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 amendment modifies the rule to describe the rate setting methodology for residential supports funded under the home and community-based waiver and purchase of service program administered by the Department of Mental Health Division of Developmental Disabilities.

PURPOSE: This rule prescribes procedures for establishing per-diem base rates for [certain waiver and nonwaiver residential] providers [which accept] supporting persons with [mental retardation] intellectual and developmental disabilities [under the department’s community placement program] funded by the Department of Mental Health Division of Developmental Disabilities.

{(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.

(I) Definitions

(A) Acuity based rate—a per unit rate of reimbursement for an individual which is based upon the individual’s level of need or function as determined by a standardized assessment adopted by the Division;

(B) Floor rate—the minimum unit rate based on acuity for a service and funding available;

(C) Home and community-based waivers—a set of long term community-based supports and services authorized by the Centers for Medicare and Medicaid Services which are provided as an alternative to care in institutions such as nursing facilities and intermediate care facilities for individuals with intellectual disabilities. The specific services provided under a home and community-based waiver are referred to as home and community-based services (HCBS);

(D) Individual—person receiving services from the Division of Developmental Disabilities;
(E) Market rate—a per unit rate calculated by an independent agency with expertise in Medicaid rate setting that represents the true market cost to provide a service;

(F) Provider—any entity or person under contract or applying for a contract with the Department of Mental Health (DMH) to serve individuals with developmental disabilities funded by general revenue or through home and community-based waivers administered by DMH;

(G) Purchase of Service program—services funded with general revenue only;

(H) Rate allocation score (RAS)—a numeric score given to an individual which derived from a standardized assessment approved by the division that correlates to a per unit rate of reimbursement for a given service; and

(I) Residential—a per diem residential habilitation service in a group home, shared living or individualized supported living (ISL) setting that provides 24 hour support and oversight;

(2) This rule shall apply to residential rates contracted for by the Division under its Home and Community-based waivers and the Purchase of Service program.

(3) A Rate Committee shall be created to advise the Division on methodology, distribution of funding and market rate studies and other provider rate issues. The committee will contain members who are providers of various services and Division staff.

(4) Rates

(A) Group home rates are based on each individual’s RAS, reflect a percentage of the market rate, and shall not be negotiated. Individual rate adjustments are made due to changes in the individual’s acuity and the RAS. Cost of living adjustments and/or rate standardization applied across service types may only be made as a result of approved budget actions. Temporary adjustment to an individual’s reimbursement may be approved for staffing through Central Office by the Division Director or designee on an individual case by case basis when additional support is justified due to extraordinary behavior or medical issues that are time limited.

(B) ISL hourly rates are based on each individual’s RAS, reflect a percentage of the market value, and shall not be negotiated. Rate changes may only be made as result of approved budget actions.

(C) Shared living rates are based on the level of support needed by the individual and shall not be negotiated. Rate changes may only be made as a result of governor approved budget actions.

(5) Rate Setting

(A) Division shall administer a functional based assessment tool for the purpose of determining a Rate Allocation Score (RAS) for individuals receiving residential habilitation and shared living services.

(B) Division shall obtain an independent rate study as required by the terms and conditions of the HCBS waiver to set the market rate for each RAS.
(C) Barring sufficient appropriations to fund the market rates, a floor rate shall be established for each RAS which is the minimum rate paid for residential services.

(D) New individuals placed in residential services after the effective date of this rule shall receive a percentage of the market based rate.

(E) Individuals transferring between a group home and ISL shall be paid at the floor rate at the new setting.

(F) Individuals who are placed without a current assessment will be paid at the floor rate at the new setting.

(F) If an individual’s RAS changes due to a new assessment, the rate will be adjusted accordingly on the effective date of the new assessment. If an individual’s RAS changes upon reassessment, the new rate shall not be above market rate or below floor rate for the new RAS. Rate adjustments are retroactive effective the date of reassessment.


*Original authority: 630.655, RSMo 1980.