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<td>Therapeutic Leave Day</td>
<td>Routine and Fixed Costs allowance as determined by Facility’s rate letter as under 0169</td>
<td>Per day</td>
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<tr>
<td>0185</td>
<td>Medical Leave Day</td>
<td>Routine and Fixed Costs allowance as determined by Facility’s rate letter as under 0169</td>
<td>Per day</td>
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Procedure Code: G9007 HK

| Procedure Code: G9007 HK | Board Certified Behavior Analyst (BCBA) | $16.60 | Per 15 minutes |

Established