



Department of Health and Human Services
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DATE: October 25, 2016

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: **Emergency Major Substantive Adoption:** Chapter 101, MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institution Services

This letter gives notice of an Emergency Major Substantive rulemaking for 10-144 C.M.R. ch. 101, MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institution Services.

The Department of Health and Human Services (“the Department”) adopts this emergency major substantive rulemaking to increase the rates of reimbursement for Private Non-Medical Institution Services providers pursuant to Public Law 2016, Chapter 477, *An Act To Increase Payments to MaineCare Providers That Are Subject to Maine’s Service Provider Tax*. In addition, for Chapter III, Section 97 (the “Main Rule”) and Chapter III, Section 97, Appendix C only, the Department repeals and replaces the March 8, 2016 emergency major substantive rule, which made changes pursuant to Resolves 2015, ch. 45, Resolve, *To Require the Department of Health and Human Services to Provide Supplemental Reimbursement to Residential Care Facilities in Remote Island Locations*. Those changes are incorporated into this emergency major substantive rulemaking.

The Department makes the following findings in support of this emergency major substantive rulemaking. Similar to the determinations made by the Legislature in P.L. 2016, ch. 477, the Department finds that these rule changes should be implemented immediately to preserve public health and safety. Section 97 providers have insufficient reserves to withstand cost increases and have experienced an increase in the Service Provider Tax since January 1, 2016. In addition, Appendix C providers who are “remote island facilities” also require the reimbursement increases implemented pursuant to Resolves 2015, ch. 45 and the Department’s March 8, 2016 emergency major substantive rule be continued, so that providers are not negatively affected. Remote island facilities are facilities located on an island and not connected to the mainland by a bridge. All of these changes provide benefits to the Section 97 providers, and ensure the continued provision of services to MaineCare members.

The Change in Reimbursement Methodology Notices required by 42 C.F.R. §447.205 relating to the Service Provider Tax reimbursement increase were published on June 16, 2016 (for Appendices B and D) and August 11, 2016 (for Appendices C, E, and F). The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services (CMS) for these changes to Appendices B and D. Pending approval, the one percent direct care component increase will be effective retroactive to July 1, 2016.

In regard to the remote island facility rule changes, in the “Main Rule” and Appendix C, the Department published its Notice of Change in Reimbursement Methodology on September 30, 2015. The Department is seeking and anticipates receiving approval from CMS for the remote island facility reimbursement increases. Pending CMS approval, those changes shall be effective retroactive to October 1, 2015.

Each of these retroactive effective dates are consistent with 22 M.R.S. §42(8), because they provide benefits to MaineCare providers, ensure that vulnerable members have access to medically necessary covered services, and otherwise have no adverse impact on members or providers.

These emergency rule changes shall be effective for one (1) year or until the Legislature approves the rule. The Department shall engage in “regular” major substantive rulemaking to permanently adopt these Section 97 rule changes.

Rules and related rulemaking documents may be reviewed at and printed from 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. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

If you have any questions regarding the policy, please contact Provider Services at 1-866-690-5585 or TTY users call Maine relay 711.

Notice of Agency Major Substantive Emergency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R. ch. 101, MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institution Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The Department of Health and Human Services (“the Department”) adopts this emergency major substantive rule to increase the rates of reimbursement to Private Non-Medical Institution Services providers pursuant to Public Law 2016, Chapter 477, *An Act To Increase Payments to MaineCare Providers That Are Subject to Maine’s Service Provider Tax*. In addition, for Chapter III, Section 97 (the “Main Rule”) and Chapter III, Section 97, Appendix C only, the Department repeals and replaces the March 8, 2016 emergency major substantive rule, which made changes pursuant to Resolves 2015, ch. 45, *Resolve, To Require the Department of Health and Human Services to Provide Supplemental Reimbursement to Residential Care Facilities in Remote Island Location*. Those changes are incorporated into this emergency major substantive rulemaking.

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HTTP://WWW.MAINE.GOV/DHHS/OMS/RULES/INDEX.SHTML for rules and related rulemaking documents.

EFFECTIVE DATE: October 25, 2016

AGENCY CONTACT PERSON: Heidi Bechard, Comprehensive Health Planner

AGENCY NAME: Division of Policy

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10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

TABLE OF CONTENTS

	Page
1000 Purpose	1
1100 Scope/Authority.....	1
1300 Adult Family Care Homes	1
1400 Requirements for MaineCare Reimbursement	1
1500 Responsibilities of Owners or Operators.....	3
1600 Duties of the Owner or Operator	3
1700 Covered Services	4
1900 Termination Under Title XIX.....	4
2000 Accounting Requirements	4
2300 Cost Related to Resident Care	5
2400 Allowability of Cost	5
2500 Non-Allowable Costs	7
2600 Substance Over Form	7
2700 Record Keeping and Retention of Records	7
2900 Billing Procedures	8
3000 Reimbursement Method	9
3100 Financial Reporting	10
3300 Uniform Cost Reports.....	11
3400 Settlement of Cost Reports	12
3500 Adjustments to Audit Settlements	12
3600 Settlements of Overpayments or Underpayments	13

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

TABLE OF CONTENTS (cont.)

	Page
4000 Public Hearing.....	14
5000 Waiver	14
6000 Post Audit Appeal Procedures.....	14
7000 Deficiency Per Diem Rate	15
8000 Start Up Costs Applicability.....	16
10000 General Definitions	16
11000 Procedure Codes.....	19

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

GENERAL PROVISIONS

1000 PURPOSE

The purpose of these regulations is to define which items of expense will be taken into account and which will be excluded in the calculation of reasonable costs for Private Non-Medical Institutions. These Principles of Reimbursement for Private Non-Medical Institutions identify which costs are reimbursed under Chapter II, Section 97 - Private Non-Medical Institution (herein after, PNMI) Services of the MaineCare Benefits Manual. The Department will consider allowable costs identified by these Principles for reimbursement of services in a residential child care facility, substance abuse treatment facility, and community residences for persons with mental illness (for those facilities covered under Appendices B, D, and E) on the first day of the provider's fiscal year beginning on or after July 1, 2001. The Department will consider allowable costs identified by these Principles of Reimbursement for Private Non-Medical Institution medical and remedial facility services (under Appendices C and F) rendered on or after July 1, 2001. Prior to July 1, 2001, PNMI services rendered in a medical and remedial facility and non-case mixed medical and remedial facility shall follow the applicable appendix in effect prior to July 1, 2001, and the Principles of Reimbursement for Residential Care Facilities- Room and Board Costs.

1100 SCOPE/AUTHORITY

These Principles define scope and authority within the specific Appendix applicable to that type of Private Non-Medical Institution. These Principles define Department and member/resident in Section 10000 of this policy. These Principles define facility in each specific Appendix.

1300 ADULT FAMILY CARE HOMES

1300.1 The Department does not use these PNMI Principles in the determination of reimbursable amount paid to Adult Family Care Homes.

1400 REQUIREMENTS FOR MAINECARE REIMBURSEMENT

1400.1 In order to be reimbursed, all PNMI's identified as residential child care, substance abuse treatment, community residences for persons with mental illness, and Appendix F scattered site PNMI's for people for mental retardation must be licensed as applicable, in accordance with the Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug treatment Services, or Rules for the Licensure of Residential Child Care Facilities/Rights of Recipients of Mental Health Services Who are Children in Need of Treatment. In order to be reimbursed, medical and remedial service PNMI's and non-case mixed must be licensed by the Division of Licensing and Certification

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

1400 **REQUIREMENTS FOR MAINECARE REIMBURSEMENT** (cont.)

in the Department of Health and Human Services (See 10-149 C.M.R., Ch. 113), with the exception of Appendix F scattered site PNMI for persons with mental retardation, which may be licensed as either a residential care facility or as a mental health provider in accordance with the Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug treatment services.

1400.2 All PNMI must obtain licensure and a signed Provider/Supplier Enrollment Agreement with the Department of Health and Human Services, Office of MaineCare Services (OMS). Providers must submit a copy of the license accompanying the Provider/Supplier Enrollment Agreement to the Department.

1400.3 Types of PNMI considered for MaineCare reimbursement, subject to the availability of funds, include:

1400.31 Facilities providing Private Non-Medical Institution services to members with significant mental or physical disability requiring structured, individualized habilitative or rehabilitative in-home programming as outlined in the provider agreement with the PNMI.

1400.32 Facilities with licensed Private Non-Medical Institution beds at scattered locations serving a minimum of four eligible members, as long as the service provided consistently fits within the definition of the applicable appendix stated below.

Appendix B Substance Abuse Treatment Facilities
Appendix D Child Care Facilities
Appendix F Non-Case Mixed Medical and Remedial PNMI

1400.4 Except for Child Care Facilities covered under Appendix D, the Department will reimburse PNMI for services provided to eligible members based on an interim rate that the Department establishes and determines as reasonable and adequate to meet the costs that are 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. Appendix D standard rates are not interim and are not subject to cost settlement guidelines detailed in this Chapter.

1400.5 The Department requires cost reimbursed facilities to submit annual cost reports as stated in Section 3300.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97	PRIVATE NON-MEDICAL INSTITUTION SERVICES	Established 6/11/90
		Final Adoption: 6/30/14
		EMERGENCY RULE: 10/25/16

1400 **REQUIREMENTS FOR MAINECARE REIMBURSEMENT (cont.)**

1400.6 The Department will respond in writing to written requests for interpretation of these Principles. Providers should direct written requests to the Director, Office of MaineCare Services.

1400.7 The Department reserves the right to take legal action against, and/or terminate the provider agreement if a facility fails to comply with these Principles, or submits, or causes to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

1500 **RESPONSIBILITIES OF OWNERS OR OPERATORS**

The owners or operators of a Private Non-Medical Institution must prudently manage and operate a PNMI of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Commissioner, nor a duly authorized representative may in any way relieve the owner or operator of a PNMI from full responsibility for compliance with the requirements and standards of the Department or Federal requirements and standards.

1600 **DUTIES OF THE OWNER OR OPERATOR**

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

1600.1 Comply with the provisions of Chapter I; and Chapters II, III, and the applicable Appendix of Section 97 of the MaineCare Benefits Manual.

1600.2 Submit master file documents and cost reports in accordance with the provisions of Sections 3100 and 3300 of these Principles. Child Care providers under Appendix D must also submit these documents and cost reports, which the Department utilizes in setting appropriate reimbursement rates.

1600.3 Maintain adequate financial and statistical records and make them available for inspection by an authorized representative of the Department, State, or the Federal government upon request.

1600.4 Assure that annual records are prepared in conformance with Generally Accepted Accounting Principles (GAAP), except where otherwise required.

1600.5 Assure that the construction of buildings and the maintenance and operation of premises and residential services comply with all applicable health and safety standards.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97	PRIVATE NON-MEDICAL INSTITUTION SERVICES	Established 6/11/90 Final Adoption: 6/30/14 EMERGENCY RULE: 10/25/16
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1600 **DUTIES OF THE OWNER OR OPERATOR** (cont.)

1600.6 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 per diem rate described in Section 7000 of these Principles.

1700 **COVERED SERVICES**

See applicable section of Chapter II, Section 97, Private Non-Medical Institution Services.

1900 **TERMINATION UNDER TITLE XIX**

Termination of participation in Title XIX will result in the provider being terminated simultaneously from financial participation under PNMI cost reimbursement. Alternatively, termination of participation in cost reimbursement will result in the provider being terminated simultaneously from participation in Title XIX. Conditions that may result in termination of participation in MaineCare are listed in Chapter I of the MaineCare Benefits Manual. These conditions may result in termination of the provider contract to provide PNMI services:

- 1900.1 The Federal Government fails to provide agreed upon funds; or
- 1900.2 The State share of funds is unavailable; or
- 1900.3 The life, health, or safety of persons served is endangered, in the opinion of the Department; or
- 1900.4 The provider fails to submit fiscal or program reports on the prescribed dates; or
- 1900.5 Either the Department or the provider receives a written notice from the other for any reason stating that termination will occur in no later than 30 days; or
- 1900.6 The provider fails to meet the applicable licensing regulations after a reasonable time for correction, or if the provider fails to deliver services in accordance with the plan of care; or
- 1900.7 The license to operate is revoked by Department or court action, or if the facility's owner or its administrator is convicted of any crime related to operation of the facility; or
- 1900.8 The same services can be provided at a lower rate on a fee-for-service basis or if the per diem rate is greater than the rates that third party payers are paying for comparable services under comparable circumstances.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

2000 ACCOUNTING REQUIREMENTS

- 2000.1 All financial and statistical reports must be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless specific variations are required by these principles.
- 2000.2 The provider must establish and maintain a financial management system that assures adequate internal control and accuracy of financial data, the safeguarding of assets and operational efficiency.
- 2000.3 The provider must report on an accrual basis, unless it is a State or municipal institution that operates on a cash basis, unless the Department and the Department providing the State share of MaineCare reimbursement approves exceptional circumstances. The provider whose records are not maintained on an accrual basis must develop accrual data for reports on the basis of an analysis of the available documentation. The provider must retain all such documentation for audit purposes.
- 2000.4 It is the duty of the provider to notify the Division of Audit within 5 days of any change in its customary charges to the general public. The provider may submit a rate schedule to the Department to satisfy this requirement if the schedule allows the Department the ability to determine with certainty the charge structure of the Private Non-Medical Institution.

2300 COST RELATED TO RESIDENT CARE (Excluding Appendix D Facilities)

- 2300.1 In order to be allowable, compensation must be reasonable and for services that are necessary and related to PNMI services. The services must actually be performed and incurred by the PNMI or its contractors. Providers must report all compensation to all appropriate state and federal tax authorities to the extent required by law for income tax, social security, and unemployment insurance purposes.

Providers may not claim reimbursement for personal expenses unrelated to member care. Bonuses that are part of a written policy of the provider and which require some measurable and attainable employee job performance expectations are allowable. Bonuses based solely on the availability of any anticipated savings are not allowable.

- 2300.2 Costs incurred for PNMI 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.

2400 ALLOWABILITY OF COST

- 2400.1 Allowable costs shall include salaries and wages for direct service staff.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

2400 **ALLOWABILITY OF COST** (cont.)

See applicable Appendix for each type of PNMI for the list of approved direct service staff:

- Appendix B Substance Abuse Treatment Facilities
- Appendix C Medical and Remedial Service Facilities
- Appendix D Child Care Facilities
- Appendix E Community Residences for Persons with Mental Illness
- Appendix F Non-Case Mixed Medical and Remedial Facilities

2400.2 Allowable costs shall also include the following taxes and benefits applicable to direct service staff as defined in the applicable Appendix:

- Payroll taxes/unemployment payroll taxes
- Health insurance
- Dental insurance
- Employer term life/disability insurance
- Qualified retirement contributions
- Worker's Compensation insurance

2400.3 The Department will approve the direct care staffing.

2400.31 The Department will determine the reasonableness of costs based on the budget submitted prior to the beginning of the provider's fiscal year, subject to final approval by the Office of MaineCare Services. The total amount approved in the budget will serve as a cap for reimbursement.

2400.32 A Rate Letter will inform the provider of the approved total cost cap and per diem rate based on a review of the submitted budget per Section 2400, Chapter III, General Provisions. For case mix facilities covered under Appendix C, the rate letter informs the agency of the Industry Price and Average Case Mix Index.

2400.4 Allowable costs may also include contract fees, which are fees paid in lieu of salary, paid for use of foreign exchange fellows, such as those participating in the ILEX international professional exchange program for social workers, in lieu of direct service staff as defined in the applicable appendix. Contract fees must be prior-approved by the Department, and must meet all staff qualifications. The Department will reimburse the provider for the contract fee, based on a calculation of hours worked by the foreign exchange fellow, at the salary, wages and taxes and benefits that would be allowable under these regulations for a comparable direct service staff working those hours. The Department will only reimburse up to the allowed contract fee amount, and will not reimburse any wages and benefits to the foreign exchange fellow other than reimbursing the allowable contract fee amount.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97	PRIVATE NON-MEDICAL INSTITUTION SERVICES	Established 6/11/90 Final Adoption: 6/30/14 EMERGENCY RULE: 10/25/16
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2400 **ALLOWABILITY OF COST** (cont.)

2410 State-Mandated Service Tax: Effective July 1, 2004, allowable costs shall include a State-mandated service tax. The State-mandated service tax is a tax on the value of PNMI services, as defined in 36 M.R.S.A. §2552(1)(G).

2450 Program Allowance: See the applicable Appendix for the allowable program allowance.

The maximum reimbursement amount allowed, including the program allowance, will not be greater than the total costs of the program.

2470 **Certifying Other Qualified Staff (With exception for Appendix C and F facilities)**
Training and experience requirements of other qualified staff may vary by definition. However, in all cases, other qualified staff including exchange fellows must be certified or approved by a specified State agency, or its designee, as meeting these requirements. (The specified State agency, or its designee, would be the agency approving the staff for the facility.) These certifications/approvals must be on file. The approval must be in writing and dated at the time the approval is made. This approval process must not be delegated to a provider. The PNMI provider may certify to the approving agency that employees have or will have the requisite training. However, the approving agency must provide the written approvals for the provider to maintain on file. MaineCare payments made for individuals who have not been approved provisionally or fully certified by the State agency, or its designee, are subject to recoupment.

2480 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.

2500 **NON-ALLOWABLE COSTS**

An unallowable cost includes all costs not included in Section 2400.

2600 **SUBSTANCE OVER FORM**

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.

2700 **RECORD KEEPING AND RETENTION OF RECORDS**

2700.1 Providers must make all financial and member records available to representatives of the State of Maine, Department of Health and Human Services or the U.S. Department of Health and Human Services, or the Maine Attorney General's Office, as required by Section 2700.3.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

2700 RECORD KEEPING AND RETENTION OF RECORDS (cont.)

The Department will give providers a three-day notice when requesting fiscal records.

2700.2 Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the cost report.

2700.3 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, Federal and State income tax information, asset acquisition, lease, sale, or any other action, franchise or management arrangement, 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 will 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.

2700.4 The provider must maintain all such records for at least 5 years from the date of settlement of the final audit. The Division of Audit must keep all cost reports, supporting documentation submitted by the provider, correspondence, work papers and other analysis supporting audits for a period of three years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division of Audit must 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.

2700.5 When the Department determines that a provider is not maintaining records as outlined above for the determination of reasonable cost in the PNMI, the Department, upon determination of just cause, may impose the deficiency rate as described in Section 7000 of these Principles.

2900 BILLING PROCEDURES

2900.1 Substance abuse treatment facilities, child care facilities, and community residences for persons with mental illness will bill the Department of Health and Human Services and be reimbursed at the agreed rate in accordance with MaineCare billing instructions for the UB-92 Claim Form.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97	PRIVATE NON-MEDICAL INSTITUTION SERVICES	Established 6/11/90
		Final Adoption: 6/30/14
		EMERGENCY RULE: 10/25/16

2900 **BILLING PROCEDURES** (cont.)

- 2900.2 Medical and remedial service facilities will bill the Department of Health and Human Services and be reimbursed at the agreed rate in accordance with MaineCare billing instructions for the UB-92 Claim Form.
- 2900.3 Claims cannot include dates of service that overlap the provider's fiscal years.

3000 **REIMBURSEMENT METHOD**

3000.1 The Department will reimburse facilities for services provided to members based on a rate that the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs incurred by an efficiently and economically operated facility. The provider must provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

3000.11 Except for Appendix D facilities, the Department will limit reimbursement to the approved amount in Section 2400. Appendix D facilities receive a standard rate not subject to Section 2400 adjustments for allowability of cost.

3000.2 Rate Setting Procedures

See applicable Appendix for type of Private Non-Medical Institution:

- Appendix B Substance Abuse Treatment Facilities
- Appendix C Medical and Remedial Service Facilities Participating in Case Mix
- Appendix D Child Care Facilities
- Appendix E Community Residences for Persons with Mental Illness
- Appendix F Non-Case Mixed Medical and Remedial Facilities

3000.3 Rate Adjustments For Facilities Under Appendix B, E, and F

Facilities covered under Appendix B, E, and F may request rate adjustments as necessary. The relevant Appendix details the process for such requests. The Department will not grant retroactive rate adjustments unless they are approved by the OMS and the Department under exceptional circumstances as determined by these two agencies.

3000.4 For out-of-state PNMI services provided by out-of-state providers, the Division of Financial Services will determine whether the rate paid to these providers will be either 1) based on the methodology set forth in this section, or 2) be the Medicaid rate of the state in which the PNMI services are provided.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97 PRIVATE NON-MEDICAL INSTITUTION SERVICES Established 6/11/90
Final Adoption: 6/30/14
EMERGENCY RULE: 10/25/16

3000 **REIMBURSEMENT METHOD** (cont.)

Subject to
CMS approval
Effective
10/1/15

The following is subject to CMS approval

- 3000.5 An Appendix C PNMI that qualifies as a “remote island facility” under this section will receive a fifteen (15) percent supplemental payment in addition to their MaineCare rate. This increase will apply only to facilities located on an island not connected to the mainland by a bridge.

3100 **FINANCIAL REPORTING**

3100.1 Master File

When requested by the Department the provider must submit the following documents to the Office of MaineCare Services or its designee. Providers must update documents to reflect any changes. The Department will use the following documents to establish a master file for each facility in MaineCare:

- 3100.11 Copies of the articles of incorporation and bylaws, of partnership agreements of any provider or any entity related to the provider;
- 3100.12 Chart of accounts and procedures manual, including procurement standards;
- 3100.13 Plant layout;
- 3100.14 Terms of capital stock and bond issues;
- 3100.15 Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing, and bonus agreements;
- 3100.16 Schedules for amortization of long-term debt and depreciation of plant assets;
- 3100.17 Summary of accounting principles, cost allocation plans, and step-down statistics used by the provider;
- 3100.18 Related party information on affiliations, and contractual arrangements;
- 3100.19 Tax returns of the Private Non-Medical Institution; and
- 3100.20 Any other documentation requested by the Department for purposes of establishing a rate.

If any of the items listed in Subsections 3100.11 through 3100.20 are not submitted in a timely fashion, the Department may impose the deficiency per diem rate described in Section 7000 of these Principles.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

3300 UNIFORM COST REPORTS

3300.1 The Department requires all PNMI's to submit cost reports. Cost reports, as prescribed herein, must be mailed to the State of Maine, Department of Health and Human Services, Division of Audit, and to the Division of Financial Services, Office of MaineCare Services, 11 State House Station, Augusta, ME, 04333-0011. Those out-of-state providers who are using another state's Medicaid rate or have two or fewer MaineCare residents must obtain prior authorization from the OMS Division of Financial Services, # 11 State House Station, Augusta, Maine 04333-0011 to be exempted from filing a cost report. The facility's financial statements will be the basis for completing the cost report. The cost reports must be based on the fiscal year of the facility. If the provider determines from its as filed cost report that it owes money to the Department, a check equal to 50% of the amount owed to the Department must accompany the cost report. If the Department does not receive a check with the cost report, the Department may elect to offset, pursuant to State and federal law, the current payments to the facility until the entire amount is collected from the provider.

3300.2 Forms/Electronic Media. The Department will supply annual cost report forms/electronic media for use by PNMI's in the State of Maine.

3300.3 Each PNMI in Maine must submit a completed annual cost report within five months of the end of each fiscal year on forms/media prescribed by the Division of Audit. If available, the PNMI will submit a copy of the cost report on a computer disk or electronically.

The inclusive dates of the reporting year are the 12-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 an acceptable cost report in the time prescribed above may result in the Department imposing the deficiency per diem rate described in Section 7000.

3300.4 Certification by operator. Each provider must examine the cost report and supporting schedules prepared for submission to the Department and must certify that the report is a true, correct, and complete statement prepared from the books and records of the provider. The owner or administrator of the PNMI must certify the cost report. If someone other than the owner or administrator prepares the return, the preparer must also sign the report.

3300.5 The provider must submit the Cost Report with required supporting documentation to the Division of Audit. Supporting documentation requirements are defined by the Division of Audit. Supporting documentation includes, at a minimum, financial statements and reconciliation of the financial statements to the cost report. All cost reports must bear original signatures.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97 PRIVATE NON-MEDICAL INSTITUTION SERVICES Established 6/11/90
Final Adoption: 6/30/14
EMERGENCY RULE: 10/25/16

3300 **UNIFORM COST REPORTS (cont.)**

Providers must also submit a copy of the cost report without supporting documentation to the Division of Financial Services at the Office of MaineCare Services.

- 3300.6 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.
- 3300.7 The Division of Audit may reject any cost report filing that does not comply with these regulations. In such case, the report will be deemed not filed, until refiled and in compliance. A rejected cost report will subject the provider to the deficiency per diem as stated in Section 7000.
- 3300.8 Extension for filing of the cost report with the required supporting documentation beyond the prescribed deadline will only be granted under the regulations stated in the Medicare Provider Reimbursement Manual (HIM-15).
- 3300.9 When a provider fails to file an acceptable cost report by the required date, the Department will send the provider a notice by certified mail, return receipt requested, advising the provider that all payments will be suspended 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 will be at the deficiency rate as stated in Section 7000.

3400 **SETTLEMENT OF COST REPORTS**

3400.1 Uniform Desk Review

See applicable PNMI Appendix for uniform desk review procedures.

3400.2 Calculation of the Final Settlement

See Applicable Appendix for calculation of the final settlement. Calculation of the final settlement is subject to reimbursement methods, limits, and reductions set forth in this Section. Appendix D facilities are not subject to cost settlement.

3500 **ADJUSTMENTS TO AUDIT SETTLEMENTS (Except for Appendix D)**

- 3500.1 Finalized cost report determinations and decisions may be reopened and corrected when the Division of Audit finds new and material evidence submitted by the provider or discovered by the Department or evidence of a clear and obvious material error.
- 3500.2 Reopening means an affirmative action taken by the Division of Audit to re-examine the correctness of a determination or decision that is otherwise final. Such action may only be taken:

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

3500 **ADJUSTMENTS TO AUDIT SETTLEMENTS (Except for Appendix D)** (cont.)

3500.21 At the request of either the Department or a provider, within the applicable time period set out in paragraph 3500.4; and,

3500.22 When the reopening may have a material effect (more than one percent) on the provider's MaineCare rate payments.

A correction is a revision (adjustment) in the Division of Audit's determination, otherwise final, that is made after a proper re-opening. The Division may make a correction, or require the provider to file an amended cost report.

3500.4 A re-opening of an audit may occur within three 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. No time limit will apply in the event of fraud or misrepresentation.

3500.41 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.

3500.42 No final audit will be reopened, or any hearing allowed concerning matters contained in any final audit if three years following the date of the final audit settlement have passed. This limitation does not apply in the event of fraud or misrepresentation.

3600 **SETTLEMENTS OF OVERPAYMENTS OR UNDERPAYMENTS (Except for Appendix D)**

3600.1 Underpayments: If, at the time the audit is completed, the Department determines that it has underpaid a facility; the Department will pay the amount due and forward the result to the facility within thirty working days.

3600.2 Overpayments:

3600.21 If the Department has overpaid a provider, it will recover overpayments by offset, recoupment, or other methods allowed by law.

3600.22 The department may withhold payment on pending or future claims in an amount equal to the overpayment, pursuant to State and federal law. The amount may be withheld all at once or over a period of time established by the Department. Amounts are to be repaid within 90 days of the date the audit is finalized unless otherwise negotiated by the Department.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

3600 SETTLEMENTS OF OVERPAYMENTS OF UNDERPAYMENTS (Except for Appendix D) (cont.)

3600.23 If there are insufficient claims sent to the Department against which the Department can offset the amount of an overpayment, the Department will direct the provider to remit the payment in full. If repayment is not made, the Department may exercise any or all appropriate action against the provider and exercise all other civil remedies in order to recover the overpayments.

4000 PUBLIC HEARING

The State of Maine will provide for public hearings as described MBM, Chapter I.

5000 WAIVER

The failure of the Department to insist, in any one 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, will 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.

6000 POST AUDIT APPEAL PROCEDURES (Except for Appendix D)

6000.1 These provisions apply only to appeals after audit adjustment. See MBM, Chapter I for all other appeals procedures. A provider may administratively appeal an audit adjustment made by the Division of Audit.

6000.2 An administrative appeal will proceed in the following manner:

6000.21 Within sixty (60) 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.

6000.22 The Director or his/her designee will 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

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

6000 POST AUDIT APPEAL PROCEDURES (Except for Appendix D) (cont.)

presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within sixty (60) days of receipt of the decision made as a result of the informal review.

6000.23 To the extent the Department rules in favor of the provider, the audit report will be revised.

6000.24 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 Procedures Act, 5 M.R.S.A. §11001 *et seq.*

7000 DEFICIENCY PER DIEM RATE (Except for Appendix D)

In addition to the deficiency rate, civil and/or monetary sanctions may be applied by the State agency responsible for licensing the facility when a facility is found not to have provided the quality of service or level of care required. The Department will reimburse at 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:

7000.1 Staffing over a period of two weeks or more does not meet the Federal Certification and State Licensing requirements;

7000.2 Food service does not meet the Federal Certification and State Licensing requirements;

7000.3 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 30 days from written notification that such deficiencies exist;

7000.4 Failure to correct, within the time frames of an accepted Plan of Correction, deficiencies in meeting the Federal Certification and State Licensing requirements, which cause a threat to the health and safety of residents in a facility or the surrounding community;

7000.5 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 per diem rate, suspension, withholding of, or recoupment of MaineCare reimbursement. The deficiency per diem rate for these items will go into effect immediately upon receipt of written notification from the Department.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

7000 **DEFICIENCY PER DIEM RATE (Except for Appendix D)** (cont.)

7000.6 Failure to complete acceptable assessments, as defined in Appendix C.

A reduction in rate because of deficiencies will remain in effect until the deficiencies have been corrected, as defined in the applicable Appendix, or 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 will be made for the 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.

8000 **START UP COSTS APPLICABILITY**

Prior to admitting residents, certain costs are incurred, which are referred to as start-up costs. No start-up costs can be allowed for the PNMI component.

10000 **GENERAL DEFINITIONS**

“Accrual Basis 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.

“Allowable Costs” are those operating costs remaining after the adjustments required by the Principles have been applied to the provider’s total operating costs reported in the annual cost reports.

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

“Census/Days of Care”: For purposes of counting the number of patient days, the day of the patient’s admission will be counted, but the day of discharge will not be counted.

“Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)” is the Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and federal Medicaid programs.

“Common Ownership” exists if an individual or individuals possess significant 10% ownership or equity in the provider and the institution or organization serving the provider.

“Control” exists if 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” are the processes of segregating costs by cost centers and allocating indirect cost to determine the cost of services provided.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

10000 **GENERAL DEFINITIONS** (cont.)

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

“Generally Accepted Accounting Principles (GAAP)” are 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.

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

“Division of Audit” used throughout these Principles refers to the Department of Health and Human Services, Division of Audit.

“MaineCare Eligible Days” are the actual days of service for which payment was made by the Office of MaineCare Services through the claims process.

“Necessary and Proper Costs” are costs for services and items that are essential to provide appropriate resident care and resident 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.

“Occupancy Level” as referenced in this policy consists of the total licensed beds of a PNMI times the number of days available in the fiscal period (e.g.: A PNMI licensed for 10 beds and open for a full 12 month period, with the fiscal period covering the full 12 months, would have its occupancy level stated at 3650. Ten beds multiplied by 365 days in the year equals 3650 days.)

“Owners” include any individual or organization with 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.

“Per Diem Rate” includes total allowable costs divided by days of care.

“Reasonable Costs” are those incurred by a provider which are reasonable and necessary in providing adequate care to eligible residents and which are within the requirements and limitations of this policy. The reasonableness and necessity of any costs will be determined by reference to, or in comparison with, the cost of providing comparable services.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14

EMERGENCY RULE: 10/25/16

10000 **GENERAL DEFINITIONS** (cont.)

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

“Remote Island Facility” for the purposes of this section, means a facility located on an island not connected to the mainland by a bridge.

“Resident” as used throughout this policy refers to the person residing in the facility and is receiving services in the PNMI. The term is also synonymous with “member.”

“Rider A” is used to denote the State’s share of funds used to draw down the federal Medicaid funds by a specific agency/facility. The form states the amount of State money available, the total federal match (Medicaid) that can be drawn down and the combined total (of State and Federal) that the agency/facility can receive in that fiscal year.

“State Licensing and Federal Certification” as used throughout these principles are the applicable “Regulations Governing the Licensing and Functioning of Level I Private Non-Medical Institutions,” “Regulations Governing the Licensing and Functioning of Level II Private Non-Medical Institutions,” “Regulations Governing the Licensing and Functioning of Level III Private Non-Medical Institutions,” or “Regulations Governing the Licensing and Functioning of Level IV Private Non-Medical Institutions”, “Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services,” “Regulations for Licensing and Certifying of Alcohol and Drug Treatment Services,” or “Rules for the Licensure of Residential Child Care Facilities/Rights of

“Recipients of Mental Health Services Who are Children in Need of Treatment;” and the Federal Certification requirements for Private Non-Medical Institutions that are in effect at the time the cost is incurred.

“Leave (bedhold) days” are when the resident is not in the facility and no treatment is provided. Leave days are not a covered service.

Subject to
CMS
approval
Effective
10/1/15

10-144 Chapter 101
 MAINECARE BENEFITS MANUAL
 CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICE

Established 6/11/90
 Final Adoption: 6/30/14
 EMERGENCY RULE 10/25/16

Effective
 retroactive
 to
 7/1/16

PROC. CODE	DESCRIPTION * See Below	MAXIMUM ALLOWANCE
SUBSTANCE ABUSE TREATMENT FACILITIES		
H0010	Detoxification (Non Hospital based)	\$212.96 per diem
H2034	Halfway House Services	\$103.89 per diem
H2036	Extended Care	\$114.46 per diem
H2036 HF	Residential Rehabilitation Type 1	\$219.78 per diem
H2034 HF	Residential Rehabilitation Type II	\$117.17 per diem
H2036 HA	Adolescent Residential Rehabilitation	\$183.77 per diem
T1020 HF	Personal Care - Substance Abuse (Substance Abuse Shelter Services)	\$55.69 per diem

* Room and Board costs are not reimbursed in the rates for PNMI Substance Abuse Treatment Service
The Department is seeking and anticipates receiving approval from CMS for this Section. Pending approval, the increased rates are effective retroactive to July 1, 2016.

10-144 Chapter 101
 MAINECARE BENEFITS MANUAL
 CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

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The Department is seeking and anticipates receiving approval from CMS for this Section. Pending approval, the increased rates are effective retroactive to July 1, 2016.

Effective retroactive to 7/1/16

RESIDENTIAL CHILD CARE FACILITY		
	Child Care Facility PNMI Services	Maximum Allowance Per Diem
H0019-HE	Child Mental Health Level I*	\$330.72per diem
H0019-CG	Child Mental Health Level II*	\$435.40per diem
H0019-SE	Mental Retardation and Pervasive Developmental Disorder Level I*	\$396.47per diem
H0019-U9	Mental Retardation and Pervasive Developmental Disorder Level II*	\$585.60per diem
H0019-HA	Crisis Residential	\$539.89per diem
H0019-HU	Treatment Foster Care	\$103.51per diem
H0019-HY	Treatment Foster Care-Multidimensional (Juvenile Justice)	\$150.45per diem
S9485	*Temporary High Intensity Service for Children in ITRT Setting. This service is only available for Mental Health Level I and II and Mental Retardation Level I and II	By Report per diem

10-144 Chapter 101
 MAINECARE BENEFITS MANUAL
 CHAPTER III

SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90

Final Adoption: 6/30/14
 EMERGENCY RULE: 10/25/16

The Department is seeking and anticipates receiving CMS approval for this Section. Pending approval, the increased rates will be effective retroactive to July 1, 2016.

Effective
 retroactive
 To 7/1/16

COMMUNITY RESIDENCES FOR PEOPLE WITH MENTAL ILLNESS		
* (H0019)	Rehabilitation Services	By Report
* (T1020-HE)	Personal Care Services-Residences For People With Mental Illness	By Report

RESIDENTIAL CARE FACILITIES		
* (T1020)	Medical and Remedial Personal Care Services	By Report
* (T1020)	Medical And Remedial Services	By Report
COMMUNITY RESIDENCES FOR PEOPLE WITH MENTAL RETARDATION		
RMR* (T1020)	Personal Care Services-Residences For People With Mental Retardation	By Report
MRP* (H0019)	PNMI Services	By Report

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX B

SUBSTANCE ABUSE TREATMENT FACILITIES

Established 1/1/85

Last Updated 2/13/11

EMERGENCY RULE 10/25/16

TABLE OF CONTENTS

	PAGE
1000 PURPOSE.....	1
1200 AUTHORITY.....	1
1210 DEFINITIONS	1
2400 SERVICE COMPONENTS OF THE STANDARD RATE.....	2
2500 NON-ALLOWABLE COSTS	3
3400 COST REPORTS.....	3
5120 PERSONAL CARE SERVICES.....	3
6000 RATE SETTING	4

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX B

SUBSTANCE ABUSE TREATMENT FACILITIES

Established 1/1/85

Last Updated 2/13/11

EMERGENCY RULE 10/25/16

INTRODUCTION

1000 PURPOSE

The purpose of Appendix B is to identify reimbursement regulations that are specific to substance abuse treatment facilities under Chapter III, Private Non-Medical Institutions (PNMI) services of the MaineCare Benefits Manual. The general provisions of Chapter III for PNMI services contain reimbursement regulations that are applicable to all categories of service under the PNMI regulations. It shall be the prerogative of the Commissioner of the Department of Health and Human Services to impose a ceiling on reimbursement for private non-medical institutions. These regulations identify which costs are reimbursable within Section 97, Chapters II and III and Appendix B, Private Non-Medical Institution Services of the MaineCare Benefits Manual. As of November 15, 2010, Substance Abuse Treatment Facilities under this Appendix are reimbursed using a standard rate for each defined type of substance abuse treatment service, and are not subject to establishment of interim rates and cost settlement procedures, as detailed in Section 97, Chapter III. Rates may be found at <http://www.maine.gov/dhhs/audit/rate-setting/index.shtml>.

1200 AUTHORITY

The authority of the Department of Health and Human Services to accept and administer funds which may be available from State and/or Federal sources for the provision of the services as set forth in Appendix B is contained in 22 MRSA Section 3173-D and Title XIX of the Social Security Act as Amended; 42 U.S.C.A. §1396 *et seq.*

1210 DEFINITIONS

The term “member” as used throughout this Appendix refers to an individual who has been determined to be eligible for MaineCare by the Department of Health and Human Services and who is receiving substance abuse treatment by qualified staff of a Private Non-Medical Institution as defined in Section 97.01-1(A) of the MaineCare Benefits Manual.

The term “facility” as used throughout these Principles of Reimbursement refers to private non-medical institutions licensed and funded by the State of Maine, Department of Health and Human Services (DHHS) Office of Substance Abuse Services (OSA) under Sections 4.06, 4.08, 4.09, 4.10, 4.11 and/or 4.13 of the "Regulations for Licensing/Certifying of Substance Abuse Treatment Facilities in the State of Maine," but excludes any Department-licensed facilities staffed by a solo provider.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX B

SUBSTANCE ABUSE TREATMENT FACILITIES

Established 1/1/85

Last Updated 2/13/11

EMERGENCY RULE 10/25/16

2400 **SERVICE COMPONENTS OF THE STANDARD RATE**

Providers must follow all State of Maine licensing regulations and guidelines for staffing levels and must maintain professional staffing sufficient to serve the individual needs of each recipient as reflected in his individual service plan (as defined in Chapter II, §97.) Professional services may be provided only within the scope of the professional's license.

2400.1 The standard per diem rates provided for Detoxification (non-hospital based), Halfway House Services, Extended Care, Residential Rehabilitation Services (Type^oI), Residential Rehabilitation Services (Type II), Adolescent Residential Rehabilitation and Personal Care Substance Abuse (Substance Abuse Shelter Services) are intended to include the service costs listed below. Providers may not bill separately under this section or any other section of the MaineCare Benefits Manual for providing these services. Salaries and wages for direct service staff and services listed below:

- Physicians
- Psychiatrists
- Psychologists
- Social workers
- Licensed clinical professional counselors
- Licensed professional counselors
- Registered nurses
- Practical nurses
- Licensed alcohol and drug counselors
- Psychiatric nurses
- Personal care services staff
- Certified interpreters
- Clinical Consultants
- Other qualified alcohol and drug treatment staff as defined in Section 97.07-2, of the MaineCare Benefits Manual.

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

2400.2 The Department shall determine the reasonableness of the treatment costs on an annual basis. Providers must submit any requested data to the Department including, but not limited to, utilization data.

2410 The rates in this Section include a State-mandated service tax. The State-mandated service tax is a tax on the value of PNMI services pursuant to 36 M.R.S. §2552. Since providers will no longer

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX B

SUBSTANCE ABUSE TREATMENT FACILITIES

Established 1/1/85
Last Updated 9/20/16
EMERGENCY RULE 10/25/16

2400 **SERVICE COMPONENTS OF THE STANDARD RATE** (cont.)

receive Rate letters detailing this information, they will need to calculate the service tax of reimbursed services.

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

2500 **NON-ALLOWABLE COSTS**

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

3400 **COST REPORTS**

3400.1 Uniform Desk Review

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

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

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

- a. Request more information,
- b. Issue a final report of findings, or
- c. Conduct a field audit and issue a final report of findings.

5120 **PERSONAL CARE SERVICES**

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

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX B

SUBSTANCE ABUSE TREATMENT FACILITIES

Established 1/1/85

Last Updated 9/20/16

EMERGENCY RULE 10/25/16

6000 RATE SETTING

6000.1

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services for this Section. Pending approval, the following reimbursement rates will be effective retroactive to July 1, 2016:

The following capitated rates apply to Appendix B services:

Effective
retroactive
to
7/1/16

Detoxification (Non Hospital based) - \$212.96 per diem

Halfway House services - \$103.89 per diem

Extended Care - \$114.46 per diem

Residential Rehabilitation Type I - \$219.78 per diem

Residential Rehabilitation Type II - \$117.17 per diem

Adolescent Residential Rehabilitation - \$183.77 per diem

Personal Care Substance Abuse (Substance Abuse Shelter Services) - \$55.69 per diem

Members are assessed as described in Chapter II, Section 97, and assigned to one of the types of substance abuse treatment services described above. Providers bill the Department on a per diem basis for each member receiving service. The capitated rate includes all PNMI services required by the member for his or her type of service including all staffing required pursuant to State of Maine licensing guidelines and as identified in the members individual service plan. There is no cost settlement for Appendix B PNMI services.

6000.2 The provider must submit, upon request, such data, statistics, schedules, or other information required by the OMS and OSA.

6000.3 The standardized rate for each Substance abuse treatment service type will begin November 15, 2010.

10-144 Chapter 101
 MAINECARE BENEFITS MANUAL
 CHAPTER III, PRINCIPLES OF REIMBURSEMENT
 SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88
		Provisionally Adopted 6/6/16
		EMERGENCY RULE 10/25/16

TABLE OF CONTENTS

		PAGE
1000	INTRODUCTION	1
	1010 Purpose.....	1
	1020 Authority.....	1
	1030 Principle.....	1
	1040 Scope.....	1
2000	DEFINITIONS.....	2
	2010 Member.....	2
	2020 Room and Board Costs	2
	2030 Resident Assessment Instrument	2
	2040 Remote Island Facility	2
2400	ALLOWABILITY OF COST.....	2
	2400.1 Case Mix Adjusted Price	2
	2400.2 Program Allowance	2
	2400.3 Personal Care Services Not Included in the Case Mix Adjusted Price.....	2
	2400.4 Contract Fee Allowable Costs	3
	2400.5 State Mandated Service Tax	3
	2400.6 Remote Island Facility Supplemental Payment	3
3000	GENERAL DESCRIPTION OF THE PRICING METHODOLOGY	3
	3010 Direct Care Services Included in the Case Mix Adjusted Price	3
	3020 Personal Care Services Component Not Included in the Case Mix Adjusted Price	4
	3030 Medical Supplies Included in the Case Mix Adjusted Price.....	5
4000	FACILITIES EXEMPT FROM THE DIRECT CARE PRICE (DCP) PAYMENT METHOD	5
5000	CASE MIX ADJUSTED DCP.....	5
6000	PEER GROUPS	6
7000	RESIDENT ASSESSMENTS	6
	7010 Purpose of Resident Assessments.....	6
	7020 Schedule of Resident Assessments	6
	7030 Accuracy of Assessments	6
	7040 Quality Review of MDS-RCA Process.....	8

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88
		Provisionally Adopted 6/6/16
		EMERGENCY RULE 10/25/16

TABLE OF CONTENTS (cont.)

7050	Criteria for Assessment Review.....	9
7060	Sanctions.....	9
8000	CASE MIX PAYMENT SYSTEM	10
8010	Industry Specific DCP10	10
8020	Case Mix Resident Classification Groups and Weights	11
8030	Rate Setting Case Mix	11
8040	New Facilities	12
8050	Inflation Adjustment	12
8060	Hold Harmless Provisions	12
9000	REGIONS	13

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C MEDICAL AND REMEDIAL SERVICE FACILITIES Established 3/1/88
Provisionally Adopted 6/6/16
EMERGENCY RULE 10/25/16

1000 **INTRODUCTION**

1010 **Purpose.** The purpose of these regulations is to define the payment mechanism for Title XIX funds in medical and remedial services facilities under Chapter II, Section 97 - Private Non-Medical Institution Services of the MaineCare Benefits Manual. The Department pays a case mix adjusted industry-specific price for direct care services provided in medical and remedial services facilities, plus a program allowance and a personal care services component.

1020 **Authority.** The authority of the Maine Department of Health and Human Services to accept and administer funds that may be available from private, local, State, or Federal sources for the provision of services set forth in these Principles of Reimbursement is established in Title 22 of the Maine Revised Statutes Annotated (MRSA), §3, §10, §42, §3273, §7906-A and 7910. The regulations are issued pursuant to authority granted to the Department of Health and Human Services by Title 22 MRSA §42(1).

1030 **Principle.** In order to receive payment for services according to this Appendix, a provider must be licensed as a residential care facility and have a provider contract specifying the conditions of participation in Title XIX as a Private Non-Medical Institution as described in Section 97, Chapter II of the MaineCare Benefits Manual. Determination of members' eligibility for PNMI services is made according to Chapter II, Section 97 of the MaineCare Benefits Manual. Residents 18-64 years of age and living in Institutions for Mental Disease are not eligible for services under this Appendix. However, the cost of covered services to residents of Institutions for Mental Diseases who are 65 years of age and over can be claimed under this appendix provided they meet all other requirements for eligibility.

Payment will be made for any eligible member only if the provider obtains the signature of a physician prescribing covered services prior to the first date of service. The PNMI must maintain this information as part of the member's record at the facility.

The Department will not make payment under this Appendix for residents who are family members of the owner or provider staff providing medical and remedial services.

1040 **Scope.** Residential Care Facilities that provide custodial (e.g. supervision, medication administration, and room and board) services to six or fewer residents and do not provide individualized in-home programming to persons with severe physical or functional disability are not eligible for payment under Appendix C. The Department reimburses these providers on a flat rate basis.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88 Provisionally Adopted 6/6/16 EMERGENCY RULE 10/25/16
------------	-----------------------------------------	-------------------------------------------------------------------------------

2000 **DEFINITIONS**

2010 **Member** as used throughout this Appendix refers to an individual who is MaineCare eligible.

2020 **Room and Board** costs means those costs that are not medical and remedial services costs and are not covered services under Appendix C.

2030 **Resident Assessment Instrument (RAI)** is the assessment tool approved by the Department for use by the provider to obtain an accurate, standardized, reproducible assessment of each resident’s functional capacity. It consists of the Minimum Data Set–Residential Care Assessment instrument (hereinafter MDS-RCA), the training manual for the MDS-RCA Tool, and any updates provided by the Department.

Subject to
CMS
approval
effective
10/1/15

2040 **Remote Island Facility** for the purposes of this section, means a facility located on an island not connected to the mainland by a bridge.

2400 **ALLOWABILITY OF COST**

2400.1 **Case Mix Adjusted Price**

The case mix adjusted price includes services provided by the direct care services staff listed below. Allowable costs include salaries, wages, benefits, and consultant fees for direct care staff and services listed below:

- Clinical consultant services
- Interpreter services
- Licensed practical nurse services
- Licensed social workers or other social worker services
- Personal care services staff
- Practical nurses
- Registered nurse consultant services, and
- Other qualified medical and remedial staff.

2400.2 **Program Allowance**

A program allowance of thirty (35) percent, expressed as a percentage of the allowable costs, as defined in Chapter III, Section 97, Sections 2400.1 and 2400.2 will be allowed in lieu of indirect and/or PNMI related cost.

2400.3 **Personal Care Services Not Included in the Case Mix Adjusted Price**

Effective July 1, 2002, personal care services not included in the case mix adjusted price include salaries, wages, and benefits (as described in Chapter III, Section 2400.2) for direct care staff listed below:

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88 Provisionally Adopted 6/6/16 EMERGENCY RULE 10/25/16
------------	-----------------------------------------	-------------------------------------------------------------------------------

2400 **ALLOWABILITY OF COST** (cont.)

Laundry
Housekeeping, and
Dietary services

The personal care services component is determined by inflating the facility’s 1998 audited costs for these services to June 30, 2003. This becomes the PNMI’s facility specific cap. The actual allowable personal care services costs will be settled at audit up to this cap.

2400.4 **Allowable Costs Related to Contract Fees for Exchange Fellows**

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

2400.5 **State Mandated Service Tax**

As of July 1, 2004, allowable costs shall include a State-mandated service tax. The State-mandated service tax is a tax on the value of PNMI services pursuant to 36 M.R.S. §2552.

2400.6 **Remote Island Supplemental Payment**

Eligible facilities will be allowed to retain the “remote island facility” supplemental payment, representing a fifteen (15) percent rate increase, in addition to the total allowable rate for Private Non-Medical Institution direct care services and personal care services costs otherwise determined under these rules.

3000 **GENERAL DESCRIPTION OF THE PRICING METHODOLOGY**

3010 **Direct Care Services Included in the Case Mix-Adjusted Price**

The Department utilizes a case mix-adjusted pricing methodology with three peer groups for medical and remedial services provided in residential care facilities, unless the provider is exempted from participation in this Appendix. The Department calculates the price by:

- Grouping residential care facilities that had completed MDS-RCA assessments for MaineCare residents on 9/15/98, and that had audited costs for 1998 (hereinafter the base year), into four peer groups, as described in Section 6000;

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10/1/15

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88
		Provisionally Adopted 6/6/16
		EMERGENCY RULE 10/25/16

3000 **GENERAL DESCRIPTION OF THE PRICING METHODOLOGY** (cont.)

Aggregating total allowable direct care costs, applicable workers compensation costs, medical supplies (see Section 3020) and Department-approved medical and remedial services training costs in the base year to calculate each provider's adjusted direct care costs;

- Dividing the adjusted direct care costs by the actual occupancy to determine an adjusted direct care cost/day;
- Inflating the direct care cost from the base year through June 30, 2001 using the regional variations in labor costs by comparing the percentage increase in the weighted average of the actual salaries paid to direct care staff in the base year by medical and remedial PNMI's covered under this Appendix to the weighted average of the actual salaries paid to direct care staff in the subsequent year (based on that subsequent year's audited or as filed cost report);
- Dividing each facility's inflated adjusted direct care cost/day by the facility-specific MaineCare case mix index as of September 15, 1998, and aggregating to arrive at an average industry Direct Care Price (hereinafter DCP) for each of the four peer groups. MDS assessments that could not be classified on the September 15, 1998 roster were excluded from the calculation;
- Adding a Program Allowance (PA) determined by the Commissioner, as set forth in Chapter III, Section 97; and
- Calculating the MaineCare payment to each provider by multiplying the DCP by the facility-specific case mix index for MaineCare members, and adding the applicable program allowance.

3020 **Personal Care Services Component Not Included in the Case Mix-Adjusted Price**

Effective July 1, 2002, the Department will determine the rate for the personal care services component by the following method:

- Aggregating total audited allowable costs for housekeeping, laundry, and dietary wages, taxes, and benefits, including applicable Worker's Compensation costs, and benefits in the facility's base year;
- Dividing the costs by the actual occupancy to determine the personal care services component rate; and
- Inflating the personal care services component rate through June 30, 2003.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88
		Provisionally Adopted 6/6/16
		EMERGENCY RULE 10/25/16

3000 GENERAL DESCRIPTION OF THE PRICING METHODOLOGY (cont.)

The actual allowable personal case services costs will be determined at the time of audit of the cost report required under Chapter III, Section 3300, and cost settled up to each PNMI's facility-specific personal services cap.

For new facilities, the allowable personal care services costs will be determined initially based on a proforma cost report.

3030 Medical Supplies Included in the Price

Medical supplies contained in the direct care price include but are not limited to the following items: non-prescription analgesics, non-prescription antacids, applicators, bandages, blood pressure equipment, non-prescription calcium supplements, cotton, cough syrup and expectorants, dietary supplements, disinfectants, dressings, enema equipment, gauze bandages, sterile or non-sterile gloves, ice bags, non-prescription laxatives, lotions, ointments and creams, stethoscopes, non-prescription supplies, tapes, thermometers, and rectal medicated wipes.

4000 FACILITIES EXEMPT FROM THE CASE MIX PRICING METHOD

The following types of medical and remedial PNMI's are exempt from case mix pricing method and will be reimbursed in accordance with Appendix F:

- Facilities whose total population consists of residents diagnosed with HIV/AIDS;
- Facilities whose total population consists of residents who are blind;
- Facilities whose total population consists of individuals with severe and prolonged mental illness;
- Facilities serving individuals with mental retardation and other development disabilities; and
- CARF Accredited Brain Injured Facilities.

5000 CASE MIX ADJUSTED DCP

The basis for case mix adjustment is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them. The DCP is multiplied by the average case mix weight for all MaineCare residents in the facility as of the payment roster date. The PA is added to the case mix adjusted DCP and becomes the facility's MaineCare rate. The Direct Care Price will be inflated annually. Every six months the Department will adjust data for facility-specific acuity.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88
		Provisionally Adopted 6/6/16
		EMERGENCY RULE 10/25/16

6000 PEER GROUPS

The Department will classify facilities into one of four peer groups. The peer groups are divided as follows: freestanding facilities with 15 or fewer beds, facilities that are not freestanding with 15 or fewer beds or facilities with 16 to 24 beds, facilities with 25 or more beds, and Specialty Alzheimer’s Units. Each peer group has its own DCP and PA calculated in accordance with Sections 3000 and 9000. The Department will notify facilities the amounts of the DCP and PA.

7000 RESIDENT ASSESSMENTS

7010 Purpose of Resident Assessments

The provider shall assess each resident, regardless of payment source utilizing an assessment tool on which provider staff will base a service plan designed to assist the resident to reach his/her highest practicable level of physical, mental, and psychosocial functioning. The MDS-RCA is the Department’s approved resident assessment instrument

7020 Schedule of Resident Assessments

The provider must complete the MDS-RCA within 30 days of admission and at least every 180 days thereafter during a resident’s stay. The provider will sequence the assessments from the date in Section S.2.B of the MDS-RCA, Assessment Completion Date. The provider will complete subsequent assessments within 180 days from the date in S.2.B. Providers must complete a significant change MDS-RCA assessment within 14 calendar days after determination is made of a significant change in resident status as defined in the Training Manual for the MDS-RCA Tool. Providers must complete a Resident Tracking Form within 7 days of the discharge, transfer, or death of a resident. Providers must maintain all resident assessments completed within the previous 12 months in the resident’s active record.

7030 Accuracy of Assessments

- 7030.1 Each assessment must be conducted or coordinated by staff trained in completion of the MDS-RCA.
- 7030.2 Certification: Each individual who completes a portion of the assessment must sign and date the form to certify the accuracy of that portion of the assessment.
- 7030.3 Documentation: Documentation is required to support the time periods and information coded on the MDS-RCA.
- 7030.4 Penalty for Falsification: The provider may be sanctioned whenever an individual willfully and knowingly certifies (or causes another individual to

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88
		Provisionally Adopted 6/6/16
		EMERGENCY RULE 10/25/16

7000 **RESIDENT ASSESSMENTS** (cont.)

certify) a material and false statement in a resident assessment. This may be in addition to any other penalties provided by statute, including but not limited to, 22 MRSA §15. The Department’s R.N. assessors will review the accuracy of information reported on the MDS-RCA instruments. If the Department determines that there has been a knowing and willful certification of false statements, the Department may require (for a period specified by the Department) that the resident assessments under this Appendix be conducted and certified by individuals who are independent of the provider and who are approved by the Department.

- 7030.5 Review of Assessment Forms: The Department may review all forms, documentation and evidence used for completion of the MDS-RCA at any time. The Department will undertake quality review periodically to ensure that assessments are completed accurately, correctly, and on a timely basis.
- 7030.6 Facilities shall submit completed assessments to include Admissions, Semi-Annuals, Annuals, Significant Change, other required assessments and MDS Tracking Forms within 30 days of completion to the Department or the Department’s designated agent.
- 7030.7 Providers must submit all claims on electronic media to be specified by the Department. Failure to submit on electronic media on or after this date may result in the provider being paid the DCP adjusted by the default classification (not classified) weight of 0.731.
- 7030.8 Providers must use the MDS-RCA Correction Form in order to request modification or inactivation of erroneous data previously submitted as part of the MDS record (assessment or tracking forms). The MDS-RCA Correction Form is for corrections of two types:
 - 1) Modification, which should be requested when a valid MDS-RCA record (assessment or tracking form) is in the State MDS-RCA database, but the information in the record contains errors; or
 - 2) Inactivation, which should be requested when an incorrect reason for assessment has been submitted under item “Reason for Assessment.” Providers must then resubmit the record with the correct reason for assessment. An inactivation should also be used when an invalid record has been accepted into the State MDS-RCA database. A record may considered invalid for the following reasons: 1) the event did not occur; 2) the record submitted identifies the wrong resident;
 - 3) the record submitted identifies the wrong reason for assessment; or

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88
		Provisionally Adopted 6/6/16
		EMERGENCY RULE 10/25/16

7000 **RESIDENT ASSESSMENTS** (cont.)

- 4) it was an inadvertent submission of a non-required record.

7040 **QUALITY REVIEW OF THE MDS-RCA PROCESS**

7040.1 **Definitions**

- 7040.1.1 MDS-RCA assessment review is conducted at residential care facilities (RCFs) by the Department, and consists of review of assessments, documentation and evidence used in completion of the assessments, in accordance with Section 7000, to ensure that assessments accurately reflect the resident's clinical condition.
- 7040.1.2 Assessment review error rate is the percentage of unverified Case Mix Group Records in the drawn sample. Samples shall be drawn from Case Mix Group Records completed for residents who have MaineCare reimbursement. MDS-RCA Correction forms received in the central repository or included in the clinical record will be the basis for review when completed before the day of the review and included as part of the resident's clinical record.
- 7040.1.3 Verified Case Mix Group Record is an MDS-RCA assessment form completed by the provider, which has been determined to accurately represent the resident's clinical condition during the MDS-RCA assessment review process. Verification activities include reviewing resident assessment forms and supporting documentation, conducting interviews, and observing residents.
- 7040.1.4 Unverified Case Mix Group Record is one which, for payment purposes, the Department has determined does not accurately represent the resident's condition and, therefore, results in an inaccurate classification of the resident into a case mix group that increases the case mix weight assigned to the resident. If the Department identifies any such record, it will require providers to follow appropriate clinical guidelines for completion and submission. Correction forms received prior to calculating the rate setting quarterly index will be used in the calculation of that index.
- 7040.1.5 Unverified MDS-RCA Record is one that, for clinical purposes, does not accurately reflect the resident's condition.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88
		Provisionally Adopted 6/6/16
		EMERGENCY RULE 10/25/16

7050 CRITERIA FOR ASSESSMENT REVIEW

- 7050.1 Providers may be selected for an MDS-RCA assessment review by the Department based upon but not limited to any of the following:
 - (a) The findings of a licensing survey conducted by the Department indicate that the provider is not accurately assessing residents;
 - (b) An analysis of a provider's case mix profile of RCFs indicates changes in the frequency distribution of the residents in the major categories or a change in the facility average case mix score; or
 - (c) Resident assessment performance of the provider, including but not limited to, on-going problems with assessment completion and timeliness, untimely submissions and high assessment error rates.

7050.2 Assessment Review Process

- 7050.2.1 Assessment reviews shall be conducted by staff or designated agents of the Department.
- 7050.2.2 Providers selected for assessment reviews must provide reviewers with reasonable access to residents, professional and direct care staff, the provider assessors, clinical records, and completed resident assessment instruments as well as other documentation regarding the residents' care needs and treatments.
- 7050.2.3 Samples shall be drawn from MDS-RCA assessments completed for residents who have MaineCare coverage.
- 7050.2.4 At the conclusion of the on-site portion of the review process, the reviewers shall hold an exit conference with provider representatives. Reviewers will share written findings for reviewed records. The reviewer may also request reassessment of residents where assessments are in error.

7060 SANCTIONS

- 7060.1 The Department will sanction providers for failure to complete assessments completely, accurately and on a timely basis.
- 7060.2 When a sanctionable event occurs, the Department shall base the sanctions on the total MaineCare payment received by the provider during the 4th through 6th months preceding the month in which the sanctionable event occurred. (For example, if the sanctionable event occurred in May, the sanction would be

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88
		Provisionally Adopted 6/6/16
		EMERGENCY RULE 10/25/16

7060 **SANCTIONS** (cont.)

calculated by multiplying the sanction rate times the total MaineCare payments to the provider during the preceding November, December and January).

7060.3 The amount of the sanction will be based on an application of the percentages below multiplied by the MaineCare payments to the provider during the 4th through 6th months preceding the event. In no event will the payment to the provider be less than the price that would have been paid with an average case mix weight equal to 0.731. The sanctions shall be calculated as follows:

- a) 2% of MaineCare payments when the assessment review results in an error rate of 34% or greater, but is less than 37%
- b) 5% of MaineCare payments when the assessment review results in an error rate of 37% or greater, but is less than 41%.
- c) 7% of MaineCare payments when the assessment review results in an error rate of 41% or greater, but is less than 45%.
- d) 10% of MaineCare payments when the assessment review results in an error rate of 45% or greater.
- e) 10% of MaineCare payments if the provider fails to complete reassessments within 7 days of a written notice/request by the Department.

8000 **CASE MIX PAYMENT SYSTEM**

8010 **Industry-Specific DCP**

The Department multiplies the industry-specific DCP for each peer group by the facility's average MaineCare case mix so that this payment system can take into consideration that some residents are more costly to care for than others. Thus, the system requires:

- a) The assessment of residents on the Department's approved MDS-RCA form;
- b) The classification of residents into groups that are similar in resource utilization by use of the case mix resident classification groups defined in Section 9020 of this Appendix; and
- c) A weighting system that quantifies the relative cost of caring for different classes of residents by direct service staff to determine a resident's case mix index.

10-144 Chapter 101
 MAINECARE BENEFITS MANUAL
 CHAPTER III, PRINCIPLES OF REIMBURSEMENT
 SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88 Provisionally Adopted 6/6/16 EMERGENCY RULE 10/25/16
------------	-----------------------------------------	-------------------------------------------------------------------------------

8000 CASE MIX PAYMENT SYSTEM (cont.)

8020 Case Mix Resident Classification Groups and Weights

There are a total of 15 case mix resident classification groups, including one resident classification group used when residents cannot be classified into one of the 14 clinical classification groups.

The Department assigns each case mix classification group a specific case mix weight, as follows:

RESIDENT CLASSIFICATION GROUP CASE MIX WEIGHT

Resident Group	Order	Short description	MaineCare Weight
IC1	1	IMPAIRED 15-28	2.25
IB1	2	IMPAIRED 12-14	1.568
IA1	3	IMPAIRED 0-11	1.144
CD1	4	COMPLEX 12+	1.944
CC1	5	COMPLEX 7-11	1.593
CB1	6	COMPLEX 2-6	1.205
CA1	7	COMPLEX 0-1	0.938
MC1	8	BEHAVIORAL HEALTH 16+	1.916
MB1	9	BEHAVIORAL HEALTH 5-15	1.377
MA1	10	BEHAVIORAL HEALTH 0-4	0.98
PD1	11	PHYSICAL 11+	1.418
PC1	12	PHYSICAL 8-10	1.019
PB1	13	PHYSICAL 4-7	1.004
PA1	14	PHYSICAL 0-3	0.731
BC1	15	NOT CLASSIFIED	0.731

8030 Rate Setting Case Mix

8030.1 The Department will calculate rates on January 1st and July 1st of each year, beginning on July 1, 2001.

8030.2 The Department will calculate each facility's rate setting case mix index using the number of MaineCare residents in each case mix classification group determined from the most recent MDS-RCA on all MaineCare residents in the facility as of the 15th of March for the July rate and the 15th of September for the January rate.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88
		Provisionally Adopted 6/6/16
		EMERGENCY RULE 10/25/16

8000 CASE MIX PAYMENT SYSTEM (cont.)

- 8030.3 The Department will compute the applicable rate setting case mix index by multiplying the number of residents in each case mix classification group, including those in the unclassified group, by the case mix weight for the relevant classification group. The sum of these products divided by the total number of MaineCare residents in the facility equals the rate setting case mix index.

- 8030.4 The Department will calculate the case mix rate by multiplying the rate setting case mix index by the DCP. The program allowance will be added to the case mix rate.

- 8030.5 The Department will send a roster of residents and source of payment as of March 15th and September 15th to facilities for verification prior to rate setting.

- 8030.6 The Department will utilize the roster in identifying MaineCare residents and their most recent assessment. It is the provider's responsibility to check the roster, make corrections and submit corrections to the Department or its designee within one week of receiving the roster.

- 8030.7 For purposes of this Appendix, the Department will not utilize assessments of residents for whom assessments are incomplete due to the death, discharge, or nursing facility or hospital admission of the resident during the time frame in which the assessment must be completed to compute payment.

8040 New Facilities

For new facilities opening after July 1, 2002, the Department will apply a case mix index of 1.000 to the price for new facilities for the first rate setting period. The Department will apply the actual case mix index to the first rate setting period after either a March 15th or September 15th roster is available, as applicable. The Department will not apply sanctions to new facilities until an actual case mix index is used in rate setting.

8050 Inflation Adjustment

Except when there is specific statutory direction, the Commissioner of the Department of Health and Human Services will determine if an inflation adjustment will be made, the amount of that adjustment, and any performance standards related to that adjustment.

8060 Hold Harmless Provisions

For the twelve (12) month period beginning on July 1, 2001, the direct care price and program allowance for each provider will be calculated as follows: Each provider's rate beginning on July 1, 2001 will be calculated by taking 50% of the interim rate that would otherwise be in effect on July 1, 2001, with inflation to the provider's year end, and 50%

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX C	MEDICAL AND REMEDIAL SERVICE FACILITIES	Established 3/1/88
		Provisionally Adopted 6/6/16
		EMERGENCY RULE 10/25/16

8000 CASE MIX PAYMENT SYSTEM (cont.)

of the case mix-adjusted direct care price, to which the applicable program allowance will be added. These rates will not be cost settled.

On July 1, 2002, the Department will base payments on the case mix adjusted direct care price plus the applicable program allowance, plus the personal services component.

The Department will base rates for new facilities to be reimbursed under this Appendix after July 1, 2001 on the case mix adjusted direct care price and the applicable program allowance.

9000 REGIONS

The Department defines regions for calculation of inflation as:

- Region I - Cumberland County, Knox County, Lincoln County, Sagadahoc County, and York County.

- Region II - Androscoggin County, Franklin County, Kennebec County, Oxford County, and Somerset County.

- Region III - Penobscot County, Piscataquis County, Waldo County, Hancock County, and Washington County.

- Region IV - Aroostook County

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX D

CHILD CARE FACILITIES

Established 1/1/85

Updated 5/15/10

EMERGENCY RULE 10/25/16

1000 PURPOSE

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

1200 AUTHORITY

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

1210 DEFINITIONS

The term "member" as used throughout this Appendix refers to an individual who has been determined to be eligible for MaineCare by the Department of Health and Human Services and who is receiving mental health treatment and/or rehabilitative services as a resident of a child care facility as defined in Section 97.01-1(B) of the MaineCare Benefits Manual.

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

2400 SERVICE COMPONENTS OF THE STANDARD RATE

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

2400.1 Appendix D PNMI services for: MENTAL Retardation and Pervasive Developmental Disorder- Level I, Mental Retardation and Pervasive Developmental Disorder- Level II, Child Mental Health- Level I, Child Mental Health-Level II, Intensive Mental Health for Infants and/or Toddlers, and Crisis Stabilization Residential Services include the following components in the standardized rate, which may not be billed separately under this or other Sections of MaineCare:

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX D

CHILD CARE FACILITIES

Established 1/1/85

Updated 5/15/10

EMERGENCY RULE 10/25/16

2400 SERVICE COMPONENTS OF THE STANDARD RATE (cont.)

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

Appendix D PNMI services for Treatment Foster Care include the following components in the standardized rate, which may not be billed separately under this or other Sections of MaineCare:

- a. Treatment Foster Care Parents
- b. Licensed Social Worker Services
- c. Other Qualified Child Care Professional
- d. Other Qualified Child Care Facility Professional.

Direct service staff who meet residential licensing requirements are considered to be an allowable expense within an Appendix D facility.

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

2400.2 The Department shall determine the reasonableness of the treatment costs on an annual basis. Providers must submit any requested data to the Department including but not limited to utilization data.

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

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III , PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX D	CHILD CARE FACILITIES	Established 1/1/85 Updated: 5/15/10 EMERGENCY RULE 10/25/16
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2400 **SERVICE COMPONENTS OF THE STANDARD RATE** (cont.)

2410 The rates in this Section include a State-mandated service tax. The State-mandated service tax is a tax on the value of PNMI services pursuant to 36 M.R.S. §2552. Since providers will no longer receive Rate letters detailing this information, they will need to calculate the service tax of reimbursed services.

3400 **COST REPORTS**

Appendix D services are not audited; however providers are required to submit cost reports so that the Department has accurate data for rate setting purposes.

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

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

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

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

6000 **RATE-SETTING**

6000.1

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services for this Section. Pending approval, increased reimbursement rates will be effective retroactive to July 1, 2016:

The following capitated rates apply to Appendix D services:

- Mental Retardation and Pervasive Developmental Disorder- Level I- \$396.47 per diem
- Mental Retardation and Pervasive Developmental Disorder- Level II- \$585.60 per diem
- Child Mental Health- Level I- \$330.72 per diem
- Child Mental Health – Level II- \$435.40 per diem
- Intensive Mental Health for Infants and/or Toddlers- \$622.01 per diem
- Crisis Stabilization Residential Services- \$539.89 per diem
- Therapeutic Foster Care- \$103.51 per diem
- Therapeutic Foster Care- Multidimensional - \$150.45 per diem

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III , PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX D

CHILD CARE FACILITIES

Established 1/1/85

Updated: 5/15/10

EMERGENCY RULE 10/25/16

6000 **RATE SETTING** (cont.)

Temporary High Intensity Service- By Report

Children are assessed by the Department, as described in Chapter II, Section 97, and will be assigned to one of the categories of level of care described above. Providers bill the Department on a per diem basis for each child. The capitated rate includes all PNMI services required by child for his/her category of level of care including all staffing required pursuant to State of Maine licensing guidelines, and as identified in the child's individual service plan. See Chapter II requirements for Temporary High Intensity Services. There is no cost settlement for Appendix D PNMI services.

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

6000.4 The rate will be effective for services provided on August 1, 2009 and approved individually for each child.

6000.5 Providers and children's parent or guardian shall receive a written prior authorization letter that indicates the model level of care for which the child is eligible, and the date of the eligibility.

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

6000.7 The total allowable costs for the budget period, based on prior year actual allowable costs, current year costs and funding levels, and pre approved changes expected in the budget period, as reported by the provider, are used to determine the level of reasonable costs to be recognized in setting the prospective rate and total cost cap for the budget period. Only costs that are allowable pursuant to Section 2400 are included in calculating the prospective rate.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX E COMMUNITY RESIDENCES FOR PERSONS WITH MENTAL ILLNESS Established 3/1/88
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

TABLE OF CONTENTS

	PAGE
1000 PURPOSE	1
1200 AUTHORITY	1
1210 DEFINITIONS	1
2400 ALLOWABILITY OF COST	2
2500 NON-ALLOWABLE COSTS.....	3
3400 SETTLEMENT OF COST REPORTS	3
5120 PERSONAL CARE SERVICES	4
6000 RATE-SETTING	4
7000 RATE ADJUSTMENTS	5

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX E COMMUNITY RESIDENCES FOR PERSONS WITH MENTAL ILLNESS Established 3/1/88
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

1000 PURPOSE

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

1200 AUTHORITY

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

1210 DEFINITIONS

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

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

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX E COMMUNITY RESIDENCES FOR PERSONS WITH MENTAL ILLNESS Established 3/1/88
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

2400 ALLOWABILITY OF COST

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

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

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

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

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

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

2410 As of July 1, 2004, allowable costs shall include a State-mandated service tax. The State-mandated service tax is a tax on the value of PNMI services pursuant to 36 M.R.S. §2552.

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

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX E COMMUNITY RESIDENCES FOR PERSONS WITH MENTAL ILLNESS Established 3/1/88
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

2400 **ALLOWABILITY OF COST** (cont.)

facilities covered under this Appendix.

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

2500 **NON-ALLOWABLE COSTS**

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

3400 **SETTLEMENT OF COST REPORTS**

3400.1 Uniform Desk Review

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

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

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

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

3400.2 Calculation of Final Settlement

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

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

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

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

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

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX E COMMUNITY RESIDENCES FOR PERSONS WITH MENTAL ILLNESS Established 3/1/88
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

3400 SETTLEMENT OF COST REPORTS (cont.)

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

5120 PERSONAL CARE SERVICES

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

6000 RATE-SETTING

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

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

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

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

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

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

6000.7 The total allowable costs for the budget period, based on prior year actual allowable costs, current year costs and funding levels, and pre approved changes expected in the budget period, as reported by the provider, are used to determine the level of reasonable costs to be recognized in setting the prospective rate and total cost cap for the budget period. Only costs that are allowable pursuant to Section 2400 are included in calculating the prospective rate.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX E COMMUNITY RESIDENCES FOR PERSONS WITH MENTAL ILLNESS Established 3/1/88
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

6000 **RATE-SETTING** (cont.)

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

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

7000 **RATE ADJUSTMENTS FOR PROVIDERS UNDER APPENDIX E**

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

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

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

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

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

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

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

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

10-144 Chapter 101
 MAINECARE BENEFITS MANUAL
 CHAPTER III, PRINCIPLES OF REIMBURSEMENT
 SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX F NON-CASE MIXED MEDICAL AND REMEDIAL FACILITIES Established 6/11/90
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

TABLE OF CONTENTS

		Page
1000	INTRODUCTION	1
	1010 Purpose	1
	1020 Authority	1
	1030 Principle	1
	1040 Scope	1
2000	DEFINITIONS	2
	2010 Department	2
	2020 Member	2
	2030 Room and Board Costs	2
2400	ALLOWABILITY OF COST	2
	2400.1 Salaries and Wages for Direct Service Staff	2
	2400.2 Program Allowance	2
	2400.3 Personal Care Services	2
	2400.4 Tax and Benefit Costs	3
	2400.5 Staffing Approvals	3
	2400.6 Consultation Services	3
	2400.7 Department Approved Training	4
	2400.8 Medical Supplies	4
	2400.9 Costs Related to Accreditation	4
	2400.10 Contract Fees	4
	2410 State-Mandated Service Tax	4
	2450 Program Allowance	5
2500	NON-ALLOWABLE COSTS	5
3000	METHOD OF PAYMENT	5
	3010 Per Diem Rate	5
	3020 New Facilities	5
	3030 Request for Change	5
	3040 Interim Per Diem Rate	5
	3050 Intensive Rehabilitation for Individuals with Acquired Brain Injury (ABI)	6
	3060 Facilities for Persons with HIV/AIDS	6

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX F NON-CASE MIXED MEDICAL AND REMEDIAL FACILITIES Established 6/11/90
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

TABLE OF CONTENTS (cont.)

	Page
3070 Facilities for the Blind.....	6
3080 Facilities for Persons with Severe and Prolonged Mental Illness	7
3090 Facilities for Persons with Mental Retardation	7
4000 JUSTIFICATION FOR EXEMPTIONS	7
5000 AUDIT SETTLEMENTS.....	7
6000 INFLATION ADJUSTMENTS	8

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX F NON-CASE MIXED MEDICAL AND REMEDIAL FACILITIES Established 6/11/90
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

1000 INTRODUCTION

1010 Purpose. The purpose of this Appendix is to define the payment mechanism for Title XIX funds in medical and remedial services facilities under Section 97, Chapter II, Private Non-Medical Institution (hereinafter PNMI) Services of the MaineCare Benefits Manual, that are exempt from Appendix C. It shall be the prerogative of the Commissioner of the Department of Health and Human Services to impose a ceiling on all or a portion of reimbursement for PNMI's provided by their Departments. These regulations identify those costs that are covered under this Section and the method of payment.

1020 Authority. The authority of the Maine Department of Health and Human Services to accept and administer funds that may be available from private, local, State, or Federal sources for the provision of services set forth in this Appendix is established in Title 22 of the Maine Revised Statutes Annotated, §3, §10, §42, §3273, §7906-A and 7910. The Department of Health and Human Services issues these regulations pursuant to authority granted by Title 22 of the Maine Revised Statutes Annotated §42(1).

1030 Principle. In order to receive reimbursement according to this Appendix, a facility must be licensed as a residential care facility and have a provider contract specifying the conditions of participation in Title XIX as a Private Non-Medical Institution as described in Section 97, Chapter II of the MaineCare Benefits Manual, except for scattered site facilities for persons with mental retardation, which may be licensed either as a residential care facility or as a mental health provider in accordance with The Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug Treatment Services.” Determination of resident eligibility is made according to Chapter II, Section 97 of the MaineCare Benefits Manual. Residents who are 18-64 years of age and living in Institutions for Mental Diseases are not eligible under this Appendix. However, the cost of covered services to residents of Institutions for Mental Diseases who are 65 years of age or older can be claimed under this Appendix provided they meet all other requirements for eligibility.

The Department will make payment for any eligible member only if the provider obtains the signature of a physician prescribing covered services prior to the first date of service. The provider must maintain this information as part of the member’s record.

The Department will not make payment for residents who are family members of the owner or provider staff providing medical and remedial services.

1040 Scope. Level 1 Residential Care Facilities that provide custodial (e.g. supervision, medication administration, and room and board) services to six or fewer residents and do not provide individualized in-home programming to persons with severe physical or functional disability are not eligible for payment under this Appendix. These facilities are paid on a flat rate basis.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX F NON-CASE MIXED MEDICAL AND REMEDIAL FACILITIES Established 6/11/90
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

2000 DEFINITIONS

- 2010 Department as used throughout this Appendix refers to either the Maine Department of Health and Human Services.
- 2020 Member as used throughout this Appendix refers to an individual who is MaineCare eligible.
- 2030 Room and Board costs are those costs that are not medical and remedial services as defined in this Appendix, and not allowable costs to Title XIX.

2400 ALLOWABILITY OF COST

2400.1 Salaries and Wages for Direct Service Staff

Allowable costs shall include salaries and wages for direct service staff and services, as defined in Chapter II, Section 97, as listed below:

- Registered nurses
- Licensed practical nurses
- Licensed social workers
- Personal care services staff
- Other qualified medical and remedial staff
- Other qualified mental health staff
- Clinical consultant services

All staff must meet qualification requirements specified in Chapter II, Section 97.

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

- 2400.2 A program allowance, expressed as a percentage of the allowable costs, as defined in Chapter III, Section 97, Sections 2400 will be allowed in lieu of indirect and/or PNMI related cost.

- 2400.3 Personal care services include salaries, wages, benefits, and consultant fees for laundry, housekeeping, and dietary services.

The personal care services component is determined by inflating the most recent audited costs for these services to the facility's fiscal year ending after July 1, 2002. This becomes the PNMI's facility-specific personal care cap. The personal care cap is

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX F NON-CASE MIXED MEDICAL AND REMEDIAL FACILITIES Established 6/11/90
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

2400 ALLOWABILITY OF COST (cont.)

deducted from the facility's routine costs as of July 1, 2002. The actual allowable personal care services costs will be settled at audit up to this facility-specific cap.

2400.4 Tax and Benefit Costs

Allowable costs include, in addition to salaries and wages, the taxes and benefit costs described in Chapter III.

2400.5 Staffing Approvals

The Department shall approve staffing based on the services necessary to carry out individualized service plans at an accepted standard of care. In the case of services that were created as a result of a competitive bidding (request for proposal) process, the provider must deliver the services accepted and approved by the Department during that process. The Department will use the description of the PNMI services, and any additional information from onsite review or surveys of the facility, including payroll information, as the basis for reviewing/approving staff.

2400.51 Additional Requirements for Staffing Approvals

Staffing approvals may, at the discretion of the Department, be accompanied by requirements with regard to admission, discharge and service provision, non-discrimination, reasonable accommodation, dispute resolution procedures, quality improvement practices, access to departmental consultants, training, and other areas as may be required to provide members with a person centered service plan.

2400.52 Audit of Approvals

All approvals are subject to audit. Those staffing hours not utilized for the purpose approved by the Department will be disallowed at audit, either in whole or in part.

2400.6 Consultation Services

Consultation services referred to in this Appendix may be considered as part of the allowable per diem cost, with the prior approval of the Department, in accordance with the following:

2400.61 Pharmacy Consultants. Pharmacy consultant services are allowable to the extent required by the applicable licensing regulations.

2400.62 R.N. Consultants. R.N. consultant services are allowable to the extent required by the applicable licensing regulations for residential care facilities. If a provider employs an R.N. as part of approved direct care staffing, the provider

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX F NON-CASE MIXED MEDICAL AND REMEDIAL FACILITIES Established 6/11/90
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

2400 **ALLOWABILITY OF COST** (cont.)

shall submit written justification when seeking approval for consultant services.

2400.63 Dietary Consultants. Dietary consultant services shall be allowed for the development of therapeutic diets prescribed by a physician and when necessary to monitor and address specific nutritional problems.

2400.64 Procedure for Requesting Approval of Staffing/Consultant Costs Providers must make written requests for staffing approvals to the Department. The request must explain the circumstances that justify the request and the total cost to implement the request, including wages, taxes and benefits; financial information; specifics related to resident needs; operational costs; and other information as requested by the Department.

2400.65 Denials. Requests will not be approved if they are intended to circumvent limitations established by the Department. All approvals are subject to audit and a test of reasonableness and necessity. Those not utilized for the purpose approved by the Department will be disallowed at audit, either in whole or in part.

2400.7 Department Approved Training

Department-approved training is an allowable cost.

2400.8 Medical Supplies

Medical supplies are an allowable cost.

2400.9 Costs Related to Accreditation

If the Department requires a provider to maintain an accredited status with a recognized accreditation organization, then the costs related to accreditation are allowable.

2400.10 Allowable costs will also include the contract fee paid for use of exchange fellows in lieu of direct service staff as defined in the applicable appendix. Contract fees must be prior-approved by Department. The contract fee paid cannot exceed the normal salary plus benefits and taxes for comparable direct service staff within the provider agency.

2410 State-Mandated Service Fee

As of July 1, 2004, allowable costs shall include a State-mandated service tax. The State-mandated service tax is a tax on the value of PNMI services pursuant to 36 M.R.S. §2552.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX F NON-CASE MIXED MEDICAL AND REMEDIAL FACILITIES Established 6/11/90
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

2400 ALLOWABILITY OF COST (cont.)

2450 Program Allowance

A program allowance, expressed as a percentage of the allowable costs in Sections 2400 through 2410 will be allowed in lieu of indirect and/or PNMI related cost. The program allowance, as set forth in Chapter III, Section 97, is a percentage specific to this Appendix and is applicable to all facilities covered under this Appendix. The program allowance will be 35%.

2500 NON-ALLOWABLE COSTS

Non-allowable costs include room and board costs, as well as all costs not approved under this Appendix.

3000 METHOD OF PAYMENT

3010 Per Diem Rates

For services provided on or after July 1, 2001, the MaineCare per diem rates for existing facilities will be adjusted to add the program allowance and any applicable accreditation costs. The Department will base the rates on an occupancy level that is the greater of actual or 90% of licensed capacity for facilities greater than 6 beds, and the greater of actual or 80% for facilities with 6 or fewer beds. Once the per diem rates are established, this becomes the facility's cap. This cap will be adjusted at time of audit on State-mandated service tax expense, as defined in Chapter III, Section 2410. See MBM, Chapter III, Section 97 regarding inflation adjustments.

3020 New Facilities

For new facilities opening after July 1, 2002, total projected allowable costs approved by the Department will be divided by the estimated annual occupancy, which shall not be less than 90% of the actual licensed capacity for facilities more than 6 beds or 80% in facilities of 6 or fewer beds. The program allowance and costs related to accreditation, if applicable, will then be added to calculate the interim MaineCare rate.

3030 Request for Change

Requests for changes in allowable costs may be made no more often than every 6 months, and only for good cause, except in emergency situations. The Department will not grant retroactive rate adjustments.

3040 Interim Per Diem Rates

Department personnel set interim per diem daily rates as follows:

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX F NON-CASE MIXED MEDICAL AND REMEDIAL FACILITIES Established 6/11/90
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

3000 METHOD OF PAYMENT (cont.)

3040.1 The Office of MaineCare Services sets interim daily rates for medical and remedial service facilities not participating in the case mix payment system, and funded by the Department of Health and Human Services.

3040.2 The Division of Audit sets interim daily rates for medical and remedial service facilities not participating in the case mix payment system.

3050 Intensive Rehabilitation Services for Individuals with Acquired Brain Injury (ABI)

To be covered under this Appendix, and be exempt from the payment method described in Appendix C, the residential care facility must provide individualized intensive rehabilitative services and supports exclusively to persons with acquired brain injury. The facility must possess characteristics, in terms of staffing, philosophy and physical design, which create a unique unit providing rehabilitative and community support services to ABI residents. Approved staffing shall be reasonable and adequate for an efficiently and economically operated facility.

3050.1 Reimbursement for intensive rehabilitation services is subject to the Request for Proposal (RFP) bidding process and the availability of funding. The Department will approve staffing necessary to carry out the services approved in the bidding process.

3050.2 The provider must acquire and maintain CARF accreditation within 2 years of becoming a MaineCare provider of intensive rehabilitation services under this Section. The cost of CARF accreditation is an additional allowable cost, in accordance with this Section.

3060 Facilities for Persons with HIV/AIDS

To be covered under this Appendix, and be exempt from the payment method described in Appendix C, the residential care facility must provide services exclusively to individuals diagnosed with HIV/AIDS. The facility must possess characteristics, both in terms of staffing, philosophy and physical design, which provides residential support to residents. The provider must have established relationships with home health agencies, hospices and other services for support of individuals.

3070 Facilities for the Blind

To be covered under this Appendix, the residential care facility must provide services exclusively to individuals who are blind and for whom a comprehensive PNMI facilitates and supports each individual's placement and provides opportunities for skills training that would enable residents to move to a less restrictive setting. The facility must possess characteristics, in terms of staffing, philosophy and physical design, which enable residents to achieve optimal functioning.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX F NON-CASE MIXED MEDICAL AND REMEDIAL FACILITIES Established 6/11/90
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

3000 METHOD OF PAYMENT (cont.)

3080 Facilities for Persons with Severe and Prolonged Mental Illness

3080.1 To be covered under this Appendix, the provider must serve primarily public wards for whom the Department has a legal responsibility or others with similar programmatic needs. The facilities shall only admit residents with a primary diagnosis of severe and prolonged mental illness. Residents may have functional impairments and behavioral issues. Priorities for admission will be determined in collaboration with the Department. Service plans shall be individualized and person centered.

3080.2 Facilities covered under Section 3080 must have a license as a Mental Health Treatment Facility in addition to a residential care facility license.

3090 Facilities for Persons with Mental Retardation

3090.1 To be covered under this Section, the provider must serve persons who have mental retardation or autism.

3090.2 Facilities must have 4 or more beds and have a MaineCare Provider Agreement with the DHHS.

4000 JUSTIFICATION FOR EXEMPTION

Each provider is required to evidence practices and maintain documentation describing the specialized nature of its services that warrants exclusion from Appendix C. In addition, each provider shall follow a written quality assurance and improvement program that will incorporate feedback from residents, guardians and others.

5000 AUDIT SETTLEMENTS

Audit settlements will be made based on Principles of Reimbursement, Chapter III and this Appendix.

5010 Reimbursement will be limited to the total actual allowable costs of the facility, not to exceed the maximum prospective rates approved by the Department, including the medical and remedial rate and the personal care services rate.

5020 The lesser of the cost per bed day, or the maximum prospective rate approved by the Department, shall be multiplied by the number of MaineCare eligible days to determine the total MaineCare cost.

5030 Final settlement consists of allowable costs determined through the audit, compared to the interim payments received by the provider.

10-144 Chapter 101
MAINECARE BENEFITS MANUAL
CHAPTER III, PRINCIPLES OF REIMBURSEMENT
SECTION 97, PRIVATE NON-MEDICAL INSTITUTION SERVICES

APPENDIX F NON-CASE MIXED MEDICAL AND REMEDIAL FACILITIES Established 6/11/90
Last Updated 5/15/10
EMERGENCY RULE 10/25/16

6000 INFLATION ADJUSTMENT

Except when there is specific statutory direction, the Commissioner of the Department will determine if an inflation adjustment will be made, the amount of that adjustment, and any performance standards related to that adjustment.