

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

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APPENDIX C                      MEDICAL AND REMEDIAL SERVICE FACILITIES                      Established 3/1/88  
 Last Updated 5/15/10

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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.

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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.
- 2040 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.

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 35%, 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:

- Laundry
- Housekeeping, and
- Dietary services.

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2400 ALLOWABILITY OF COST (cont.)

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 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.

2410 As of July 1, 2004, allowable costs shall include a State-mandated service tax. The State-mandated service tax is a 5% tax on the value of PNMI services.

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:

- o 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;
- o 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;
- o Dividing the adjusted direct care costs by the actual occupancy to determine an adjusted direct care cost/day;
- o 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);

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3000 GENERAL DESCRIPTION OF THE PRICING METHODOLOGY (cont.)

- o 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;
- o Adding a Program Allowance (PA) determined by the Commissioner, as set forth in Chapter III, Section 97; and
- o 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:

- o 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;
- o Dividing the costs by the actual occupancy to determine the personal care services component rate; and
- o Inflating the personal care services component rate through June 30, 2003.

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.

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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:

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

6000 PEER GROUPS

Effective  
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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.

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7000 RESIDENT ASSESSMENTS (Cont)

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 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.



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7000 RESIDENT ASSESSMENTS (cont.)

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

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7040 Quality Review of the MDS-RCA process

7040.1 Definitions

7040.11 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.

7040.12 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.

7040.13 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.

7040.14 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.

7040.15 Unverified MDS-RCA Record is one that, for clinical purposes, does not accurately reflect the resident's condition.

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:

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7050 Criteria for Assessment Review (cont.)

- (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

- 7050.21 Assessment reviews shall be conducted by staff or designated agents of the Department.
- 7050.22 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.
- 7050.23 Samples shall be drawn from MDS-RCA assessments completed for residents who have MaineCare coverage.
- 7050.24 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 4<sup>th</sup> through 6<sup>th</sup> months preceding the month in which the sanctionable event occurred. (For example, if the sanctionable event occurred in May, the sanction would be calculated by multiplying the sanction rate times the total MaineCare payments to the provider during the preceding November, December and January)

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7060 Sanctions

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 4<sup>th</sup> through 6<sup>th</sup> 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.

9000 CASE MIX PAYMENT SYSTEM

9010 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.

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9000 CASE MIX PAYMENT SYSTEM (cont.)

9020 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

9030 Rate Setting Case Mix

9030.1 The Department will calculate rates on January 1<sup>st</sup> and July 1<sup>st</sup> of each year, beginning on July 1, 2001.

9030.2 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 15<sup>th</sup> of March for the July rate and the 15<sup>th</sup> of September for the January rate.

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9000 CASE MIX PAYMENT SYSTEM (cont.)

9030.3 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.

9030.4 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.

9030.5 The Department will send a roster of residents and source of payment as of March 15<sup>th</sup> and September 15<sup>th</sup> to facilities for verification prior to rate setting.

9030.6 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.

9030.7 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.

9040 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 3/15 or 9/15 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.

9050 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.

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9000 CASE MIX PAYMENT SYSTEM (cont.)

9060 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% 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.

10000 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