Rules of
Department of Mental Health
Division 45—Division of Mental Retardation and Developmental Disabilities
Chapter 4—Financial Procedures

Title 9—DEPARTMENT OF MENTAL HEALTH
Division 45—Division of Mental Retardation and Developmental Disabilities
Chapter 4—Financial Procedures

9 CSR 45-4.010 Residential Rate Setting

PURPOSE: This rule prescribes procedures for establishing per-diem base rates for certain waiver and nonwaiver residential providers which accept persons with mental retardation under the department's community placement program.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) Terms defined in sections 630.005 and 633.005, RSMo are incorporated into this rule. As used in this rule, the following terms mean:

(A) Administrative costs—all support and indirect service costs as defined in the rate packet. Administrative costs include: 1) staff time spent in administration, 2) staff time that cannot be directly associated with a specific service and 3) other costs that are not directly associated with a specific service. Administrative costs include management fees and home office and central office costs;

(B) Administrative salaries—salaries or portions of salaries, including fringe benefits, which support administrative functions or staff time not directly associated with specific services;

(C) Alternative rate with an end date—rate of reimbursement for a specific time limited period;

(D) Ancillaries—time-limited reimbursement for individual client-specific costs or services included in the individualized habilitation plan (IHP) which are not a part of the per-diem base rate;

(E) Community placement program—an array of residential facilities and specialized services licensed, certified or funded by the department;

(F) Direct care salaries—nonadministrative salaries or portions of salaries, including fringe benefits, paid to staff associated with direct client care and habilitation;

(G) Division—the Division of Mental Retardation and Developmental Disabilities;

(H) Extraordinary circumstance—a situation beyond the control of a residential facility which is not experienced by residential providers in general, but which results in a substantial cost;

(I) Facility staffing schedule—a listing of daily working hours for each direct care employee;

(J) Food services—the cost of raw food and consumable supplies used in preparation of food eaten by clients and staff. Staff food may be included only when the staff is required to eat with clients because of IHP requirements;

(K) Fringe benefits—retirement plans, health and medical insurance, life insurance, disability and accident insurance, and other incentives for employees only;

(L) Group home—a residential facility serving nine (9) or fewer clients and providing basic health supervision, habilitation training in skills of daily and independent living and community integration and social support;

(M) Interim rate—temporary rate of reimbursement until a permanent rate can be established;

(N) Investment—the total amount of the owner's private monies utilized for building purchase, construction or renovation and documented by the owner in a format prescribed by the department;

(O) Levels-of-care model—a residential model with three (3) residential facility categories established by service intensity, each with a staffing level defined by the division.

1. Category I is a residential facility designed to provide a group living environment and minimum level of habilitation and supervision for persons with no severe medical needs or maladaptive behaviors.

2. Category II is a residential facility designed to provide a group living and habilitation environment for persons with no severe medical needs or severe maladaptive behaviors, but who need self-help or habilitation training.

3. Category III is a specialized residential facility designed to provide a habilitation environment for persons with intensive physical or medical needs, severe maladaptive behaviors or other specialized care needs;

(P) Occupancy factor—the percent of full capacity at which a facility operates;

(Q) Paid time off work—any combination of paid holidays, vacation, sick leave or other time an employee may be away from work with pay;

(R) Per-diem base rate—the daily rate of reimbursement to a residential provider for room, board and residential habilitation services for one (1) resident;

(S) Physical plant costs—reasonable costs like lease or rent, payments, mortgage interest, real estate and property taxes or payments in lieu of taxes, insurance and building depreciation as defined in the rate packet;

(T) Professional services—contracted services rendered to a provider by individuals, in a professional or advisory capacity;

(U) Provider—a vendor as defined in section 630.005, RSMo;

(V) Rate packet—budget development documents and instructions issued by the division for use by residential providers in preparing and submitting rate requests;

(W) Residential center—a residential facility serving ten (10) or more clients that provides social support, health supervision and habilitation training in skills of daily living;

(X) Residential habilitation services—care, skills training and supervision of clients in accordance with the provisions in the clients IHPs;

(Y) Room and board—all costs associated with clients' living space and three (3) meals per day;

(Z) Service Provider's Audit Guide—a definitive document issued by the department that prescribes audit requirements of the department from its service providers; and

(AA) Waiver provider—a residential facility approved by the department to participate as a residential facility in accordance with P.L. 99-272 (the Consolidated Omnibus Budget and Reconciliation Act of 1985) and subsequent legislation and 42 CFR parts 435, 436, 440 and 441.

(2) In accordance with section 630.605, RSMo, the department shall establish and maintain a community placement program.

(A) Through the division, the department shall set per-diem base rates for residential providers which accept persons with mental retardation.

1. For waiver and nonwaiver group homes and residential centers, per-diem base rates shall be set through a levels-of-care model established by the division.

2. The division's regional centers shall determine the level-of-care category for each residential facility according to characteristics of fifty percent (50%) or more of the clients living in or proposed for living in the residential facility at the time of the determination.

A. Regional centers shall base determinations upon clinical judgment, IHPs or other assessment data.

B. Facilities with an equal or near equal mix of clients shall receive a per-diem profile base rate consistent with the needs of clients with the more intensive service needs.

C. Regional centers shall review annually each of their residential facility categories and redetermine categories based upon changes in client mix.

D. Residential facilities may appeal to regional centers for category redeterminations due to extraordinary circumstances.

3. Disputes between regional centers and residential facilities over facility categories may be appealed to the division director whose decision shall be final.

4. Disputes between regional centers and residential facilities over extraordinary circumstances may be appealed to the division director whose decision shall be final.

(B) The division shall establish and publish profile base rates for residential facility categories within the levels-of- care model.

1. Fiscal Year 1990 shall be the base year for calculating amounts of cost included in per-diem profile base rates.

2. Profile base rates shall include limits established by the division for certain costs.

3. The department shall conduct periodic surveys of residential providers which shall become the basis for realigning costs.

4. Realignments shall be made effective the first day of the fiscal year following the fiscal year in which the surveys were conducted.

5. These rates shall be adjusted annually by the National Consumer Price Index/Urban.

(C) Residential providers who appeal profile rates shall appeal to the division in accordance with the following procedures and conditions:

1. The provider shall contact the regional center, which may advise in preparing the rate packet; and

2. The provider shall submit the completed rate packet to the regional center, which shall transmit it to the division with the center's recommendations.

(D) Residential providers, upon recommendation in writing by the respective district deputy for just cause, may be approved by the division director to operate under interim rates or alternative rates with an end date, for a specified period of time with a maximum duration of eighteen (18) months.

1. Examples of just cause include, but are not limited to:

A. Down sizing or up sizing of client population;

B. Changes in level of care required for client population; and

C. Changes in physical plant configuration.

2. These rates will be subject to review and adjustment, within the specified period, following the same procedures, conditions and processes used in the profile rate appeal process.

(E) All rates and rate adjustments covered by this rule shall be subject to availability of funds appropriated for that purpose.

(F) The division director shall establish a rate setting committee to advise him/her on establishment of per-diem base rates for residential providers who appeal profile rates.

1. The rate setting committee shall be composed of members appointed by and serving at the pleasure of the division director.

2. The committee chairperson shall be a department employee. Staff for the committee shall be provided by the division .

3. The rate setting committee shall meet in Jefferson City or in other locations at the call of the chairperson.

4. The rate setting committee may hold meetings when a majority of the members are present and may make recommendations to the division director when a simple majority of those present and voting concur.

5. Provider members who have an interest in a rate must disclose that interest in a meeting of the committee prior to discussion.

6. Provider members must abstain from voting on any project in which they have administrative control or a monetary interest.

7. Provider members shall be reimbursed for necessary expenses.

8. Providers whose appeals are under discussion and respective regional center directors or designees shall be invited to attend meetings of the rate setting committee.

9. Staff of the rate setting committee shall summarize each appeal of a profile rate and make recommendations to the committee.

A. The committee may request additional documentation and information from providers to determine if there exists an efficient and economical delivery of residential services to meet the client needs.

B. The reviews shall be made at the discretion of the committee and may be performed by its designee(s).

C. Findings from the reviews may be used by the committee to recommend per-diem base rates to the division director.

10. The rate setting committee shall have sixty (60) days from receipt of a complete rate packet or receipt of any requested additional documentation or information to submit its recommendations in writing to the division director.

A. The division director may accept, reject or modify any recommendation of the rate setting committee in arriving at a rate decision.

B. The division director shall issue a rate decision to the provider.

C. Within thirty (30) working days of the division director's tentative rate decision, the provider shall accept or appeal the rate .

D. In case of appeal, the provider shall clearly specify those costs within the tentative rate which are being appealed and shall provide written justification for restoration of the requested costs. .

E. Within fifteen (15) working days from receipt of the provider's appeal of the rate, or receipt of additional information requested by the division director after receipt of the appeal, the division director shall issue a final decision.

(G) All providers who receive annual DMH funding for POS services in excess of one hundred thousand dollars ($100,000) shall submit an annual audit to the department. The audit shall include audited financial statements and uniform cost report with their accuracy verified by a certified public accounting firm in compliance with the department's *Service Provider Audit Guide*.

1. Failure to comply with this requirement may result in the provider being placed on probation for one (1) year.

2. Each additional year of noncompliance may result in a cumulative annual five percent (5%) reduction of the provider's per-diem base rate. This sanction will remain in effect until the audit requirement is satisfied.

3. If the department has reasonable cause to believe a residential provider has knowingly presented fraudulent information to secure a more favorable per-diem base rate, the department shall refer that provider for prosecution.

4. In cases where monies have been fraudulently obtained by residential providers, the attorney general shall represent the department to seek restitution of the overpayment.

5. For nonwaiver providers, the period of operation shall be as specified in the provider's contract with the department.

6. Nonwaiver providers who receive base rate increases after appeal to the department shall submit annual audits within one hundred eighty (180) days following the close of the state or provider's fiscal year. These audits shall be based upon the state or provider's fiscal year.

7. For waiver providers, the initial period of operation begins on the effective participation date established by the Department of Social Services, the administering state agency for the Medicaid Program in Missouri and covers a period terminating at the state or provider's fiscal year end.

8. Subsequent periods begin and end with the state or provider's fiscal year.

9. For each period of operation, the provider shall submit an audit within one hundred eighty (180) days following the close of that period of operation.

(H) For facilities changing ownership after a rate is established, the following shall apply:

1. For a facility with a rate at or above the profile rate, the profile rate for that facility category shall become the facility's per-diem base rate. This profile rate may be appealed;

2. For a facility with a rate below the profile rate, the profile rate for that facility shall become the facility's per- diem base rate, also subject to appeal; and

3. All changes are subject to availability of appropriate community placement funds.

(I) The department shall establish reasonable cost allowance limitations and may exclude certain costs. Providers may neither appeal costs above limitations established by the department nor costs excluded by it. The department shall not approve—

1. Administrative costs which exceed fifteen percent (15%) of the total direct (nonadministrative) costs contained in the facility budget;

2. Total fringe benefits which exceed those granted to employees of Missouri;

3. Physical plant costs in excess of two thousand eight hundred twenty-five dollars ($2825) per resident bed per year during Fiscal Year 1990 without just cause and prior approval by the division director. Physical plant costs for each subsequent fiscal year will be increased by the same percentage as the state-appropriated cost-of-living adjustment for that year;

4. A return on investment in excess of twelve percent (12%) of that investment. It shall not approve returns on investment for tax-funded bodies;

5. A cost for food services in excess of four dollars and fifty cents ($4.50) per client day during Fiscal Year 1990 without just cause and approval by the division director. Food services costs for each reimbursement year will be increased by the same percentage as the state-appropriated cost-of-living adjustment for that year;

6. Paid time off work for employees in excess of paid time off work granted to employees of Missouri. The provider shall submit to the department its written policy on paid time off work;

7. Costs for professional services, except costs for direct care consultation, unless costs are budgeted as administrative costs; and

8. Client-specific costs for inclusion in the per-diem base rate.

(J) Client specific items and services shall be funded separately and must be supported in writing by the regional center director and the division director or his/her designee.

Auth: section 630.655, RSMo (1994). This rule was previously filed as 9 CSR 10-5.170. Original rule filed Dec. 11, 1989, effective June 15, 1990. Amended: Filed May 25, 1995, effective Dec. 30, 1995.*

**Original authority 1980.*

9 CSR 45-4.020 Development of Intermediate Care Facilities for Persons with Mental Retardation

PURPOSE: This rule prescribes procedures on development of intermediate care facilities for persons with mental retardation.

(1) As used in this rule, a provider that owns, operates or has interest in only one (1) intermediate care facility for persons with mental retardation (ICF/MR) is—

(A) A sole proprietor that owns no interest in another ICF/MR;

(B) A partnership or a majority of the partnership that owns no interest in another ICF/MR; or

(C) A corporation that has neither any officers nor a majority of board members in common with another corporation which has any interest in an ICF/MR.

(2) Any entity intending to operate a Medicaid-reimbursed ICF/MR in excess of those beds in existence on May 29, 1991, shall give written notice of that intent to the Department of Mental Health's Division of Mental Retardation and Developmental Disabilities (Division of MRDD) between July 1 and October 1 of the fiscal year preceding the fiscal year in which the provider intends to operate the ICF/MR.

(3) No provider may be reimbursed under Medicaid to operate an ICF/MR without a provider agreement issued by the Department of Social Services' Division of Medical Services (DMS). The DMS shall not issue a provider agreement without receiving either a certificate of authorization or an acknowledgment of exemption from the Division of MRDD.

(4) After May 29, 1991, the Division of MRDD shall issue an acknowledgment of exemption to permit the DMS to issue a provider agreement to a certified ICF/MR if—

(A) The ICF/MR will have six (6) or fewer beds;

(B) The provider does not own, operate or have any interest in any other ICF/MR; and

(C) The provider has notified the Division of MRDD between July 1 and October 1 of its intent to operate the ICF/MR during the next fiscal year.

(5) Any provider that has received an exemption under section (4) and then either obtains, operates or acquires an interest in any other Medicaid-enrolled ICF/MR, or seeks to enroll an additional ICF/MR in the Medicaid program, shall forfeit the exemption granted under section (4). As soon as the ICF/MR for which exemption was originally granted can be accommodated in the Medicaid Home and Community-Based Waiver Program, the Division of MRDD shall notify the DMS to that effect, and DMS shall terminate the ICF/MR provider agreement within thirty (30) days after receipt of the notification from the Division of MRDD.

(6) After May 29, 1991, the Division of MRDD may issue a certificate of authorization to permit the DMS to issue a provider agreement for a provider to operate an ICF/MR of seven (7) or more beds if—

(A) The proposed ICF/MR is to be a free-standing facility and not attached to any other existing ICF/MR;

(B) The provider has notified the Division of MRDD between July 1 and October 1 of its intent to operate the ICF/MR during the next fiscal year; and

(C) The ICF/MR cannot be accommodated within the federal Home and Community-Based Waiver Program for persons with developmental disabilities as determined by the Division of MRDD.

Auth: sections 630.050 and 660.075, RSMo (1994). This rule originally filed as 9 CSR 30-5.060. Original rule filed Sept. 1, 1993, effective April 9, 1994. Amended: Filed May 25, 1995, effective Dec. 30, 1995.*

**Original authority: 630.050, RSMo (1980), amended 1993 and 660.075, RSMo (1991).*

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

CERTIFICATE OF AUTHORIZATION FOR ICF-MR PROVIDER AGREEMENT

The Department of Mental Health's Division of Mental Retardation and Developmental Disabilities hereby certifies to the Department of Social Services' Division of Medical Services that the Division of Medical Services may issue a provider agreement to the following intermediate care facility for persons with mental retardation (ICF-MR):

PROVIDER NAME

ADDRESS

This provider notified the Department of Mental Health on _____, 19___, of its intent to operate an ICF-MR with _____ beds. This certificate authorizes the provider to begin operation after July 1, 19_____ with _____ beds.

SIGNATURE OF DIVISION OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES REPRESENTATIVE	DATE

MO 650-6852 (8-93) DMH-9311

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

ACKNOWLEDGEMENT OF EXEMPTION FROM DEPARTMENT OF MENTAL HEALTH AUTHORIZATION FOR ISSUANCE OF ICF-MR PROVIDER AGREEMENT

This document acknowledges that _____, a provider, seeks to operate a single intermediate care facility for persons wth mental retardation (ICF-MR) to be known as _____ and to have no more than six (6) beds. Because the proposed facility will have no more than six (6) beds; because the provider does not own, operate or have any interest in any other ICF-MR; and because the provider notified the Department of Mental Health between July 1 and October 1 of the fiscal year preceding the fiscal year in which it intends to operate the facility, the provider is not required to obtain a certificate of authorization from the Department of Mental Health.

The provider understands that if it either obtains other ICFs-MR or increases the beds in this facility to more than six (6), this exemption is invalid and the provider must apply to the Department of Mental Health's Division of Mental Retardation and Developmental Disabilities for a certificate of authorization. That application process is open from July 1 until October 1 each year for certification to operate after June 30 of the following year.

I certify that _____, the provider, does not own, operate or have any interest in any ICF-MR other than _____ and that the provider will not attempt to operate more than six (6) beds in that facility. I acknowledge that violation of either of these conditions will result in loss of Medicaid payments to the provider.

NAME AND TITLE OF PROVIDER'S OWNER/PARTNER/ADMINISTRATOR (TYPE OR PRINT)	
SIGNATURE OF OWNER/PARTNER/ADMINISTRATOR	DATE

Based upon this provider's certification, the Division of Mental Retardation and Developmental Disabilities acknowledges that the provider is exempt from the requirement to obtain a certificate of authorization from the Division.

SIGNATURE OF DIVISION OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES REPRESENTATIVE	DATE

MO 650-6812 (8-93) DMH-9313

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

NOTIFICATION OF REFUSAL TO AUTHORIZE ISSUANCE OF ICF-MR PROVIDER AGREEMENT

The Department of Mental Health's Division of Mental Retardation and Developmental Disabilities hereby notifies the Department of Social Services' Division of Medical Services that the Department of Mental Health refuses a Certificate of Authorization for a provider agreement for an intermediate care facility for persons with mental retardation (ICF-MR) to the following provider:

PROVIDER NAME

ADDRESS

This provider notified the Department of Mental Health on _____, 19 _____, of its intent to operate an ICF-MR with _____ beds. The provider is refused a Certificate of Authorization because:

_____

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These reasons are authorized under Section 660.075, RSMo (1991).

SIGNATURE OF DIVISION OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES REPRESENTATIVE	DATE

MO 650-6811 (8-93) DMH-9312