Oceanview Nursing Home

2 South Street *Lubec, Maine 04652* *Tel: 207 733-4374*

Hi Diane,

Good Morning! 9/24/2013

I've had a few folks from the Long-Term care Advisory Committee inquire about what issues are most prominent for rural Nursing Facilities in Maine, so I reprinted a couple of different communications I've made in the past couple of years.

First recommendation: Get an Accountant on the Team! You already have kind, interested, motivated, invested people in the group… but the common ingredient lacking in all but two: you have never run a facility, and do not know how things work. There are two Administrators, who understand their perspective(s) on the issues… an Accountant *(Stephanie Rice-best one I know)* gets the perspective of dozens of facilities & circumstances statewide, and will ground & focus the discussions with intimate knowledge of everyone's situation(s).

Second recommendation: Forget the term Nursing Facility… we have everything from Nursing Homes to Rehabilitative Communities now, and they are as different as fingerprints in their sizes, profitability, economies of scale… 2 basic paradigms exist, and everyone falls between the two:

A. Serve your Community
B. Become as profitable as possible

Community Service and maintaining it is the intent behind your Group, so don't lose sight of the intent and try a "one size fits all" approach… relying on Providers good will, commitment to service and ethical fiscally conservative nature will ultimately be a mistake, as cost-based reimbursement demonstrated.

Everyone will first talk about needing more money to provide the care, as everyone runs over the Mainecare rate. As explained in the letter, the folks farthest over the Mainecare rate are:

1. *Unaccountable/non-profit(no owner)/government supplemented.*
2. *Duking it out with other places for high dollar referrals (spend money to make money).*
3. *Stuck competing in a market with #1 and #2. They need help too*

The facilities closest to the Mainecare rate are the folks who have no choice BUT

to be closest to the Mainecare rate, from poor areas, with small sizes, low Private and Skilled census, no hospitals *(or Critical-Access ones)* nearby . They are the most vulnerable and closest to the bone to begin with… those facilities will tend to be in rural and impoverished areas, and struggle to survive.

Skilled Nursing (Medicare) is Ambrosia for Nursing Facilities… frequent Medicare fattens one up for lean times… if you can maintain it, it allows for outstanding profitability and financial health. Everybody wants it, everybody needs it, not everyone gets it… especially now.

High Medicare census facilities that are NOT #1 don't need help.

#1 facilities with high Medicare census oftentimes STILL lose money… because they can afford to lose money, and no one exists to "stop the buck"… they just truly need someone to be in charge to say "enough's enough" and get on track. They need tough love, not a helping hand. If you have a 100 bed facility, with 25% SNF census and you STILL lose money… that's no one's fault but your own. They have the means to correct their problems, they just need the will.

Look at the average percentage of census that is Medicare, and you can immediately establish the potential health of the organizations. Facilities with under 30% Average Daily Census Skilled *(& Private too, although there's little of that: Estate Planning*) are the first at-risk grouping you want to establish.

Second, look at size. 60 beds with fair payor (10-15%) mix has always been the industry standard for when profitability could possibly begin when well-managed… I would argue 50 beds, with good payor mix (15-20%) is quite doable… 40 beds with exceptional payor mix (25% and higher) could possibly do it, if they could predictably keep that profitable census. Over 60 beds and decent economies of scale should open up for that provider.

Facilities smaller than 40 beds. Facilities with over 70% Mainecare… those are where the immediate focus should be. These places should not be surviving, so there is something unusual happening in them, and odds are they are limping quietly along waiting for retirement, death, things to turn for the better, an opportunity to get out, or the line of credit to dry up.

The beauty of an Accountant with extensive experience & knowledge of everyone's Cost Reporting, is that they will know, not suspect, who is struggling, and why they are struggling, who does what to survive, and advise to what the greater good will be. Every Provider wants to at least break even, everyone wants to be more profitable… everyone wants more… what you need to discern is who NEEDS more.

Do the math, review the Cost Report data, and to determine at what percentage of total Mainecare census does a facility seem to sputter and fail… those are the facilities

that need the attention. **Size & Payor mix.**

Once you establish the "break-even" size/mix ratios, you can set a threshold for supplementing those who fall over the range, by establishing a penalty for those who do not. This would be tremendously unpopular in our industry, because those penalized will have been turning away Mainecare members routinely for years and should have been highly profitable as a result… dropping their Mainecare rate will eat into that profitability.

Anyone could correct any type of Mainecare rate drop by having a more demographically well-represented Mainecare census, or they could simply continue to avoid taking them as they have for years.

My hope is that out of your group, changes to the Principles of Reimbursement will come that will:

1. Reward efficiency by allowing facilities to keep any component savings under the Mainecare rate, provided they are turned to employee wages and benefits. This puts those savings into local economies… otherwise the efficiency basement remains.

2. Reward performance by facilities to incentivize everyone's care… our industry is so focused on Skilled Medicare that the majority of Residents at a facility get overlooked while the facility drives it's Medicare rate… that's where the money is, so that's where the focus stays.

3. Cover the Heads: Full-time DON for every facility, Social Services, Activities… already a formula exists to pay for the Administrative Allowance. Every mandated & necessary person costs similarly regardless of size, but impacts smallest places the most.

I'll stop there, but please, again: get some more experience about the actual nuts & bolts of running facilities… Administrators, accountants, comptrollers, CFO's… all would offer actual practical knowledge of how reimbursement works… if you want the very best knowledge, go to the Independent Owner-operators.

Phil Cyr is a perfect Administrator to sit, as he knows every aspect… Stephanie Rice would be invaluable… Jane Hibbard… Larry Wilday… Ed Bennett… David Hicks… look to the Individual Independent Owner-operators for the most in-depth knowledge of how Nursing Facilities work, as they've actually run things from soup to nuts, had to take the loan or write the check themselves to make it happen, and been left the one holding the bag when things went south.

Good luck & anything I can do to help, let me know. Have a wonderful day!

Nathan

To: Calais Nursing Facility Task Force
From, Nathan Brown, Administrator OVNH
Re: Proposed facility projections

11/09/2012

I have gathered raw data from the division of Audit to give you some idea/perspectives regarding the economy of scale concerns I have raised at meetings. The point I hope to impress is on how vital the volume of service forecast as well as the designation of the type of facility created will be in arriving at decisions regarding whether or not to proceed.

The first factor, **volume is entirely related to Resident Days**… if you propose a 20 bed, the volume is at maximum 7300 days, 40 is at 14,600 days, 60 at 21,900 days. I strongly encourage a sustainable model be created, of which 60 beds really has been the industry rule of thumb for sustainability… what size is necessary for sustainability depends on the peer group of the proposed facility.

The second factor, **designation** refers to whether you seek a hospital, or community-based entity, or a stand-alone facility. What I'll give you is a projection related to the highest (hospital-based) and lowest (stand-alone) levels of reimbursement that are seen.

Every dollar that comes into a Nursing Facility is broken into 3 parts: The Direct, the Routine, and the Fixed. There is high variability from low to high debt load within the Fixed Component, as well as varying influence of acuity/Case Mix awareness from facility to facility in the Direct Component. The Routine Component is based on historical costs from 2005 which have been updated sporadically since.

Maine Nursing Facility Rates: Highs & Lows: *(based on unaudited 2011 cost reports)*

Direct	Routine	Fixed	Total	20 beds	40 beds	60 beds
$64.57	$48.25	$10.43	$123.25	$899,725	$1,799,945	$2,699,175
$139.58	$103.34	$61.37	$304.29	$2,221,317	$4,442,634	$6,663,951

Keep in mind, these are the VERY highest and lowest ranges of Nursing Facilities across the state; it is frustrating as an Independent to see just how exorbitantly paid Hospital-based facilities are, as they hold the very highest reimbursement in each category except for Fixed… if you know folks at the **Jackman Regional Health Center**, they are the ones who hold top Direct & Routine honors. It appears their levels of reimbursement are less associated with the acuity of their Residents and size of facilities as they are to historic costs & overhead.

A Genesis Flagship in Kennebunk (Riverridge) holds honors for highest Fixed Costs/indebtedness.

On the following pages I'll give you 2011 Washington County averages; with the exception of Eastport, there is nothing exceptional about these facilities except that they are smaller than average size… they have no hospital-based reimbursement structure, all are "for-profit" except Eastport & Sunrise:

Washington County Rates *(based on unaudited 2011 Cost Reports)*

Facility	Bed Count	Direct	Routine	Fixed	Total (based on 100% occupancy)
Atlantic Rehab	52	$82.32	$58.21	$18.78	$3,027,499.80
Eastport Memorial	*26*	*$88.23*	*$74.00*	*$26.55*	*$1,791,522.20 cost based not valid*
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Oceanview N&RC	31	$89.74	$57.93	$19.90	$1,896,054.55
Sunrise HCF	28	$73.72	$58.50	$25.78	$1,614,760.00
Averages	39.2	$81.81	$57.13	$23.14	$162.08/day

So you can see that just within Washington County there is some significant variability that exists in the levels of Reimbursement Allowable/received from Mainecare… the common factor among all are tremendously high Mainecare occupancy *(with the exception of Sunrise HCF which does NOT get favorable referrals from their affiliated hospital, yet maintains 11/28 Residents that are Private Pay or Medicare/SNF)*. Eastport gets cost-based reimbursement, so is withheld from averages as they are unique unto themselves.

So this gives you an idea of what you will have to work with for funding: If you wish to pursue a stand-alone, unaffiliated facility such as are struggling along Downeast… you'll contend with high Mainecare, and low reimbursement, where people will be wearing multiple hats to survive.

If in fact it is hospital-based, reimbursement will be significantly higher:

Maine Hospital-based Nursing Facilities *(based on aunaudited 2011 Cost Reports)*

Facility	Bed Count	Direct	Routine	Fixed	Total (based on 100% occupancy)
Aroostook MC	72	$91.28	$55.86	$15.49	$4,273,916.40
Houlton Regional	28	$112.44	$103.34	$35.71	$2,570,227.80
Jackman Regional	18	$139.58	$103.34	$26.92	$1,772,848.80
St. Andrews Village	30	$105.92	$79.04	$32.28	$2,378,778.00
St. Marguerite	210	$104.70	$55.86	$34.69	$14,965,912.50
Averages	71.6	$110.78	$79.49	$29.02	$219.29/day

$219.29/$162.08=1.3529 or 135% the level of reimbursement compared with non-hospital based facilities in Washington County; so options really equate to attempting to do what most are failing at, at the rate of reimbursement they are failing at, or doing the same work for the same people at a 35% higher rate. There really is no question as to what reimbursement structure is superior. The real question is desire, and ability to create a sustainable model within the rate structures.

Diane Barnes

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Commissioner's Office
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10/11/2012

Dear Commissioner Mayhew,

Thank you for taking the time to come and visit us here in Lubec, and lending your ear to hear about the unusually high burdens placed on smaller, more heavily Mainecare funded facilities.

I will be meeting with colleagues at our Annual Meeting next week in Rockport to discuss what could be done within the Principles of Reimbursement to help level the playing field for smaller & more impoverished providers.

So far I have had an opportunity to speak with most of the Independent Administrators and/or Owners and gather & collate some data… unfortunately the beginning of the month threw a hitch in my ability to devote time to this.

Independent facilities do still account for 17.6% of the total Nursing Facility bed count in the State of Maine, which I was surprised by… the number goes higher when multiple facility "Independents" are added in, but they enjoy economies of scale & lucrative payer mixes that stand-alone operators are lacking.

I have taken data from 7/01/2012 Muskie School compilations to separate out facilities that share more commonalities and put them together on one page *(attached)*.

You can see locations, sizes & payer mix are all over the place; Independents average out to ~54 beds, tend to run 12% higher Mainecare utilization rates, 47% lower Medicare utilization rates, and 60% lower Private Pay census than your "average" facility in the state.

Using the current 60 bed threshold in place in the Principles of Reimbursement to separate out "large" facilities, run the numbers again and you see "small" facilities run 14% higher Mainecare utilization, 78% lower Medicare utilization, and 69% lower Private Pay census than Maine's "average" Nursing Facility.

I've enclosed some old data from the Muskie School that reflects the differing

compositions by payer & county, as well as the start of the extinction curve for small providers. Washington & Aroostook Counties are at or near the top of the lists, and I'm sure have not deviated far from this.

Everyone appreciates the difficulties in the economies of scale encountered by small providers… everyone appreciates how difficult it is to have high Mainecare utilization… but the ones who really know how much more work is entailed are the ones attempting to continue operating with no purchasing power and no profit potential.

Cost reporting data has been difficult to obtain so far, but I have calls out to the folks I believe can locate the data for me. The findings will show that more urban facilities with higher Medicare & Private utilization, spend more money every day, and far exceed their Mainecare caps… they do, because they can & because they must!

Competitive markets, as exist in urban areas where Medicare and Private clientele exist, demand an edge over the competition: fancier meals, meals to order, 24 hour dining, artwork, fountains, bistros, fancier furnishings, live entertainment, memory gardens, spas, fitness centers, outpatient clinics, massage therapists. The increased costs inherent in upstaging your competition are not borne from necessity to spend on residents needs, but necessity to outshine the others operating within your market area and capture more of the potentially profitable business.

The more research I have done the more downtrodden I am feeling… **no one is more desperately in need of representation and consideration than small rural providers, yet we have the least time to advocate for our situation and least ability to overcome financial obstacles.** I had thought this exercise would show commonalities, and that we are all in the same boat… that is simply not the case.

There has never been equitable access of payers *(Medicare & Private)* that allowed for the offsetting of Mainecare shortfalls to the rural provider community, the bulk of which are located in DHHS Region III & IV. Better payer sources exist around larger hospitals & larger, wealthier communities. When Mainecare monies were reallocated from III & IV to go to I & II, the Providers who needed help the most got left in the cold. **A tilted playing field was tilted even more drastically against rural facilities through the Principles of Reimbursement.**

I have operated a few different facilities, always "for-profit": in Rockland for a national corporation from 1999-2000, in Machias for a Maine-based corporation from 2011-2012, as well as our family-owned 39 bed facility from 2001-2012. The economies of scale are incredibly different, the resources drawn from Components to pay for Department Heads, goods, services, power, food, medical supplies, pharmaceuticals & fuel are completely different as overall size increases. Department Heads, required by Regulation regardless of your size, are your most costly employees, and tend to cost the same no matter your size. They cost a 60 bed 2/3 what they do a 40 bed… they cost an 80 bed half as much, and a 120 bed only a quarter of the impact.

A small operator has no financial clout to negotiate contracts… the 400 Medicare days of business a year and 12,000 Mainecare & Private business Oceanview has to offer a Pharmacy carries little profit opportunity. Compare that to 80,000 Medicare days and 400,000 Mainecare & Private days a large group offers… likewise the 10,000 gallons of fuel we use compared to 400,000 gallons… likewise the 500 pounds of hamburger we use versus the 20,000 pounds. **Volume & location are the two most pivotal factors in negotiating pricing… volume**

is a thing small operators do not have, and typically, we remain only in the least desirable locations for purveyors of goods & services to compete for, especially with the current cost of fuel.

These are the initial recommendations that folks have come up with:

1. **Make energy & fuel costs part of the Fixed Component**. Consider the State taking a role like the "Crown Corporations" in New Brunswick, becoming a stakeholder & partner in the "green energy" sector in this case, where a plethora of funding exists at the moment; take advantage of the Federal push for sustainability. Mandate all providers who receive "x" percentage of Mainecare funds to purchase "x" percent of power from Maine-based/ "Crown" energy companies. Likewise municipalities, schools, hospitals… money goes back to State coffers.

2. **Shift Health Insurance, water & sewer costs, sprinkler & fire monitoring** to the Fixed Component… if Health Insurance coverage for all becomes a mandate and people elect to take the coverages rather than pay the fines there will end up being a cascade of closings that will follow… **Providers have no say as to what are charges are to Mainecare or Medicare: Take it or leave it are the only options available.**

If every employee begins costing an extra $250/month for health insurance it will be an additional $14,000/month for a company as small as ours… the options will be equally limited: close or go bankrupt. Mandate use of Dirigo/have the money return to State coffers.

3. **Adjust the minimum staffing ratios to hours per patient day** (you are already working on this).

4. Instead of 60 beds being the obligatory number differentiating large from small, **use a sliding scale based on overall size & percentage of Mainecare composition** to get a truer picture of the situation. **One Medicare Resident** can bring in nearly $13,500.00 in a month in a rural setting… in an urban setting they are paid $15,750.00 for precisely the same services and care; the same bed with a Mainecare Resident brings in on average $5,250.00... Astronomical disparity!

The system is not structured to acknowledge the unique situations each Provider is faced with… in 1979, when born, payment was cost-based, there was little to no Skilled Nursing… the only uniqueness was how many Private Pay folks were in your area.

Payers other than Mainecare give you **potential** for profitability; with Mainecare, if you could manage costs and expenses perfectly, you could **theoretically break even**… the reality is: costs are a moving target, particularly when fuel is required for all goods to arrive, as well as impacting heating & electricity costs.

5. **Align regional Mainecare cost indices with Medicare indices**; provider 20 miles apart in the southern part of the State competing for same staff and same Medicare referrals can have a 15% difference in their payment… I appreciate the idea here, **but ANY Medicare referral at ANY index is *potentially* good business**, and that's the difference between rural-rural and suburban-rural… there are few rural referrals, a problem which has been compounded with the proliferation of the Critical Access Hospital swing-bed program.

6. Put all **Mandated costs to the Fixed component**; Accounting fees, sprinkler monitoring, fire

panel monitoring, backflow preventer testing. There is no free will to the Provider to choose to incur the costs, and as a whole there is so little competition within the State to motivate purveyors of mandated services to be an economical option, they charge a premium.

7. **Recognize economies of scale among Providers**... 20 years ago a 100 bed facility contract would be cause for celebration with a vendor. When people are negotiating with 500, 1000, 10,000, 20,000 beds of purchasing power behind them, vendors work particularly hard for the business. If you compare having 20, 50, 100 separate contracts to reach a similar volume, smart vendors put their greatest resources where the greatest potential return exists.

A concrete, real-time example: last month we finally had another Medicare resident *(a rarity)* at Oceanview... finally an opportunity to come ahead... for 20 days we *(hopefully)* will be paid $8038.84, or $401.94/day... were we in Portland at an urban facility we would be paid $8521.04.

Our pharmacy expense was $2920.42, or $146.02/day; a large group would instead negotiate and pay a "per diem" rate, no higher than $50/day, so expense would be limited to $1000.00 for the same admission...

Our Therapy costs were $2231.50 for that span of time, or $111.58/day *(we pay a premium in our area--there are no options otherwise & you want the opportunity to take a potentially profitable admission)*; a large contracted group, or an in-house therapist would cost between $544.50 and $1089.00.

Forgoing the lab costs that haven't yet come in, and the wound care supplies that haven't yet come in, see the difference size makes, even before all costs are in:

	Oceanview	Big Urban
Reimbursement	$8038.84	$8521.04
Pharmacy	-$2920.42	-$1000.00
Therapy	-$2231.50	-$1089.00
Total	$2886.92 ($144.35/day)	$6422.04 ($321.10/day)

Putting the Mainecare rate at $175.00/day (about the current state average) and running it through the Cost Report (all days are, regardless of payor) **Oceanview ends up with a shortfall of $30.65/day below the Mainecare rate to attempt to make up from some other payer, of which there are few**... this was the only Medicare Resident we had for the month of September, and we now have to make up $613.00 from some payer other than our Mainecare residents.

The larger, better paid, more profitable facility that pays lower rates across the board because of their volume, actually comes ahead by $146.10 per day... a profit of $2922.00.

8. **Eliminate professional intake coordinators shopping hospitals being an allowable cost.** One of the big reasons such a disparity exists between large groups robust overall Medicare census and small providers anemic percentages are: marketing, familiarity & convenience... intake folks are stationed at large hospitals to shop for referrals, bringing them cookies, fruit baskets, pens, candy... establishing relationships with discharge planners who then direct people. People typically do not get admitted to a hospital with a place for rehabilitation in mind, they have had little to no opportunity to research, and have no true basis for making the choice. **As a matter of convenience discharge planners preferentially send referrals to the facility of the**

intake Nurses choice. I am not saying this is an unethical practice; it's a set-up that is in fact ideal… but a set-up beyond the grasp of all but the very large.

It is a "first come, first serve" paradigm that discharge planners follow, because they are busy getting people out… they no longer have to go to the phone & inquire, the intake nurse does it for them before they can even get to a phone, but only within their respective organization(s). Independents are left out in the cold… we can't afford $65,000.00 for someone who doesn't set foot in the building; it'd be $5.00 from every single patient day we had here at Oceanview… for a big group, it's $0.10/day… well worth being first in line.

9. Discourage/eliminate **swing bed programs within 30 miles of other SNF providers**; they are a drag on Federal resources (300% what a SNF costs), referrals again are left without a choice about going somewhere else, because they never leave the floor. This was what ultimately sealed Calais' fate: no hope for profitability… now the hospital is feeling the effect of their reduced volume, and having to make cutbacks… with Critical Access Hospitals picking up what few Medicare referrals exist in rural areas, rural providers are more strapped than ever… yet another challenge urban areas do not face.

10 **Add Bad Debt provisions such as Medicare has in place**. Cost Reporting is done with the assumption that every day is paid, and every cost of care collected, whether they were or not. More & more we see families & responsible parties stealing the monies that DHHS determined needed to be paid for cost of care.

This is a quadruple whammy: the Principles of Reimbursement demand you do no better than break even from your Mainecare rate; the Cost Reporting demands that any monies saved from Direct & Routine Components be returned to the State, the Provider never actually got these monies the Cost Report states were accrued, so the Provider must then attempt to return these monies which they never spent, because they never received them, to the State of Maine. AGAIN a more lucrative payer source must exist to absorb that cost, AGAIN the Principles stack against predominantly Mainecare facilities.

Commissioner Mayhew, I apologize at the length of the letter… I tried to be concise, even shrunk the font twice and it's still over four pages long. There is so much material to go over…

Nursing Facilities are currently shoe-horned into 4 groups:

1. Hospital-based
2. Non-hospital based of 60 beds or less
3. Non-hospital-based of more than 60 beds
4. Eastport Memorial Nursing Home (actual cost-based reimbursement--circa 1979)

The actuality is Nursing Facilities are tremendously varied, have tremendously different challenges facing them, and the small rural ones are on our way out, despite our best efforts to continue… like Mom & Pop Hardware, the Local Apothecary, & Independent Doctor's Offices, we are unable to compete… and it's not because we don't provide good service; our care is better than most… it's not because we're inefficient: we run more lean and efficiently than anyone… it's because we're small, so everything costs us more, and we're poorer, because we are the last to get referrals from competitive markets, and do not at all when there's a CAH in town. We work twice as hard to do better work for less money.

Circumstances have changed drastically since 1979, and with the exception of a handful of Independents fortunate enough to have the size, location and payer mix to be "good business" by any measure, only the most distasteful of us *(rural & poor)* remain. We haven't been sucked up by a bigger fish, and we haven't tried to eat the other fish in our pond… no one wants to add us to their collection because we represent risk without hope for reward; as terrifying as it is to try and make things work, we don't want to be added to anyone's collection because they are simply not concerned about our community or it's needs, only the revenue stream we represent when our beds are swifted to a more prosperous area… again, it is good business to take the beds where the money is: there is hope for profit. It devastates communities.

When you are big & profitable, and in the right market, you spend more to make more, because more is available, done properly you ultimately end up with more profit… this is good business. **Small outfits conserve, because they have little profit potential due to their market, so they continue to survive**… this is the only business available.

Every time there is a rebasing, over-spending gets rewarded, and fiscal conservatives get the screws tightened a bit further… **4 years ago the Principles of Reimbursement reallocated monies to give the very most to the folks who have the very most, and give the least to the folks who were operating on a shoestring to begin with.** Small providers did not have the free time, the specialists, the voice, or the correct statistics to argue our case properly.

When we fall, *(as it stands this is not an "if" it is a "when"),* hopefully we will be allowed to sell out before going bankrupt… is there some Master Plan? I just need to know: if Regional Hubs are the ultimate goal (like schools), and only a handful of Big Providers will remain, and Mom & Pops are to be phased out, I'll stop taking on debt, quit trying to turn hamburger into steak, and tow the line.

I love my town & the people here, but can't be a martyr, and I can't allow my family to be ruined for pride & sentimentality when the writing seems to be on the wall… my case is not a unique one, is it not confined to Independent, or "for profit". It all has to do with scale.

I will touch base after folks have had a chance to meet & brainstorm further… perhaps we can set up a meeting with you & the Health & Human Services /Appropriations Committee(s) to establish some concrete recommendations?

Again, thank you for your time and your hard work… I know we are one small segment of your duties, so I really appreciate you hearing me out.

Sincerely,

Nathan Brown
Administrator

Washington County Rates *(based on unaudited 2011 Cost Reports)*

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To: Calais Nursing Facility Task Force
From, Nathan Brown, Administrator OVNH
Re: Proposed facility projections

11/09/2012

I have gathered raw data from the division of Audit to give you some idea/perspectives regarding the economy of scale concerns I have raised at meetings. The point I hope to impress is on how vital the volume of service forecast as well as the designation of the type of facility created will be in arriving at decisions regarding whether or not to proceed.

The first factor, **volume is entirely related to Resident Days…** if you propose a 20 bed, the volume is at maximum 7300 days, 40 is at 14,600 days, 60 at 21,900 days. I strongly encourage a sustainable model be created, of which 60 beds really has been the industry rule of thumb for sustainability… what size is necessary for sustainability depends on the peer group of the proposed facility.

The second factor, **designation** refers to whether you seek a hospital, or community-based entity, or a stand-alone facility. What I'll give you is a projection related to the highest (hospital-based) and lowest (stand-alone) levels of reimbursement that are seen.

Every dollar that comes into a Nursing Facility is broken into 3 parts: The Direct, the Routine, and the Fixed. There is high variability from low to high debt load within the Fixed Component, as well as varying influence of acuity/Case Mix awareness from facility to facility in the Direct Component. The Routine Component is based on historical costs from 2005 which have been updated sporadically since.

Maine Nursing Facility Rates: Highs & Lows: *(based on unaudited 2011 cost reports)*

Direct	Routine	Fixed	Total	20 beds	40 beds	60 beds
$64.57	$48.25	$10.43	$123.25	$899,725	$1,799,945	$2,699,175
$139.58	$103.34	$61.37	$304.29	$2,221,317	$4,442,634	$6,663,951

Keep in mind, these are the VERY highest and lowest ranges of Nursing Facilities across the state; it is frustrating as an Independent to see just how exorbitantly paid Hospital-based facilities are, as they hold the very highest reimbursement in each category except for Fixed… if you know folks at the **Jackman Regional Health Center**, they are the ones who hold top Direct & Routine honors. It appears their levels of reimbursement are less associated with the acuity of their Residents and size of facilities as they are to historic costs & overhead.

A Genesis Flagship in Kennebunk (Riverridge) holds honors for highest Fixed Costs/indebtedness.

On the following pages I'll give you 2011 Washington County averages; with the exception of Eastport, there is nothing exceptional about these facilities except that they are smaller than average size… they have no hospital-based reimbursement structure, all are "for-profit" except Eastport & Sunrise:

Total Allowable Operating Costs -- Regional Averages

For Fiscal Years Ending Between 01-01-2011 to 12-31-2011

	REGION 1		REGION 2		REGION 3		REGION 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
DIRECT CARE										
Salaries - R.N.	732,428	24.33	619,205	20.35	448,848	19.73	386,744	16.67	588,787	21.34
Salaries - L.P.N.	275,444	9.15	172,953	5.68	183,956	8.09	136,041	5.86	206,079	7.47
Salaries - C.N.A.	1,188,069	39.47	1,037,184	34.08	780,729	34.32	855,529	36.88	1,002,503	36.34
Salaries - C.M.T.	17,987	0.60	31,642	1.04	8,825	0.39	30,617	1.32	21,116	0.77
Salaries - Ward Clerks	39,799	1.32	15,790	0.52	14,431	0.63	31,874	1.37	25,129	0.91
Nursing Benefits & Taxes	656,060	21.80	558,538	18.35	372,368	16.37	349,046	15.05	521,226	18.89
Contract Nursing	37,888	1.26	37,460	1.23	26,803	1.18	813	0.04	31,023	1.12
Activities Salaries	80,581	2.68	61,544	2.02	52,808	2.32	53,305	2.30	64,780	2.35
Activities Benefits & Taxes	24,531	0.81	19,825	0.65	15,134	0.67	14,473	0.62	19,627	0.71
Medical Supplies	137,638	4.57	113,693	3.74	95,153	4.18	112,933	4.87	116,828	4.23
Medicine and Drugs	10,594	0.35	27,005	0.89	6,744	0.30	3,280	0.14	13,839	0.50
Total DIRECT CARE	3,201,020	106.34	2,694,838	88.55	2,005,800	88.17	1,974,656	85.13	2,610,936	94.64
FIXED COSTS										
Depreciation of Building & Improvements	163,083	5.42	111,561	3.67	104,840	4.61	114,123	4.92	127,275	4.61
Depreciation - Land Improvements	5,871	0.20	2,908	0.10	1,061	0.05	3,809	0.16	3,515	0.13
Depr.- Furniture, Fixtures & Equipment	65,031	2.16	70,983	2.33	41,944	1.84	40,101	1.73	58,297	2.11
Depreciation - Motor Vehicle	1,586	0.05	3,269	0.11	2,813	0.12	2,523	0.11	2,512	0.09
Start Up Cost Amortization	110	0.00	0	0.00	182	0.01	0	0.00	84	0.00
Amortization of Leasehold Improvements	5,269	0.18	8,346	0.27	5,866	0.26	0	0.00	5,808	0.21
Amortization of Finance Costs	3,563	0.12	1,099	0.04	1,024	0.04	490	0.02	1,837	0.07
Interest on Long-Term Debt	135,304	4.49	81,332	2.67	48,512	2.13	24,071	1.04	84,884	3.08
Facility Rent (in lieu of above)	21,490	0.71	6,836	0.22	0	0.00	2,223	0.10	9,480	0.34
Equipment Rental	11,519	0.38	7,276	0.24	13,735	0.60	3,616	0.16	9,968	0.36
Return on Owner"s Equity	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Real Estate & Personal Property Tax	40,856	1.36	29,959	0.98	37,419	1.64	34,248	1.48	35,959	1.30
Insurance (Fire, Liability, etc.)	34,970	1.16	27,315	0.90	27,967	1.23	31,374	1.35	30,460	1.10
Motor Vehicle Insurance	1,133	0.04	1,585	0.05	1,447	0.06	1,324	0.06	1,372	0.05
Worker"s Compensation Insurance	111,784	3.71	88,450	2.91	74,708	3.28	137,154	5.91	97,797	3.54
Administrator in Training - Wages	3,735	0.12	276	0.01	1,079	0.05	1,178	0.05	1,730	0.06
Admin. in Training - Benefits & Taxes	1,590	0.05	27	0.00	222	0.01	252	0.01	622	0.02
Other1	402,901	13.38	335,143	11.01	273,522	12.02	223,366	9.63	330,174	11.97
Other2	39,456	1.31	8,877	0.29	6,287	0.28	8,408	0.36	18,355	0.67
Other3	23,060	0.77	25,287	0.83	11,514	0.51	16,411	0.71	20,073	0.73
Total FIXED COSTS	1,072,312	35.62	810,528	26.63	654,141	28.75	644,670	27.79	840,200	30.45

From Stephanie Rae 10/25

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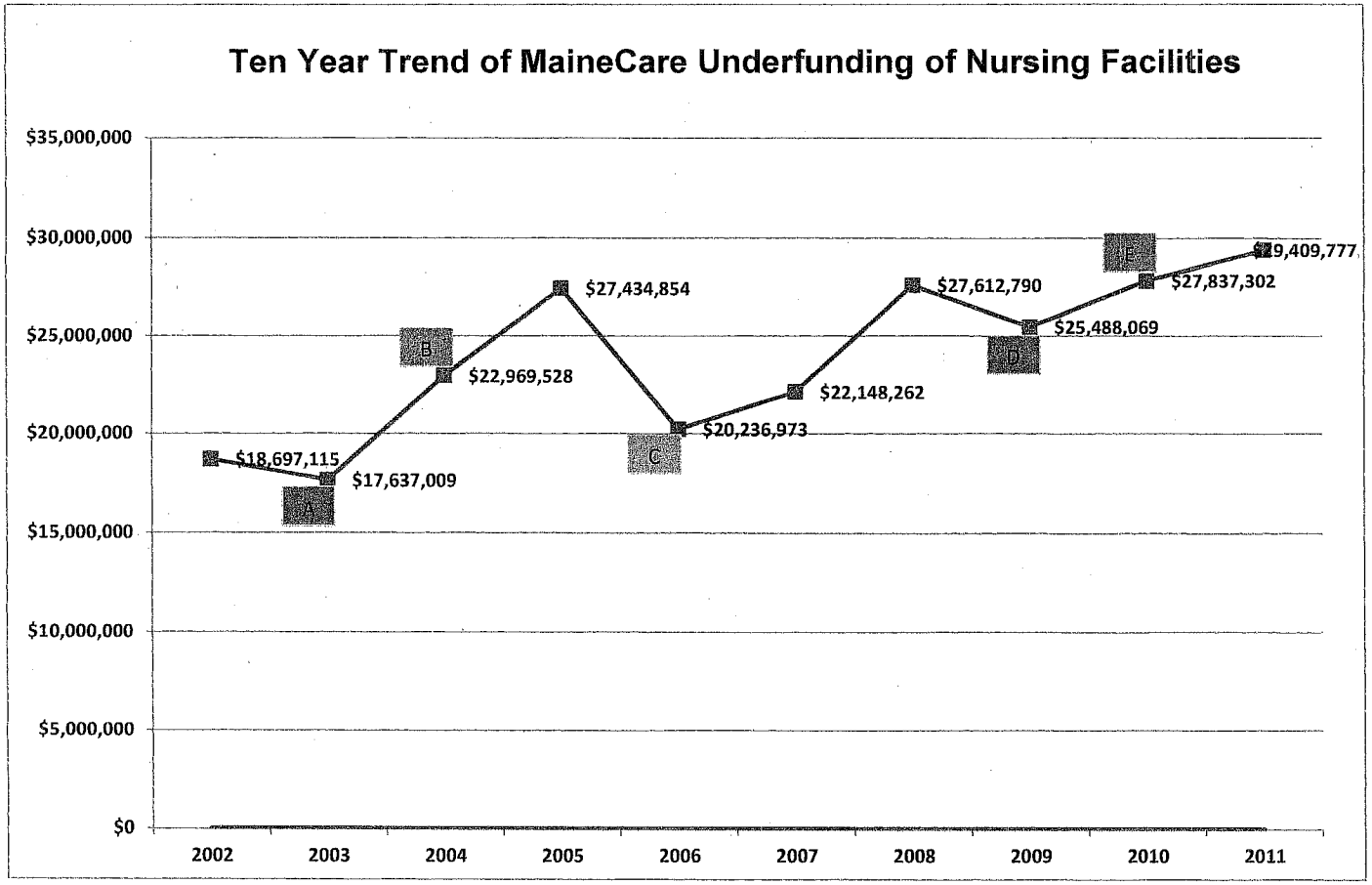

Data includes all non-hospital based facilities and was compiled using "as filed" cost reports.

Underfunding is defined as the difference between Medicaid Payments to Nursing Facilities and Total Allowable Medicaid costs.

Legend related to issues impacting MaineCare funding

- A Provider Tax & Staff Enhancement Payment instituted
- B January 2004 - Loss of Return on Equity and Cost of Living Adjustment (COLA)
- C July 2005 - 1.8% COLA reinstated
- D Receipt of one-time supplemental payment & Remote Island rules instituted
- E July 2010 - Rebasing in effect

From Stephanie Rice 10/25

2013 Upper Limits Utilized in Rate Setting
Based on 2005 Base Year

Peer Group	Direct Care		Routine	
	Median	Limited to 88.73%	Median	Limited to 88.73%
1 60 or fewer beds	$ 59.56	$ 52.84	$ 65.61	$ 58.21
2 More than 60 beds	65.23	57.87	62.96	55.86
3 Hospital-Based	71.63	63.56	116.47	103.34

From Stephanie Rice 10/25

Life Care Funding
888.670.7773
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States Ease Use of Life Policies for Elder Care

Taken from The Wall Street Journal
June 17th, 2013
THE WALL STREET JOURNAL. WSJ

***By Kelly Green** – The Wall Street Journal*

State lawmakers are encouraging elderly residents to use life insurance as a way to pay for long-term care—and lower the Medicaid tab in the process.

The strategy marks a tacit endorsement of so-called life settlements, a practice in which policyholders sell their policies at a discount in the secondary market and the buyer takes over premiums and consequently collects the death benefit.

Texas Gov. Rick Perry signed a law Friday that gives state Medicaid officials the authority to tell people applying for help they can sell long-held life-insurance policies to a third party to pay for custodial health care of their choice. Those who do so would remain eligible for Medicaid when those funds run out.

Similar bills are pending in at least seven other states, including New York—where lawmakers introduced legislation last week—California, Florida, Kentucky, Louisiana, Maine and New Jersey.

The states hope to stop people from dropping their life-insurance policies in order to qualify for Medicaid. To keep policy owners from spending settlements frivolously, the bills generally require that the money go straight to an irrevocable bank account used solely to pay for long-term care.

Medicaid is a jointly run state and federal health program for the poor that also provides long-term care to people who generally have used up all but a few thousand dollars in savings.

A complete, original version of this article appeared June 17, 2013, on page C1 in the U.S. edition of The Wall Street Journal, with the headline: States Ease Use of Life Policies for Elder Care.

In most cases, there is nothing to prevent life-insurance owners from selling their policies now to pay for long-term care, but the new laws will help publicize and regulate the strategy. "This focuses on middle-class policyholders with term coverage worth $100,000 on average," said Chris Orestis, chief executive of Life Care Funding LLC of Portland, Maine. "They're not wealthy enough to pay for long-term care for a long time, and they're not poor enough to qualify for Medicaid right away."

The seal of approval from some states demonstrates the desperation of lawmakers to stem rising Medicaid costs as 78 million baby boomers head into old age.

"It saves the state money, because otherwise you would just cash in the value of the life insurance and get $5,000 or something, and go on the Medicaid roll immediately," said Texas Rep. Craig Eiland, a Galveston Democrat who introduced the bill in the Texas House. "The policyholder benefits because he has cash he can direct to his own care and expenditures."

In Texas, about 27,000 people a year apply for Medicaid coverage of long-term-care bills. If 10% of the estimated 10,000 applicants with life insurance worth $75,000 used settlements to pay for long-term care, Medicaid could save $20 million a year, said Michael Freedman, a lobbyist for Coventry First LLC, a life-settlement company in Fort Washington, Pa.

Adult children facing immediate long-term-care bills for their parents in some cases are willing to take a smaller amount upfront than a larger inheritance later.

Rick Anderson, a 60-year-old AT&T

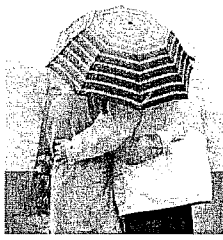
Texas lawmaker Craig Eiland

Corp. T -0.59%retiree in Lubbock, Texas, is caring for his 84-year-old father, who has had Alzheimer's disease for 15 years. For almost five years, his father has lived in a facility that costs more than $5,000 a month. He pays for half of it with a long-term-care insurance policy that will run out Dec. 31. Mr. Anderson has been covering the rest with his own savings. Now, he said, his increasingly frail mother needs to move to a facility, as well.

When Mr. Anderson discovered a $50,000 life-insurance policy on which his father was paying $71.97 a month in premiums, at about the same time he picked up a brochure at his father's facility explaining the life-settlement option to pay for long-term care, "I didn't even hesitate," Mr. Anderson said. "You've got to use the resources you have at the time."

He is getting a $35,000 settlement, which "I've told a lot of people about, because they didn't know they had that option. They say, 'You're giving up $15,000.' I guess it's how you look at it. I need the help now," Mr. Anderson said.

Few families attempting to care for frail, elderly relatives realize they have the option, so many simply abandon or surrender the policies instead, getting little or no cash after years of paying premiums, advocates say.



lifecare funding

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Legislative Bulletin

Multiple States Legislatively Endorse Life Insurance Policy Conversions to pay for Senior Care—*Texas first state to enact Private Pay Law*

As of June, 2013, eight states have introduced legislation based on Life Care Funding's program as a way to encourage more use of Private Pay for Homecare, Assisted Living, Skilled Nursing and Hospice through the conversion of a life insurance policy into a Life Care Benefit Plan. ***This funding option is already the legal right of every owner of a life insurance policy in the U.S.—but most don't realize it and are too quick to abandon a policy to jump onto Medicaid.*** The states that have introduced this ground breaking consumer legislation are California, Florida, Kentucky, Louisiana, Maine, New Jersey, New York and Texas. Among these states, Texas is the first to enact this Private Pay law.

The new Medicaid Life Settlement Policy Conversion law does two things:

1. Grants authority to the Medicaid department to inform and educate citizens that they can convert life insurance policies into a Medicaid qualified Long Term Care Benefit Plan to remain private pay and choose any form of long term care they want instead of abandoning a policy to go straight onto Medicaid.
2. To qualify, the Long Term Care Benefit Account must be an irrevocable, FDIC insured account that makes payments directly to the care provider; the person must be able to choose the form of care they want; a funeral benefit must be preserved; and if there is any unpaid account balance when the person dies it must go to the designated account beneficiary.

Specific requirements for the Benefit Plan to be Qualified

(a) A schedule evidencing the total amount payable, the number of payments and the amount of each payment required to be paid for long term care;

(b) All proceeds must be held in an irrevocable state or federally insured account;

(c) The lesser of five percent (5%) of the face amount of the life insurance or $5,000 is reserved as death benefit payable to the estate or beneficiary;

(d) And, the balance of payments required under the contract unpaid at death of the must be paid to the estate or a named beneficiary.

State Bill Numbers

Policy Conversion Bills introduced (as of June, 2013):

CA- SB 214	FL- HB 535
KY- HB 314	LA- HB 545
ME- LD 1092	NJ- A 4168
NY- A 7952	TX- HB 2383 (enacted into law)

The intent of this new law is to make sure people know they have the legal right in every state to use their life insurance to pay for long term care. These laws ensure that policy owners will be informed of this private pay option by their state government; and that use of this specific Long Term Care Benefit Plan will protect the funds and make sure that they are only used to pay for the long term care services of their choice.

To learn more about legislative developments in your state and to learn more about Long Term Care Benefit Plans, contact Chris Orestis, CEO Life Care Funding at 888-670-7773 or corestis@lifecarefunding.com

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ALFA
Assisted Living Federation of America

126th MAINE LEGISLATURE

FIRST REGULAR SESSION-2013

Legislative Document **No. 1092**

S.P. 374 In Senate, March 19, 2013

An Act To Increase the Use of Long-term Care Insurance

Reference to the Committee on Health and Human Services suggested and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator CRAVEN of Androscoggin.
Cosponsored by Representative GRAHAM of North Yarmouth and
Senators: President ALFOND of Cumberland, GOODALL of Sagadahoc, HASKELL of Cumberland, LACHOWICZ of Kennebec, VALENTINO of York, Representatives: GATTINE of Westbrook, LAJOIE of Lewiston.

Printed on recycled paper

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §3174-WW is enacted to read:

§3174-WW. Alternative Long-term Care Benefits Program

There is established within the department the Alternative Long-term Care Benefits Program, referred to in this section as "the program," to provide alternatives for persons to insure the costs of their own long-term care and to alleviate some of the costs of long-term care being paid by MaineCare. The department shall administer the program as a part of MaineCare.

1. Eligibility. A person is eligible for the program if the person owns a life insurance policy with any face amount in excess of $10,000 and that person enters into a settlement contract pursuant to Title 24-A, chapter 85 in exchange for payments directly to a provider of long-term care benefits for the owner of the policy from proceeds of the settlement contract in accordance with this section. In order to qualify for benefits under the program, a person must be eligible under this section and meet the other criteria required for long-term care benefits under the MaineCare program as provided in this chapter and in rules adopted by the department.

2. Benefits. The benefits of the program include coverage for long-term care services under MaineCare after the person participating in the program has used the available proceeds from the applicable settlement contract.

3. Disregard. In addition to assets disregarded or exempt under MaineCare program rules, in determining eligibility for MaineCare and the amount of MaineCare benefits and in estate recovery pursuant to section 14, subsection 2-I, the program must disregard the value of a life insurance policy as defined in Title 24-A, section 6802-A, subsection 7 that is in force and owned by an eligible person if the applicant or recipient enters into a settlement contract in accordance with this section. As used in this subsection, "value" means the value received pursuant to the settlement contract.

4. Requirements for settlement contract. In addition to any requirements in Title 24-A, chapter 85, any settlement contract entered into in accordance with this section must meet the following requirements.

A. The lesser of 5% of the face amount of the life insurance policy and $5,000 must be reserved as a death benefit payable to the policy owner's estate or beneficiary.

B. The balance of payments required under the settlement contract unpaid at the death of the policy owner must be paid to the policy owner's estate or a named beneficiary.

C. The settlement contract must include a schedule evidencing the total amount payable to the policy owner under the settlement contract.

D. All proceeds of the settlement contract must be held in an irrevocable federally insured deposit account in a financial institution authorized to do business in this State pursuant to Title 9-B.

E. Notwithstanding the provisions of Title 24-A, section 6810, subsection 1, the proceeds of a settlement contract entered into pursuant to this section must be greater than the cash surrender value or accelerated death benefit in the life insurance policy available at the time the contract is executed by all parties.

F. Notwithstanding any other provision of law, a claim from a policy owner, the policy owner's estate, a beneficiary or any other person with respect to the settlement contract may not exceed the face amount of the life insurance policy, less the proceeds paid under the settlement contract and the total amount of premiums paid subsequent to entering into the settlement contract. A payment of a claim by a settlement provider must be made from any bond, insurance or deposits maintained pursuant to paragraph I.

G. For purposes of this section, for a life insurance policy that is the subject of a settlement contract that has been in force for 5 years or more, the provisions of Title 24-A, section 6818 do not apply.

H. For purposes of this section, all advertisements of the settlement provider related to the program must be filed with the Department of Professional and Financial Regulation, Bureau of Insurance.

I. A settlement provider entering into a settlement contract pursuant to this section must maintain one of the following or any combination thereof in the amount of $500,000:

(1) A surety bond executed and issued by an insurer authorized to issue surety bonds in this State;

(2) A policy of errors and omissions insurance; and

(3) A deposit of cash, certificates of deposit or securities.

5. Disclosures. In cooperation with the Department of Professional and Financial Regulation, Bureau of Insurance, the department shall provide, as part of the application for MaineCare benefits or in a separate document to be signed by an applicant, the disclosures required by Title 24-A, section 6808-A.

6. Other laws. Eligibility for the program does not preclude enforcement of laws regarding recovery of MaineCare benefits incorrectly paid or 3rd-party liability claims by the department. The provisions of this section do not enlarge or otherwise modify medical assistance benefits under the MaineCare program. The provisions of section 14, subsection 2-I, paragraph A, subparagraph (3) do not apply to assets disregarded under the program.

7. Rulemaking. The department, after consultation with the Superintendent of Insurance within the Department of Professional and Financial Regulation, shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

SUMMARY

This bill establishes an alternative long-term care benefit program for those persons that qualify for long-term benefits under the MaineCare program. The bill allows persons otherwise eligible for long-term care benefits under MaineCare that own life insurance policies with face amounts exceeding $10,000 to enter into life settlement contracts in exchange for direct payments to a health care provider for long-term care benefits. The bill prohibits the Department of Health and Human Services from considering the value of the life settlement contract as an asset or resource in determining eligibility for MaineCare. The bill also establishes the conditions under which a life settlement contract may be used, requires certain disclosures to be made to MaineCare applicants and authorizes the Department of Health and Human Services to adopt rules after consultation with the Department of Professional and Financial Regulation, Bureau of Insurance.

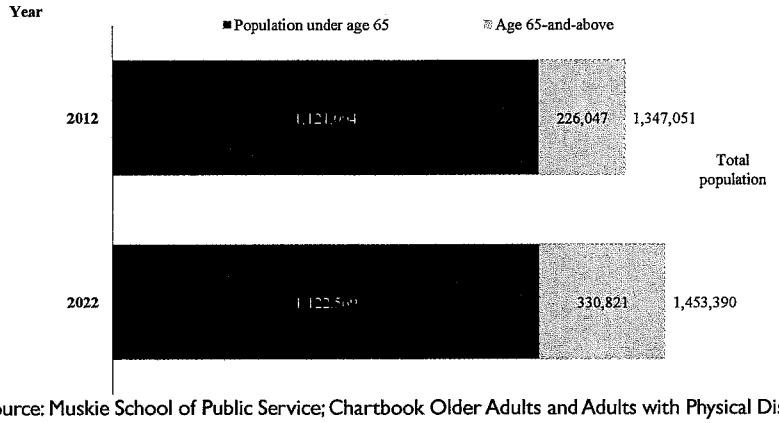
Commission to Study Long-Term Care Facilities

Julie Fralich
Muskie School of Public Service
October 25, 2013
julief@usm.maine.edu

Overview of Presentation

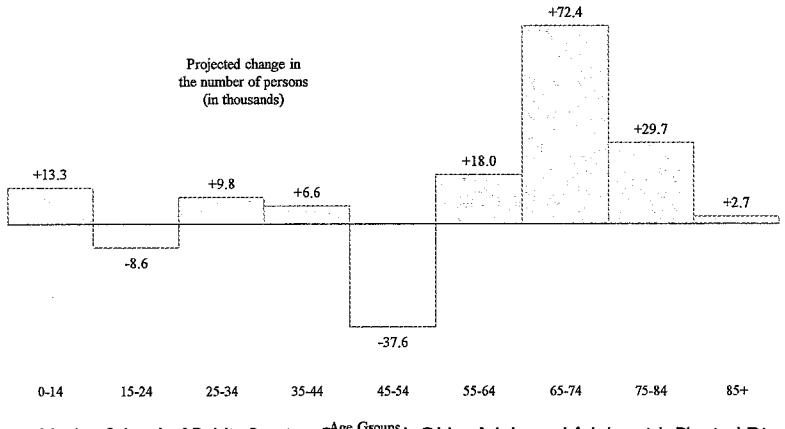
- Some Demographics for Maine
- Overview of Long Term Care System
  - Maine versus U.S.
- Nursing Facility and Residential Care Use and Supply in Maine
- Trends Across LTSS Settings in Maine
- Nursing Facility Pay for Performance and other Incentives
- Other LTSS Initiatives (Maine and US)

The number of people in Maine who are over age 65 will increase by 105,000 in 10 years.



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The greatest increase in the next 10 years is among those who are 65-74. Maine is also seeing a decline in the number of people in the age 45-54 age group.



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Comparison of Maine and U.S.

	Maine	U.S.	Rank (High to Low)
NF beds per 1000/65+, 2010	34	42	38
NF Occupancy Rate, 2008	90%	83%	9
Residents w/low care needs, 2010	2%	17%	49
Residents w/dementia, 2010	55%	46%	1
Residents with Medicare as primary payer, 2010	16%	14%	12
Percent change in NF residents (2005 to 2010)	-5%	-4%	30
Medicaid payment per day for nursing facility care, 2011	$178	$178	20

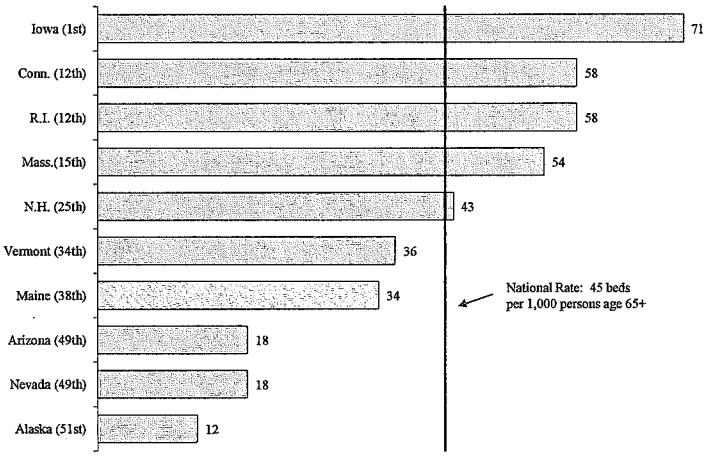
Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Comparison of LTSS Expenditures for Maine and US

	Maine	US	Rank (High To Low)
Medicaid Nursing Facility Expenditures per person served, 2008	$23,988	$29,533	44
Medicaid Aged/Disabled Waiver Expenditures per person served, 2008	$14,163	$10,710	11
ICF-MR Expenditures per person, 2008	$137,218	$123,053	19
MR/DD Waiver Services Expenditures per person served, 2008	$77,736	$42,896	3

Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Number of nursing facility beds per 1,000 persons age 65-and-above



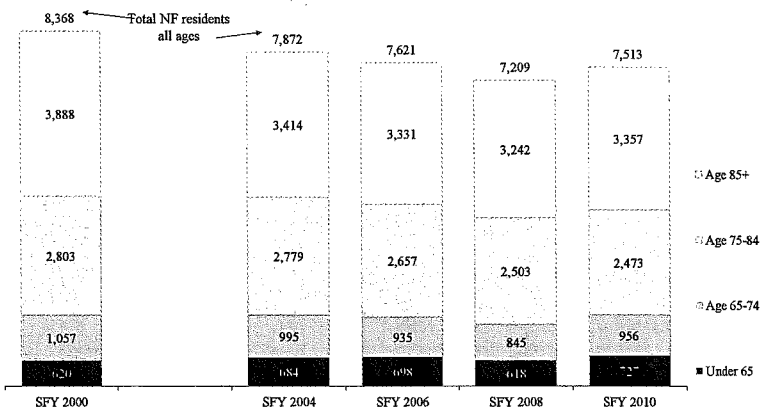
Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Change in LTSS Spending, 2004- 2009, by Service

	Maine	% Change	
		Maine	US
Nursing Facilities	+$8 million	+3%	+12%
Aged/Disabled Waivers	-$1 million	-5%	+77%
Personal Care Services and other HCBS	+$7 million	+15%	+67%
ICF/MR	+$4 million	+7%	+8%
MR/DD Waivers	+$173million	+88%	+54%

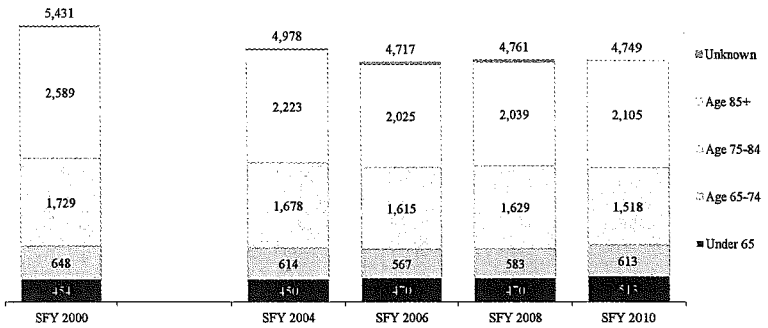
Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Maine's average monthly number of nursing facility residents declined from 2000 to 2008, then increased



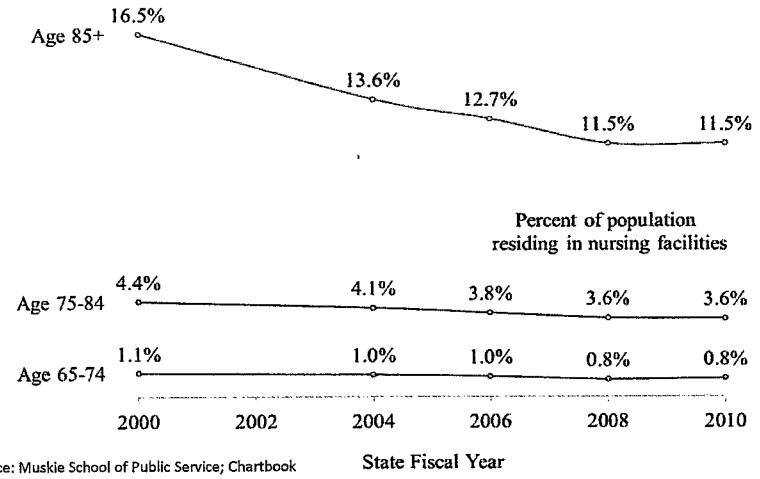
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The average monthly number of MaineCare members in nursing facilities declined from 2000 to 2010



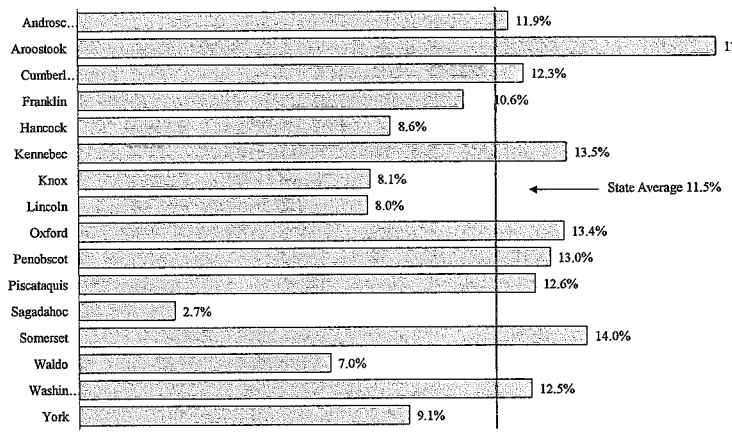
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The percent of Maine's population residing in nursing facilities (all payers) declined steadily across all age groups from 2000 to 2008, and then leveled off in 2010.



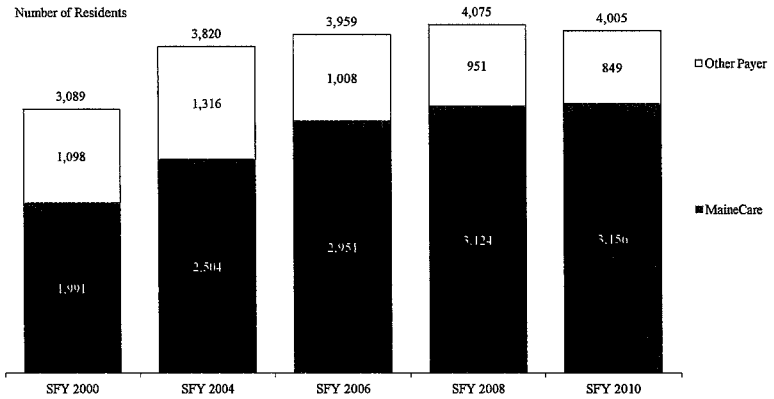
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Percent of population age 85 and above who resided in nursing facilities in 2010



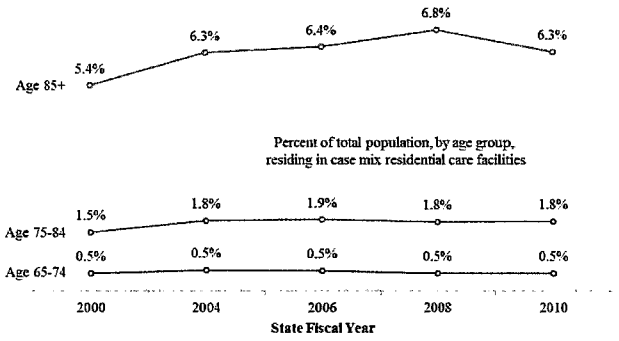
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Average number of residential care residents grew 30% between SFY 2000 and SFY 2010



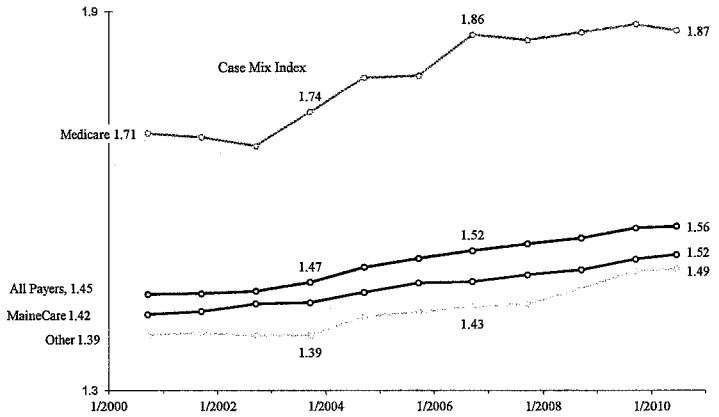
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The percent of Maine's population residing in residential care facilities by age group, 2000 to 2012



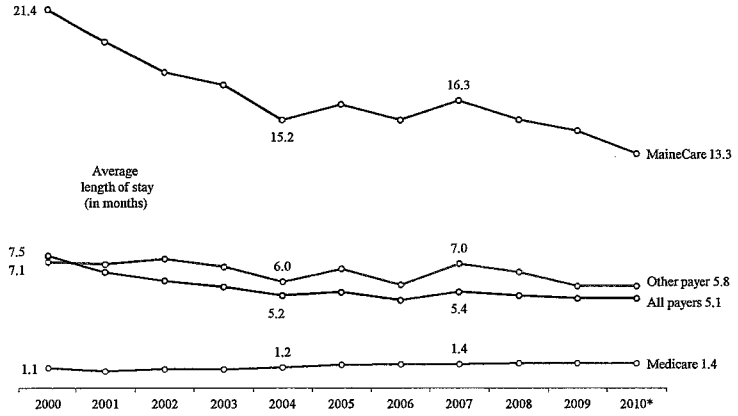
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The case mix (acuity) of nursing home residents increased from 2000 to 2010



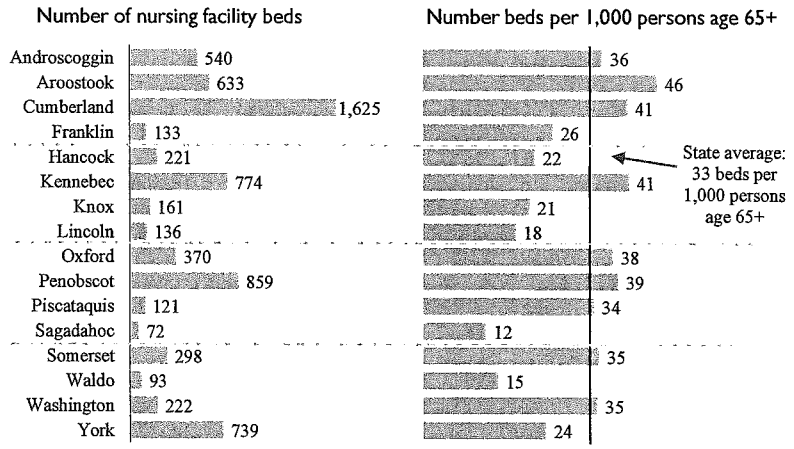
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Average length of stay in nursing facilities for MaineCare residents declined from 2000 to 2014



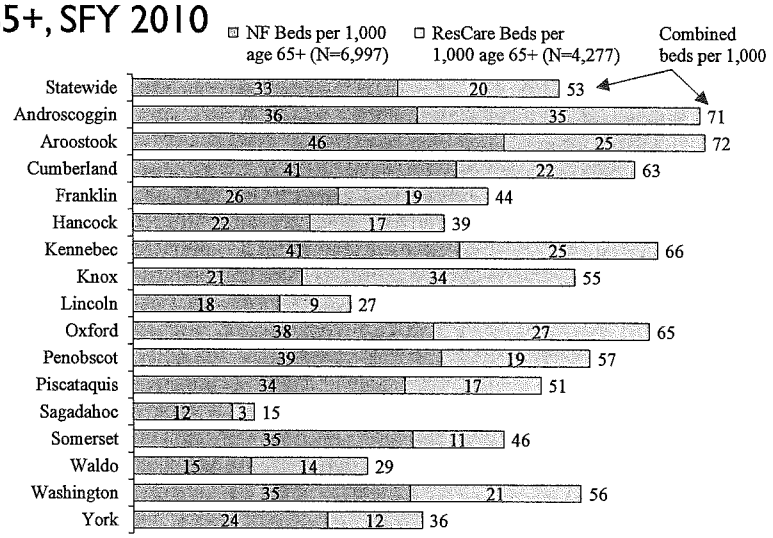
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The distribution of nursing facility beds by Maine County and number of beds per 1,000 persons, age 65-or-above, SFY 2010



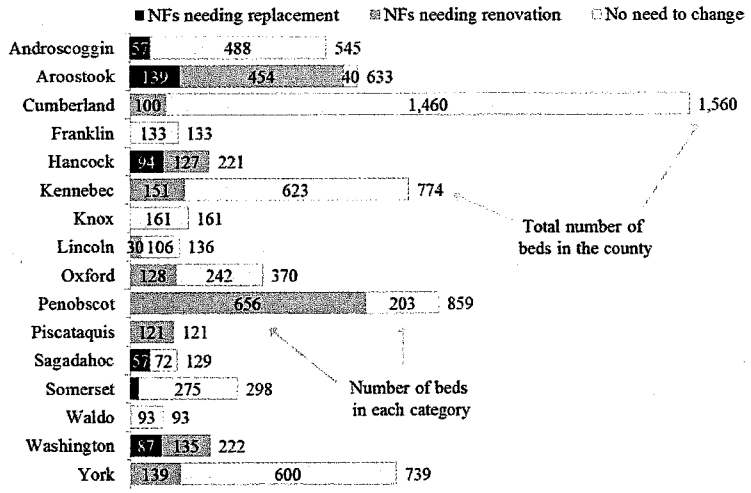
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The number of nursing facility and case-mix residential care beds per 1,000 persons age 65+, SFY 2010



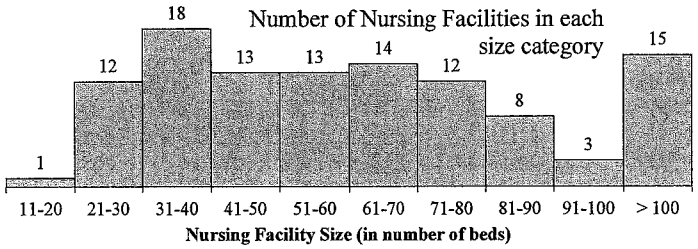
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

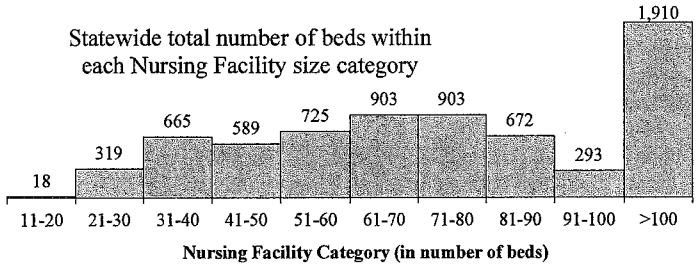
In 2009, nearly 3-out-of-10 Maine Nursing Facility beds were in buildings needing renovation and 7% of beds were in buildings in need of replacement.



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

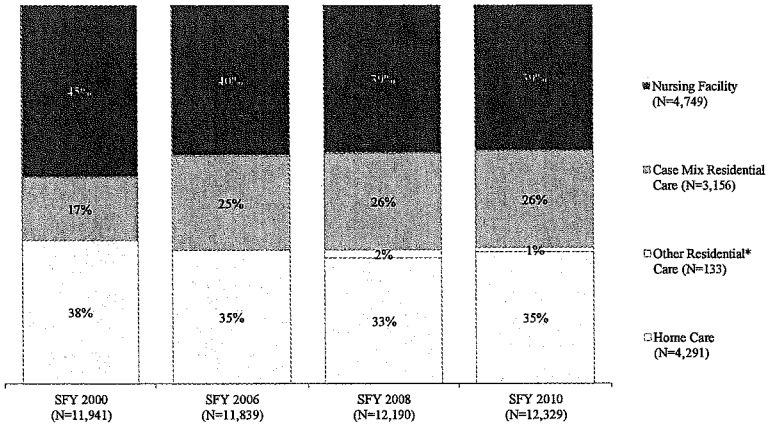
In 2010, nearly half of Maine's nursing facilities (48%) were larger than 60 beds (N=109)





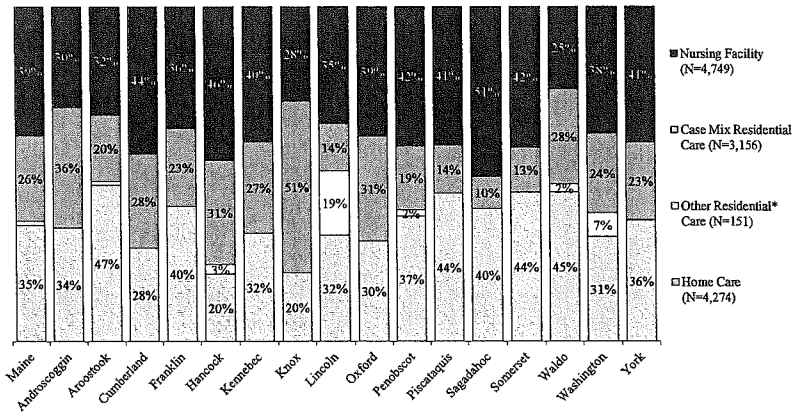
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Distribution of average monthly MaineCare LTC users by setting



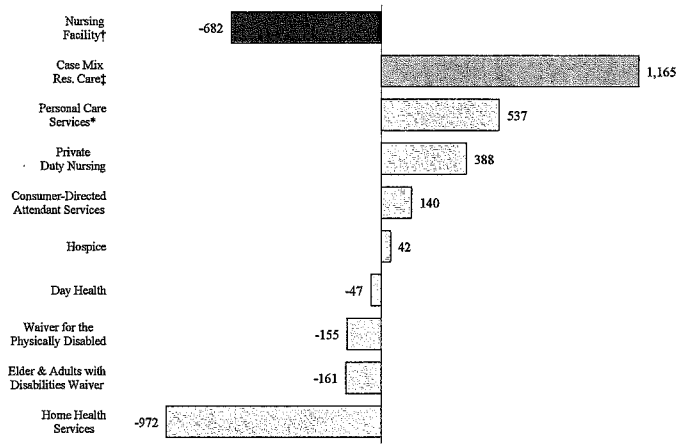
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Distribution of average monthly number of MaineCare LTC users by setting by county



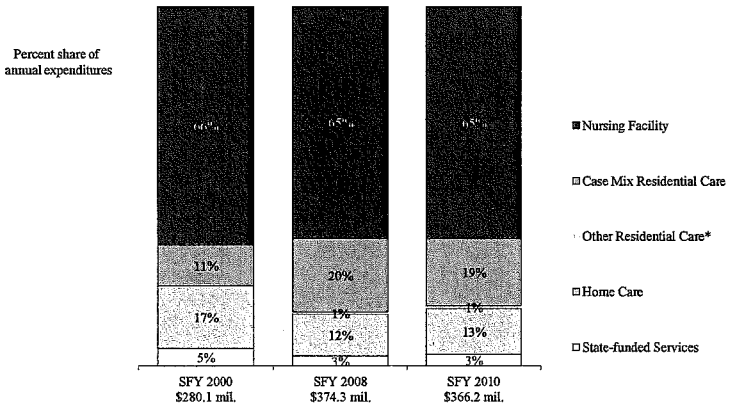
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Change in average monthly number of MaineCare members using MaineCare LTSS, 2000-2010



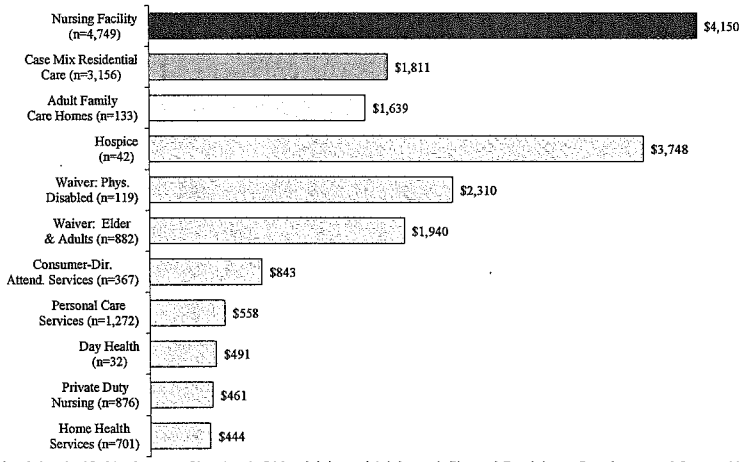
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Annual MaineCare LTC expenditures by setting, SFY 2010



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Average MaineCare LTSS expenditures per service user per month, SFY 2010



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Nursing Home Pay for Performance Systems

Types of Quality Measures

- Staffing
- Consumer satisfaction
- Inspection performance
- Clinical quality indicators
- Person-centered/quality of life
- Efficiency
- Access
- Employee satisfaction
- Quality improvement

Performance Methods

- Benchmarks
- Percentile ranking
- Year to year improvements
- Structure versus process
- Risk adjustments

(Source: Performance in 5 states: Lessons for the Nursing Home Sector. States included Iowa, Minnesota, Oklahoma, Utah and Vermont)

Nursing Home Pay for Performance Systems (cont)

Administration

- Complex versus Simple
- Relies on existing data and/or additional data (e.g. consumer surveys)
- Composite index versus simple approach

Payment method

- Added to per diem
- Funds allocated competitively

Findings

Need to incentivize engagement

- Secure funding
- Design systems that are perceived as fair and workable
- Minimize administrative burden on facilities
- Address different aspects of quality
- Encourage improvement among low-middle tier performers

- Slow Phase-in
- Availability of funding
- Provider participation is key
- Flexibility

Results

- Indiana study found that nursing home quality improved in 3 areas (falls, quality of life and rehospitalizations)
- Study of 8 states (2001 to 2009) found 3 quality measures improved (people in restraints, with pain, with pressure sores); other measures did not change or worsened
- Study in Minnesota found that facilities that participated in the program had greater gains in targeted areas of improvement and overall quality.

Other Nursing Home Incentives

Access Incentives

- Add-ons for serving people with certain conditions (e.g. ventilator dependent; brain injury; dementia); for serving Medicaid recipients; encourage higher occupancy

Efficiency Incentives

- Facility paid a state-wide rate; median; or peer group rate
- Facility receive bonuses for keeping costs below a ceiling

Other LTSS Initiatives

- Money Follows the Person
- Health Homes/Medical Homes and Nursing Homes
- Long Term Care Managed Care
- Rebalancing Services

Money Follows the Person

- Provides opportunities for people living in nursing homes to return to the community
- Maine participates in this program

Health Homes/Medical Homes

- People with hi costs/multiple chronic conditions assigned to "health home" to coordinate care and identify gaps in care
- Some states implementing health homes with nursing home and residential care residents
- Maine has a Health Home initiative for people with multiple chronic conditions and behavioral health conditions

Managed Long Term Care

- Managed long term care increasing
- States are including home and community based services and nursing facility services within managed long term care

Rebalancing Programs

- Focus on increasing access to home and community based services
- Less reliance on nursing home services

Conclusions

- Demographics will drive economic and other policy decisions in next 10 years
- It is helpful to look at long term care system as a whole – to develop a balanced system
- Pay for performance provides opportunity to implement value based purchasing within the long term care system

Other Resources

- Chartbook: Older Adults and Adults with Physical Disabilities – Population and Service Use Trends in Maine. http://muskie.usm.maine.edu/Publications/DA/Adults-Disabilities-Maine-Service-Use-Trends-chartbook-2012.pdf
- AARP Across the States Profiles of Long-Term Services and Supports 2012 http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html

Orbeton, Jane

From: Adolphsen, Nick <Nick.Adolphsen@maine.gov>
Sent: Thursday, October 24, 2013 7:54 AM
To: Orbeton, Jane
Subject: Section 67 Chapter 2 and 3
Attachments: c2s067.doc; c3s067.doc

Good Morning Jane,

Answers to many of the questions posed to the Department related to the Long Term Care Commission can be found in the pages of the attached rules. I intend to send more detail later today, but I wanted you to have copies of these so folks could begin reviewing before the meeting tomorrow.

I will be in touch shortly with more information related to the questions.

Thanks,
Nick

Director of Legislative Affairs
Department of Health and Human Services
207-975-2838

STATE OF MAINE

10-144

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MAINECARE SERVICES

Chapter 101
MAINECARE BENEFITS MANUAL

Chapter III Section 67

PRINCIPLES OF REIMBURSEMENT FOR NURSING FACILITIES

RECENT HISTORY:
Amended Effective November 14, 2007
Amended Effective September 2, 2002 (filing 2002-330) and September 29, 2002 (filing 2002-362)
Emergency Language Effective January 1, 2003 (filing 2002-514)
Amended Effective April 1, 2003 (filing 2003-84)
Amended Effective April 1, 2003 - EMERGENCY - expires June 29, 2003 (filing 2003-94)
Amended Effective June 30, 2003 (filing 2003-201)
Amended Effective January 1, 2004 (filing 2003-477)
Amended Effective September 1, 2004 (filing 2004-365)
Amended Effective October12, 2005 (filing 2005-404)
Amended Effective November 14, 2007 (filing 2007-459)
Amended Effective December 16, 2008 – EMERGENCY – expires March 15, 2009 (filing 2008-584)
Amended Effective March 15, 2009 (filing 2009-100)
Amended Effective June 11, 2009 – EMERGENCY – expires September 2, 2009(filing)- REPEALED
Amended Effective July 1, 2009 – EMERGENCY- expires September 29, 2009 (filing 2009-288)
Amended Effective September 28, 2009 (2009-210)
Amended Effective April 25, 2010 (2010-142)
Amended Effective July 1, 2010 – EMERGENCY- expires September 29, 2010 (filing 2010-271)
Amended Effective September 29, 2010 (filing 2010-443)
Amended Effective March 3, 2012 (filing 2012-55)

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INTRODUCTION

GENERAL PROVISIONS

10 PURPOSE

The purpose of these principles is to comply with Section 1902 (a) (13) (A) of the Social Security Act and the Rules and Regulations published there under (42 CFR Part 447), namely: to provide for payment of nursing care facility services (provided under the MaineCare Program in accordance with Title XIX of the Social Security Act) through the use of rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. These principles incorporate the requirements concerning nursing home reform provisions set forth by the Omnibus Budget and Reconciliation Act of 1987 (OBRA '87). Accordingly, these rates take into account the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well being of each MaineCare resident.

11 AUTHORITY

The Authority of the Department to accept and administer any funds which may be available from private, local, State or Federal sources for the provision of the services set forth in the Principles of Reimbursement is established in Title 22 of the Maine Revised Statutes Annotated, Sections 10 and 12. The regulations themselves are issued pursuant to authority granted to the Department by Title 22 of the Maine Revised Statutes Annotated Section 42(1).

12 GENERAL DESCRIPTION OF THE RATE SETTING SYSTEM

A prospective case mix payment system for nursing facilities is established by these rules in which the payment rate for services is set in advance of the actual provision of those services. The rate is established in a two-step process. In the first step, a facility's base year cost report is reviewed to extract those costs that are allowable costs. A facility's costs may fall into an allowable cost category, but be determined unallowable because they exceed certain limitations. Once allowable costs have been determined and separated into three (3) components - direct, routine and fixed costs, the second step is accomplished in which the costs which must be incurred by an efficiently and economically operated facility are identified.

13 DEFINITIONS

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

State Licensing and Federal Certification as used throughout these principles is the "Regulations Governing the Licensing and Functioning of Nursing Facilities" and the Federal Certification requirements for nursing care facilities that are in effect at the time the cost is incurred.

13 **DEFINITIONS** (cont.)

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

AICPA is the American Institute of Certified Public Accountants

Allowable Costs are costs that MaineCare will reimburse under these Principles of Reimbursement and that are below the caps (upper limits).

Ancillary Services are medical items or services identifiable to a specific resident furnished at the direction of a physician and for which charges are customarily made in addition to the per diem charge.

Base Year is a fiscal period for which the allowable costs are the basis for the case mix prospective rate.

Capital Asset is defined as services, equipment, supplies or purchases which have a value of $500 or greater.

Case Mix Weight is a relative evaluation of the nursing resources used in the care of a given class of residents.

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

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

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

Compensation means total benefit provided for the administration and policy-planning services rendered to the provider. It includes:

(a) Fees, salaries, wages, payroll taxes, fringe benefits, contributions to deferred compensation plan, and other increments paid to or for the benefit of, those providing the administration and policy-planning services;
(b) The cost of services provided by the provider to, or for the benefit of, those providing the administration and policy planning services, including, but not limited to food, lodging, and the use of the provider's vehicles.

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

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

13 **DEFINITIONS** (cont.)

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

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

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

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

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

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

Fixed Cost Component shall be determined based upon actual allowable costs incurred by an economically and efficiently operated facility.

Free Standing Facility is a facility that is not hospital-affiliated.

Front Line Employees are defined as all employees who work in the facility, except the administrator and contract labor.

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

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

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

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

13 **DEFINITIONS** (cont.)

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

(c) the allowable historical cost of the first owner of record on or after July 18, 1984.

In computing the historical cost the four (4) categories of assets will be evaluated, Land, Building, Equipment and Motor Vehicles. Each category will be evaluated based on the methods listed above.

Hospital-affiliated Nursing Facility is a nursing facility that is a distinct part of a hospital provider, located within the same building as the hospital unit or licensed as a hospital facility, or has ambulatory care services and nursing facility beds located within the same building or whose nursing facility beds were previously part of a hospital and relocated prior to January 1, 2005.

IHS Global Insight is a healthcare cost information service that publishes the Healthcare Cost Review, which is a quarterly listing of market basket indices for the healthcare industry.

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

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

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

MDS is the Minimum Data Set currently specified by the Centers for Medicare and Medicaid Services for use by Nursing Facilities.

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

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

Nursing Facility is a nursing home facility licensed and certified for participation in the MaineCare Program by the State of Maine.

OBRA Assessment is the assessment defined by CMS as a schedule of assessments performed for a nursing facility resident at admission, quarterly, and annually, whenever the resident experiences a significant change in status, and whenever the facility identifies a significant error in a prior assessment. This assessment is the active assessment

13 **DEFINITIONS** (cont.)

OBRA Assessment (cont.) instrument used for evaluating members during their stay in a nursing facility. Reimbursement is based on these assessment outcomes. With the exception of the admission assessment, the active OBRA assessment sets the payment from the Assessment Reference Date (ARD) until the day before the ARD on the next required OBRA assessment. The admission assessment sets payment from the admission date until the next required OBRA assessment.

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

Per Diem Rate is the total allowable costs divided by days of care. The prospective per diem rate, as described by days of care for MaineCare members, will determine reimbursement.

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

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

Prospective Case-Mix Reimbursement System is a method of paying health care providers rates that are established in advance. These rates take into account the fact that some residents are more costly to care for than others.

Publicly Owned Nursing Facility must be owned and operated by the State, City, Town, or other local government entity and be receiving funding from that public entity for the purposes of operating and providing nursing facility services to the residents of the facility.

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

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

Stand Alone Nursing Facility is a facility that is not physically located within a hospital.

State Assistance as used in throughout these principles is the amount of funds appropriated by the Legislature in a specific State Fiscal Year for the purpose of assisting in the reimbursement of publicly owned nursing facilities for services provided to their residents.

State Fiscal Year is defined as July 1st of the first year through June 30th of the second year. Example: State fiscal year 05-06 begins July 1st of 2005 and ends June 30th of 2006.

13 **DEFINITIONS** (cont.)

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

Total Allowable Inflated Direct Care Rate Per Day is the facility base year direct care costs divided by the days of care, adjusted for case mix and wages and held to the direct care upper limit and inflated based on Section 91 of these Principles.

Total Resident Census is the total number of residents residing in a nursing facility during the facility's fiscal year.

14 **REQUIREMENTS FOR PARTICIPATION IN MAINECARE PROGRAM**

14.1 **Nursing facilities** must satisfy all of the following prerequisites in order to be reimbursed for care provided to MaineCare members:

14.1.1 be licensed and certified by the Maine Department of Health and Human Services, pursuant to Title 22, Section 1811 and 42 CFR, Part 442, Subpart C, and

14.1.2 have a Provider/Supplier Agreement with the Department of Health and Human Services, as required by 42 CFR, Part 442, Subpart B.

14.2 **MaineCare payments** shall not be made to any facility that fails to meet all the requirements of Subsection 14.1.

15 **RESPONSIBILITIES OF OWNERS OR OPERATORS**

The owners or operators of a nursing facility shall prudently manage and operate residential health care services of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Commissioner or a duly authorized representative shall in any way relieve the owner or operator of a nursing facility from full responsibility for compliance with the requirements and standards of the Department of Health and Human Services or Federal requirements and standards.

16 **DUTIES OF THE OWNER OR OPERATOR**

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

16.1 Comply with the provisions of Sections 15 and 16 setting forth the requirements for participation in the MaineCare Program.

16.2 Submit master file documents and cost reports in accordance with the provisions of Sections 31 and 32 of these Principles.

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

16 **DUTIES OF THE OWNER OR OPERATOR** (Cont)

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

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

16.6 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 152 of these Principles.

20 **ACCOUNTING REQUIREMENTS**

20.1 ACCOUNTING PRINCIPLES

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

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

20.1.3 The provider shall report on an accrual basis, unless it is a state or municipal institution that operates on a cash basis. The provider whose records are not maintained on an accrual basis shall develop accrual data for reports on the basis of an analysis of the available documentation. The provider shall retain all such documentation for audit purposes.

21 **PROCUREMENT STANDARDS**

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

21.2 If a provider does not accept the lowest bid for a Capital Asset, the amount over the lower bid that cannot be demonstrated to be a reasonable and necessary expenditure is an unallowable cost. In situations not competitively bid, providers must act as a prudent buyer as referenced in Subsection 24.2 in these Principles. See cost to related organizations Section 24.9.

22 **COST ALLOCATION PLANS AND CHANGES IN ACCOUNTING METHODS**

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

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

22.1 Providers that have costs allocated from related entities included in their cost reports shall include as a part of their cost report submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements which must also be submitted with the MaineCare cost report. In the case of a home office, related management company, or real estate management company, this would include a completed Home Office Cost Statement that shows the costs that are removed which are unallowable. The provider shall submit this reconciliation with the MaineCare cost report. If the nursing facility is a Medicare provider, the Medicare Home Office Cost report may be used to identify the unallowable costs that are removed, if the Medicare Home Office Cost report is completed in sufficient detail to allow the Department to make its findings.

22.2 No change in accounting methods or basis of cost allocation may be made without prior written approval of the Office of MaineCare Services.

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

22.3.1 the nature of the change;

22.3.2 the reason for the change;

22.3.3 the effect of the change on the per diem rate of payment; and

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

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

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

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

22.7 Costs allocated to the nursing facility shall be reasonable and necessary, as determined by the Department pursuant to these rules.

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

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

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

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

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

22.10.1 Nursing Salaries. Services provided and hours of nursing care by licensed personnel and other nursing staff.

22.10.2 Other Nursing Costs. Nursing salaries cost allocations.

22.10.3 Plant operation and maintenance. Square feet serviced.

22.10.4 Housekeeping. Square feet serviced.

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

22.10.6 Dietary. Number of meals served.

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

23 **ALLOWABILITY OF COST**

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

24 **COST RELATED TO RESIDENT CARE**

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

24 **COST RELATED TO RESIDENT CARE (cont.)**

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

24.3 Costs must not be of the type conceived for the purpose of circumventing the regulations. Such costs will be disallowed under Section 26.

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

24.5 Wages, to be allowable, must be reasonable and for services that are necessary and related resident care and pertinent to the operation of the facility. The services must actually be performed and must be paid in full. The wages must be reported to all appropriate state and federal tax authorities to the extent required by law for income tax, social security, and unemployment insurance purposes. Bonuses which are part of a written policy of the provider and which require some measurable and attainable job performance expectation from the employee are allowable. Bonuses based solely on the availability of any anticipated savings in the MaineCare Direct Care Component are not allowable.

24.6 Costs which must be incurred to comply with changes in federal or state laws and regulations and not specified in these regulations for increased care and improved facilities which become effective subsequent to December 31,1998 are to be considered reasonable and necessary costs. These costs will be reimbursed as a fixed cost until the Department calculates the State wide peer group mean cost of compliance from the facility's fiscal year data following the fiscal year the cost was originally incurred. Following the second fiscal year the facility will be reimbursed the statewide average cost of compliance. The statewide average cost for this regulation/law will be built into the appropriate cost component in subsequent years.

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

24.9 Cost to Related Organizations Principle. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable costs of the provider at the cost to the related organization. However, such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. Providers should reference Section 21 of these Principles.

25 **UPPER PAYMENT LIMITS**

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

25.2 If the Office of Audit projects that MaineCare payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Office of Audit shall limit some or all

25 **UPPER PAYMENT LIMITS** (cont.)

of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit as set forth in subsection 25.4.

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

25.4 Facility Rate Limitations if Aggregate Limit is exceeded. If the Department projects that the MaineCare payments to nursing homes in the aggregate exceed the Medicare upper limit, the Department shall limit payments to those facilities whose projected MaineCare payments exceed what would have been paid using Medicare Principles of Reimbursement. The Department will notify the facilities when the Department projects that the MaineCare payments to nursing homes in the aggregate exceed the Medicare upper limit and that the Department must limit payments to those facilities to the level that would reduce the aggregate payments to the Medicare upper limit.

26 **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.

27 **RECORD KEEPING AND RETENTION OF RECORDS**

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

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

27.3 The provider shall maintain all such records for at least three (3) years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later. The Office of Audit shall keep all cost reports, supporting documentation submitted by the provider, correspondence, work papers and other analysis supporting audits for a period of three (3) years. In the event of litigation or appeal involving rates established under these regulations, the provider and Office of Audit shall retain all

27 **RECORD KEEPING AND RETENTION OF RECORDS** (cont.)

records that are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

27.4 When the Department of Health and Human Services determines that a provider is not maintaining records as outlined above for the determination of reasonable cost under the program, the Department, upon determination of just cause, shall send a written notice to the provider that in thirty (30) days the Department intends to reduce payments, unless otherwise specified, to a ninety percent (90%) level of reimbursement as set forth in Section 152 of these Principles. The notice shall contain an explanation of the deficiencies. Payments shall remain reduced until the Department is assured that adequate records are maintained, at which time reimbursement will be reinstated at the full rate from that time forward. If, upon appeal, the provider documents that there was not just cause for the reduction in payment, all withheld amounts will be restored to the provider.

30 **FINANCIAL REPORTING**

31 **MASTER FILE**

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

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

31.2 Chart of accounts and procedures manual, including procurement standards established pursuant to Section 21;

31.3 Plant layout;

31.4 Terms of capital stock and bond issues;

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

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

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

31.8 Related party information on affiliations, and contractual arrangements;

31.9 Tax returns of the nursing facility; and

31.10 Any other documentation requested by the Department for purposes of establishing a rate or conducting an audit.

31 **MASTER FILE** (cont.)

If any of the items listed in Subsections 31.1 - 31.10 are not submitted in a timely fashion the Department may impose the deficiency per diem rate described in Section 152 of these Principles.

32 **UNIFORM COST REPORTS**

32.1 All long-term care facilities are required to submit cost reports as prescribed herein to the State of Maine Department of Health and Human Services, Office of Audit, State House Station 11, Augusta, ME, 04333. Such cost reports shall be based on the fiscal year of the facility. If a nursing facility determines from the as filed cost report that the nursing facility owes moneys to the Department, a check equal to fifty percent (50%) of the amount owed to the Department will accompany the cost report. If a check is not received with the cost report the Department may elect to offset the current payments to the facility until the entire amount is collected from the provider.

32.2 **Forms**. Annual report forms shall be provided or approved for use by long-term care facilities in the State of Maine by the Department of Health and Human Services.

32.3 Each long-term care facility in Maine must submit an annual cost report within five (5) months of the end of each fiscal year on forms prescribed by the Office of Audit. If available, the long-term care facility can submit a copy of the cost report on a computer disk. The inclusive dates of the reporting year shall be the twelve-month period of each provider's fiscal year, unless advance authorization to submit a report for a lesser period has been granted by the Director of the Office of Audit. The cost report shall also include a calculation of the private pay rate for semi-private rooms. Failure to submit a cost report in the time prescribed above may result in the Department imposing the deficiency per diem rate described in Section 152.

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

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

32.6 The following supporting documentation is required to be submitted with the cost report:

32.6.1 Financial statements,

32.6.2 Most recently filed Medicare Cost Report (if a participant in the Medicare Program),

32.6.3 Reconciliation of the financial statements to the cost report.

32.6.4 Any other financial information requested by the Department.

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

33 **ADEQUACY AND TIMELINESS OF FILING**

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

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

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

34 **REVIEW OF COST REPORTS BY THE OFFICE OF AUDIT**

34.1 **Uniform Desk Review**

34.1.1 The Office of Audit shall perform a uniform desk review on each cost report submitted.

34.1.2 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, allowable costs and a summary of the results of the review. The Office of Audit will schedule an on-site audit or will prepare a settlement based on the findings determined by the uniform desk review.

34.1.3 Uniform desk reviews shall be completed within one-hundred-eighty (180) days after receipt of an acceptable cost report filing, including financial statements and other information requested from the provider except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider.

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

34.2 **On-site Audit**

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

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

34 **REVIEW OF COST REPORTS BY THE OFFICE OF AUDIT** (cont.)

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

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

35 **SETTLEMENT OF COST REPORTS**

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

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

35.2.1 At the request of either the Department, or a provider within the applicable time period set out in paragraph 35.4; and,

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

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

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

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

37 **REIMBURSEMENT METHOD**

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

37 **REIMBURSEMENT METHOD** (cont.)

37.2 Nursing facilities costs will be periodically rebased by the Department when the Commissioner determines that the rates paid to nursing facilities are in danger of failing to meet the residents needs or are in excess of costs which must be incurred by economic and efficient nursing facilities.

40 **COST COMPONENTS**

40.1 In the prospective case mix system of reimbursement, allowable costs are grouped into cost categories. The nature of the expenses dictates which costs are allowable under these Principles of Reimbursement. The costs shall be grouped into the following three (3) cost categories:

40.1.1 Direct Care Costs,

40.1.2 Routine Costs, and

40.1.3 Fixed Costs.

Sections 41- 49 describe the cost centers in each of these categories, the limitations and allowable costs placed on each of these cost centers.

41 **DIRECT CARE COST COMPONENT**

The basis for reimbursement within the direct care cost component is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them.

41.1 **Direct care costs** include salary, wages, and benefits for:

41.1.1 registered nurses salaries/wages (excluding Director of Nursing),

41.1.2 licensed practical nurses salaries/wages,

41.1.3 nurse aides salaries/wages,

41.1.4 patient activities personnel salaries/wages,

41.1.5 ward clerks' salaries/wages,

41.1.6 contractual labor costs,

41.1.7 fringe benefits for the positions in Sections 41.1.1 through 41.1.5 include:

(1) payroll taxes,

(2) qualified retirement plan contributions,

(3) group health, dental, and life insurance, and

41 **DIRECT CARE COST COMPONENT** (cont.)

(4) cafeteria plans.

41.1.8 Medical supplies, medicine and drugs that are supplied as part of the regular rate of reimbursement. See MaineCare Benefits Manual, Section 60. Excluded are costs that are an integral part of another cost center.

41.2 **Resident assessments**

The Resident Assessment Instrument (RAI) is the assessment tool approved by the Department to provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. It is comprised of the Minimum Data Set (MDS) currently specified for use by Centers for Medicare and Medicaid (CMS) and the Resident Assessment Protocols (RAPs).

The MDS provides the basis for resident classification into one (1) of forty-four (44) case mix classification groups. An additional unclassified group is assigned when assessment data are determined to be incomplete or in error. Resident assessment protocols (RAPs) are structured frameworks for organizing MDS elements and gathering additional clinically relevant information about a resident that contributes to care planning.

Per CMS guidelines, all residents admitted to a Nursing Facility (NF), regardless of payment source, shall be assessed using the MDS.

41.2.1 **Schedule for MDS submissions**

(1) An Admission Assessment (Comprehensive) must be completed and submitted (VB2) by the fourteenth (14th) day of the resident's stay.

(2) An Annual Reassessment (Comprehensive) must be completed and submitted (VB2) within three hundred-sixty-six (366) days of the most recent comprehensive assessment.

(3) A Significant Change in Status Reassessment (Comprehensive) must be completed and submitted (VB2) by the end of the fourteenth (14th) calendar day following determination that a significant change has occurred.

(4) A Quarterly Assessment must be completed and submitted every ninety-two (92) days.

41.2.2 **Electronic Submission of the MDS Information**

(1) **Encoding Data**: A facility must encode the data on every assessment as listed in Sec 41.2.1 within seven (7) days after a facility completes a resident's assessment.

(2) **Transmitting data**: A facility must be capable of transmitting to the State information for each resident contained in the MDS in a format

41 **DIRECT CARE COST COMPONENT** (cont.)

(2) **Transmitting data** (cont.): that conforms to standard record layouts and data dictionaries within seven (7) days after a facility completes a resident's assessment.

Should extraordinary conditions arise whereby the nursing facility is unable to submit electronically, a request to submit MDS information via diskette shall be submitted to the Office of MaineCare Services. This request must be made a minimum of five (5) days prior to the required date of submission of the MDS assessment data. Transmission of MDS information will be in accordance with standards and specifications established under CMS guidelines.

41.2.3 **Quality review of the MDS process**

41.2.3(A) **Definitions**

(1) **MDS Correction Form**. The MDS correction form is a form specified by CMS that allows for the correction of MDS assessment information previously submitted and accepted into the MDS central data repository.

Facility staff identifies and determines the need for data correction. The MDS clinical process must be maintained under CMS requirements. Corrections take two (2) forms:

(a) **Modification**: Information contained in the MDS central repository is inaccurate for an assessment and requires correction.

(b) **Deletion**: The facility determines the MDS was submitted in error and is wrong. The facility submits an MDS Correction Form requesting the inaccurate record be deleted from the database.

(2) **"MDS assessment review"** is a review conducted at nursing facilities (NFs) by the Maine Department of Health and Human Services, for review of assessments submitted in accordance with Section 41.2 to ensure that assessments accurately reflect the resident's clinical condition.

(3) **"Effective date of the Rate"** is established by the date on the rate letter. A rate letter will be generated at least annually.

(4) **"Assessment review error rate"** is the percentage of unverified Case Mix Group Record in the drawn sample. Samples shall be drawn from Case Mix Group Record completed for residents who have MaineCare reimbursement. MDS Correction Forms received in the central repository or included in the clinical record will be the basis for review

41 **DIRECT CARE COST COMPONENT** (cont.)

when completed before the day of the review and included as part of the resident's clinical record.

(5) **"Verified Case Mix Group Record"** is a NF's completed MDS assessment form, which has been determined to accurately represent the resident's clinical condition, during the MDS assessment review process. Verification activities include reviewing resident assessment forms and supporting documentation, conducting interviews, and observing residents.

(6) **"Unverified Case Mix Group Record"** is one which, for reimbursement purposes, the Department has determined does not accurately represent the resident's condition, and therefore results in the resident's inaccurate classification into a case mix group that increases the case mix weight assigned to the resident. Records so identified will require facilities to submit the appropriate MDS correction form and follow CMS clinical guidelines for MDS completion. Correction forms received prior to calculating the rate setting quarterly index will be used in the calculation of that index.

(7) **"Unverified MDS Record"** is one, which, for clinical purposes, does not accurately reflect the resident's condition. Records so identified will require facilities to submit the appropriate MDS correction form and follow the CMS clinical guidelines for MDS completion.

41.2.3 (B) **Criteria for Assessment Review**

NFs may be selected for a MDS assessment review by the Department based upon but not limited to any of the following:

(1) The findings of a licensing and certification survey conducted by the Department indicate that the facility is not accurately assessing residents.

(2) An analysis of the case mix profile of NFs included but not limited to changes in the frequency distribution of their residents in the major categories or a change in the facility average case mix score.

(3) Prior resident assessment performance of the provider, including, but not limited to, ongoing problems with assessments submission deadlines, error rates, high percentages of MDS corrections or deletions, and incorrect assessment dates.

41 **DIRECT CARE COST COMPONENT** (cont.)

41.2.3(C) **Assessment Review Process**

(1) Assessment reviews shall be conducted by staff or designated agents of the Department.

(2) Facilities selected for assessment reviews must provide reviewers with reasonable access to residents, professional and non-licensed direct care staff, the facility assessors, clinical records, and completed resident assessment instruments as well as other documentation regarding the residents' care needs and treatments.

(3) Samples shall be drawn from MDS assessments completed for residents who have MaineCare reimbursement. The sample size is determined following the CMS State Operations Manual (SOM) Transmittal 274, Table 1 "Resident Sample Selection".

(4) At the conclusion of the on-site portion of the review process, the Department's reviewers shall hold an exit conference with facility representatives. Reviewers will share written findings for reviewed records.

41.2.3(D) **Sanctions**

Effective until MIHMS go-live, the Department shall compute the quarterly facility average case mix index, as described in Section 80.3 of these principles. Effective with assessment reviews on or after October 1, 2000, the following sanctions shall be applied to the allowable case mix adjusted direct care cost component for the subsequent quarter for all MaineCare residents of the facility for which the following assessment review error rates are determined. Such sanctions shall be a percentage of the total direct care rate after the application of the case mix adjustments and upper limit.

(1) A two percent (2%) decrease in the total direct care cost component will be imposed when the NF assessment review results in an error rate of thirty-four percent (34%) or greater, but is less than thirty-seven percent (37%).

(2) A five percent (5%) decrease in the total direct care cost component will be imposed when the NF assessment review results in an error rate of thirty-seven percent (37%) or greater, but is less than forty-one percent (41%).

(3) A seven percent (7%) decrease in the total direct care cost component will be imposed when NF assessment review

41 **DIRECT CARE COST COMPONENT** (cont.)

results in an error rate of forty-one percent (41%) or greater, but is less than forty-five percent (45%).

(4) A ten percent (10%) decrease in the total direct care cost component will be imposed when the NF assessment review results in an error rate of forty-five percent (45%) or greater.

Effective with assessment reviews on or after MIHMS go-live, the following sanctions shall be applied to the total allowable inflated direct care cost per day for a three month period subsequent to the quality review date. The sanction will apply to all MaineCare resident days billed by the facility during the three month sanction period. Such sanctions shall be a percentage of the total allowable inflated direct care rate per day after the application of the wage index and upper limit. Upon notification of the error rates as determined by the reviewers (in 41.2.3(C)), the staff of the rate setting unit of the Department will implement the appropriate sanction by issuing a rate letter with the start and end dates of the three month sanction period. At the completion of the three month sanction period, the staff of rate setting unit will issue a rate letter reinstating the total allowable inflated direct care cost per day.

(1) A two percent (2%) decrease in the total allowable inflated direct care rate per day after the application of the wage index and upper limit will be imposed when the NF assessment review results in an error rate of thirty-four percent (34%) or greater, but is less than thirty-seven percent (37%).

(2) A five percent (5%) decrease in the total allowable inflated direct care rate per day after the application of the wage index and upper limit will be imposed when the NF assessment review results in an error rate of thirty-seven percent (37%) or greater, but is less than forty-one percent (41%).

(3) A seven percent (7%) decrease in the total allowable inflated direct care rate per day after the application of the wage index and upper limit will be imposed when NF assessment review results in an error rate of forty-one percent (41%) or greater, but is less than forty-five percent (45%).

(4) A ten percent (10%) decrease in the total allowable inflated direct care rate per day after the application of the wage index and upper limit will be imposed when the NF assessment review results in an error rate of forty-five percent (45%) or greater.

41.2.3(E) Failure to complete MDS corrections by the nursing facility staff within fourteen (14) days of a written request by staff of the Office of MaineCare Services may result in the imposition of the deficiency per diem as specified in Principle 152 of these Principles of Reimbursement. Completed MDS corrections and assessments, as

41 **DIRECT CARE COST COMPONENT** (cont.)

defined in Section 41.2, shall be submitted to the Department or its designee according to CMS guidelines.

41.2.3 (F) **Appeal Procedures**: A facility may administratively appeal an Office of MaineCare Services rate determination for the direct care cost component. An administrative appeal will proceed in the following manner:

(1) Within thirty (30) days of receipt of rate determination, the facility must request, in writing, an informal review before the Director of the Office of MaineCare Services or his/her designee. The facility must forward, with the request, any and all specific information it has relative to the issues in dispute. Only issues presented in this manner and time frame will be considered at an informal review or at a subsequent administrative hearing.

(2) The Director or his/her designee shall notify the facility in writing of the decision made as a result of the informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer designated by the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within thirty (30) days of receipt of the decision made as a result of the informal review.

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

(4) To the extent the Department upholds the original determination of the Office of MaineCare Services, 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.*

41.3 **Allowable costs for the Direct Care component of the rate** shall include:

41.3.1 **Direct Care Cost**. The base year costs for direct care shall be the actual audited direct care costs incurred by the facility in the fiscal year ending in calendar year 2005 except for facilities whose MaineCare rates are based on pro forma cost reports in accordance with Sections 80.6 and 80.7. All base year costs are subject to upper limits defined in Section 80.3.3(5).

43 **ROUTINE COST COMPONENT**

All allowable costs not specified for inclusion in another cost category pursuant to these rules shall be included in the routine cost component subject to the limitations set forth in these Principles. The

43 **ROUTINE COST COMPONENT** (cont.)

base year costs for the routine cost component shall be the audited costs incurred by the facility in the fiscal year ending in calendar year 2005, except for facilities whose MaineCare rates are based on pro forma cost reports in accordance with Sections 80.6 and 80.7. All base year costs are subject to upper limits defined in Section 80.5.4.

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

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

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

43.4 Allowable costs for the routine component of the rate.

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

(1) fiscal services, (not to include accounting fees)
(2) administrative services and professional fees not to exceed the administrative and management ceiling,
(3) plant operation and maintenance including utilities,
(4) laundry and linen,
(5) housekeeping,
(6) medical records,
(7) subscriptions related to resident care,
(8) employee education, as defined in Section 43.4.2.(I), except wages related to initial and on-going nurse aide training as required by OBRA,
(9) dietary,
(10) motor vehicle operating expenses,
(11) clerical,
(12) transportation, (excluding depreciation),
(13) office supplies/telephone,
(14) conventions and meetings within the state of Maine,
(15) EDP bookkeeping/payroll,
(16) fringe benefits, to include:
  (a) payroll taxes,
  (b) qualified retirement plan contributions,
  (c) group health, dental, and life insurance, and
  (d) cafeteria plans.
(17) payroll taxes,
(18) one (1) association dues, the portion of which is not related to lobbying,
(19) food, vitamins and food supplements,
(20) director of nursing, and fringe benefits,
(21) social services, and fringe benefits,
(22) pharmacy consultant and dietary consultant, and medical director.

43 **ROUTINE COST COMPONENT** (cont.)

See the explanations in Sections 43.4.2 - 43.4.5 for a more complete description of allowable costs in each cost center.

43.4.2(A) **Allowable Administration and Management Expenses**

(1) **Principle.** A ceiling shall be placed on reimbursement for all compensation for administration and policy making functions and all expenses incurred for management and financial consultation, including accounting fees that are incurred by a related organization or the facility's operating company. Any compensation received by the individual who is listed as the administrator on the facility's license for any other services such as nursing, cooking, maintenance, bookkeeping and the like shall also be included within this ceiling.

This ceiling shall be increased quarterly by the inflationary factor as defined in Section 91 to reflect the rate of inflation from July 1, 1995 to the appropriate quarter. To establish the prospective rate for nursing facilities the administrative ceiling in effect at the beginning of a facility's fiscal year will apply to the entire fiscal year of that facility.

Single-level facilities with forty (40) or fewer beds may request a waiver of the above principle by submitting a written application for waiver to the Director, DHHS, Office of Audit-MaineCare and Social Services. The facility's application shall describe the other services to be performed by the administrator, the rate of pay for these other services, the hours to be spent performing such other services and the facility's operational need to have such other services performed. The facility must obtain the written approval of the Director, DHHS, Office of Audit-MaineCare and Social Services, prior to such services being performed and in advance of claiming reimbursement. In addition, the facility must submit evidence such as time studies with the cost report to verify that such other services were actually rendered to the facility. Such other service costs will be reconciled at cost settlement in accordance with the Director's written approval and applicable cost settlement principles.

(2) For fiscal years beginning on or after July 1, 1995, the statewide average professional accounting costs by bed size (0-30, 31-50, 51-100, over 100) will be included in the administrative and policy - planning ceiling. Only those reasonable, necessary and proper accounting costs which are appropriate to the operation of nursing facilities are considered allowable accounting costs and will be included in the determination of the state wide average.

43 **ROUTINE COST COMPONENT** (cont.)

43.4.2 (B) **Ceiling.** The administration and policy-planning ceiling that is in effect as of July 1, 1995 is listed below. The ceiling shall be increased quarterly to reflect the rate of inflation from July 1, 1995, to the appropriate quarter.

*up to 30 beds: $37,772 plus $637 for each licensed bed in excess of 10;

*31 to 50 beds: $54,240 plus $545 for each licensed bed in excess of 30;

*51 to 100 beds: $67,432 plus $364 for each licensed be in excess of 50, and

*over 100 beds: $90,757 plus $273 for each licensed bed in excess of 100.

In the case of an individual designated as administrator in more than one (1) facility, the Department shall combine the number of beds in these facilities and apply one hundred-twenty percent (120%) of the above schedule. The total allowance will be prorated to each facility based on the ratio of the facility's number of beds to the combined number of beds for all facilities under the direction of the administrator.

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

(1) **Central Office operational costs** for business managers, controllers, reimbursement managers, office managers, personnel directors and purchasing agents are to be included in the administrative and policy-planning ceiling according to an allocation of those costs on the basis of all licensed beds operated by the parent company.

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

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

(3) This ceiling is not to include any Director of Nursing, Dietary Supervisor, or other department head, whose prime

43 **ROUTINE COST COMPONENT** (cont.)

duties are not of an administrative nature but who may be responsible for hiring or purchasing for his or her Department.

(4) All other regulations specific to administrative functions in Nursing Facilities that are included in State Licensing Regulations and all other State and Federal regulations.

43.4.2(D) **Dividends and Bonuses**. Bonuses, dividends, or accruals for the express purpose of giving additional funds to the administrator or owners of the facility, whether or not they are part of the administrative and management ceiling, will not be recognized as allowable costs by the Department.

43.4.2(E) **Management fees**. Management fees charged by a parent company or by an unrelated organization or individual are not allowable costs and are not considered part of the administrative and management ceiling.

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

43.4.2(G) **Central Office Operational Costs**. Central office bookkeeping costs and related clerical functions that are not included in the administration and policy-planning ceiling may be allocated to each facility on the basis of total resident census limited to the reasonable cost of bookkeeping services if they were performed by the individual facility.

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

43.4.2(H) **Laundry services** including personal clothing for MaineCare residents.

43.4.2(I) **Cost of Educational Activities**

(1) **Principle**. An appropriate part of the net cost of educational activities is an allowable cost. Appropriate part means the net cost of the activity apportioned in accordance with the methods set forth in these Principles. Expenses for education activities may be evaluated as to appropriateness, quality and cost and may or may not be included as an allowable cost based on the findings.

43 **ROUTINE COST COMPONENT** (cont.)

2) **Orientation, On-the-Job Training, In-Service Education and Similar Work Learning**. Orientation, on-the-job training, in-service education and similar work learning programs are not within the scope of this principle but, if provided by a staff person, are recognized as normal operating costs for routine services in accordance with the principles relating thereto.

(3) **Basic Education**. Educational training programs, which a staff member must successfully complete in order to qualify for a position or a job, shall be considered basic education. Costs related to this education are not within the scope of reimbursement.

(4) **Educational Activities**. Educational activities mean formally organized or planned workshops, seminars, or programs of study usually engaged in by the staff members of a facility in order to enhance the quality of resident care within the facility. These continuing education activities are distinguished from and do not include orientation, basic education programs, on-the-job training, in-service education and similar work learning programs.

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

43.4.3 **Motor Vehicle Allowance**. Cost of operation of one (1) motor vehicle necessary to meet the facility needs is an allowable cost less the portion of usage of that vehicle that is considered personal. A log that clearly documents that portion of the automobile's use for business purposes is required. Prior approval from the Office of Audit is required if additional vehicles are needed by the nursing facility.

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

43.4.5 **Consultant Services**. The following types of consultative services will be considered as part of the allowable routine costs and be built into the base year routine cost component subject to the limitations outlined in subsections 43.4.5(1) – 43.4.5(3).

(1) **Pharmacist Consultants**

Pharmacist consultant fees paid directly by the facility in the base year, will be included in the routine cost component. In addition to

43 **ROUTINE COST COMPONENT** (cont.)

any pharmacist consultant fees included in the base year rate, up to $2.50 per month per resident shall be allowed for drug regimen review.

(2) **Dietary Consultants**

Dietary Consultants, who are professionally qualified, may be employed by the facility or by the Department. The allowable amounts paid by the nursing facility to Dietary Consultants in the base year, when reasonable and non-duplicative of current staffing patterns, will be included in the routine cost component.

(3) **Medical Directors**

The base year cost of a Medical Director, who is responsible for implementation of resident care in the facility, is an allowable cost. The base year allowable cost will be established and limited to $10, 000.

43.5 **Principle**. Research Costs are not includable as allowable costs.

43.6 **Grants, Gifts, and Income from Endowments**

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

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

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

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

43 **ROUTINE COST COMPONENT** (cont.)

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

43.7 **Purchase Discounts and Allowances and Refunds of Expenses**

43.7.1 **Principle**. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

(1) **Discounts**. Discounts, in general, are reductions granted for the settlement of debts.

(2) **Allowances**. Allowances are deductions granted for damages, delay, shortage, imperfections, or other causes, excluding discounts and returns.

(3) **Refunds**. Refunds are amounts paid back or a credit allowed on account of an over-collection.

43.7.2 **Reduction of Costs**. All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

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

43.7.4 All discounts, allowances, and rebates received from the purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is

43 **ROUTINE COST COMPONENT** (cont.)

equitable and is in accord with that generally followed by other governmental programs and third-party organizations paying on the basis of costs.

43.8 **Principle. Advertising Expenses.** The reasonable and necessary expense of newspaper or other public media advertisements for the purpose of securing necessary employees is an allowable cost. No other advertising expenses are allowed.

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

43.10 **Costs Attributable to Asset Sales.** Costs attributable to the negotiation or settlement of a sale or purchase of any capital asset (by acquisition or merger) are not allowable costs.

Included among such unallowable costs are: legal fees, accounting and administrative costs, appraisal fees, costs of preparing a certificate of need, banking and broker fees, good will or other intangibles, travel costs and the costs of feasibility studies.

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

44 **FIXED COSTS COMPONENT**

44.1 All allowable costs not specified for inclusion in another cost category pursuant to these rules shall be included in the fixed cost component subject to the limitations set forth in these Principles. The base year costs for the fixed cost component shall be the costs incurred by the facility in the most recently audited fiscal year. Fixed costs include:

44.1.1 depreciation on buildings, fixed and movable equipment and motor vehicles.

44.1.2 depreciation on land improvements and amortization of leasehold improvements,

44.1.3 real estate and personal property taxes,

44.1.4 real estate insurance, including liability and fire insurance,

44.1.5 interest on long term debt,

44.1.7 rental expenses,

44.1.8 amortization of finance costs,

44.1.9 amortization of start-up costs and organizational costs,

44.1.10 motor vehicle insurance,

44 **FIXED COSTS COMPONENT** (cont.)

44.1.11 facility's liability insurance, including malpractice costs and workers compensation,

44.1.12 administrator in training,

44.1.13 water & sewer fees necessary for the initial connection to a sewer system/water system,

44.1.14 portion of the acquisition cost for the rights to a nursing facility license,

44.1.15 nursing facility health care provider tax.

See the explanations in Sections 44.2 - 44.13 for a more complete description of allowable costs in each of these cost centers.

44.2 **Principle.** An appropriate allowance for depreciation on buildings and equipment is an allowable cost.

44.2.1 The depreciation must be:

(1) Depreciation. Allowance for Depreciation Based on Asset Costs.

(2) Identified and recorded in the provider's accounting records.

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

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

Electric Components	20 years
Plumbing and Heating Components	25 years
Central Air Conditioning Unit	15 years
Elevator	20 years
Escalator	20 years
Central Vacuum Cleaning System	15 years
Generator	20 years

44.2.2 Any provider using the component depreciation method that has been audited and accepted for cost reporting purposes prior to April 1, 1980, will be allowed to continue using this depreciation mechanism.

44.2.3 Where an asset that has been used or depreciated under the program is donated to a provider, or where a provider acquires such assets through testate or in testate distribution, (e.g., a widow inherits a nursing facility upon the death of her husband and becomes a newly certified provider;) the basis of depreciation for the asset is the lesser of the fair market value, or the net

44 **FIXED COSTS COMPONENT** (cont.)

book value of the asset in the hands of the owner last participating in the program. The basis of depreciation shall be determined as of the date of donation or the date of death, whichever is applicable.

44.2.4 Special Reimbursement Provisions for Energy Efficient Improvements

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

CAPITAL EXPENDITURE

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

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

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

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

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

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

a. Insulation (fiberglass, cellulose, etc.)
b. Energy Efficient Windows or Doors for the outside of the facility, including insulating shades and shutters.
c. Caulking or Weather stripping for windows or doors for the outside of the facility.
d. Fans specially designed for circulation of heat inside the building.
e. Wood and Coal burning furnaces or boilers (not fireplaces).
f. Furnace Replacement burners that reduce the amount of fuel used.

44 **FIXED COSTS COMPONENT** (cont.)

g. Enetrol or other devices connected to furnaces to control heat usage.
h. A Device or Capital Expenditures for modifying an existing furnace that reduces the consumption of fuel.
i. Solar active systems for water and space heating.
j. Retrofitting structures for the purpose of creating or enhancing passive solar gain, if prior approved by the Department regardless of amount of expenditure. A request for prior approval will be evaluated by the Department on the basis of whether energy costs would be decreased to such an extent as to render the expenditure reasonable. The age and condition of the facility requesting approval will be also considered.
k. Any other energy saving devices that might qualify as Energy Efficient other than those listed above must be prior approved by the Department for this Special Reimbursement provision. The Department will evaluate a request for prior approval under recommendations from the Division of Energy Programs on what other items will qualify as an energy efficient device and that the energy savings device is a reliable product and the device would decrease the energy costs of the facility making the expenditure reasonable in nature.

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

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

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

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

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

44 **FIXED COSTS COMPONENT** (cont.)

(2) For facilities providing two (2) levels of care the allocation method to be used for allocating the interest, depreciation, property tax, and insurance will be based on the actual square footage utilized in each level of care. However, when new construction occurs that is added on to an existing facility the complete allocation based on square footage will not be used. Discrete costing will be used to determine the cost of the portion of the building used for each level of care and related fixed cost will be allocated on the basis of that cost.

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

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

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

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

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

44.2.9 **Gains and Losses on disposal of assets**. Gains and losses realized from the disposal of depreciable assets are to be included in the determination of allowable costs. The extent to which such gains and losses are includable is calculated on a proration basis recognizing the amount of depreciation charged under the program in relation to the amount of depreciation, if any, charged or assumed in a period prior to the provider's participation in the program, and in the current period. For sales of nursing facilities that occur on or after October 1, 2009, the Department shall either:

44 **FIXED COSTS COMPONENT** (cont.)

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

(a) The recapture will be made in cash from the seller. During the first eight (8) years of operation, all depreciation allowed on buildings and fixed equipment by the Department will be recaptured from the seller in cash at the time of the sale. From the ninth (9th) to the fifteenth (15th) year all but three percent (3%) per year will be recaptured and from the sixteenth (16th) to the twenty-fifth (25th) year, all but eight percent (8%) per year will be recaptured, not to exceed one hundred percent (100%). Recaptured accumulated depreciation, in any case, shall not exceed the extent of the gain on the sale.

(b) The buyer must demonstrate how the purchase price is allocated between depreciable and non-depreciable assets. The cost of land, building and equipment must be clearly documented. Unless there is a sales agreement specifically detailing each piece of moveable equipment, the gain on the sale will be determined by the total selling price of all moveable equipment compared to the book value at the time of the sale. No credits are allowed on moveable equipment.

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

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

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

44.2.10 **Limitation on the participation of capital expenditures**. Depreciation, interest, and other costs are not allowable with respect to any capital expenditure in plant and property, and equipment related to resident care, which has not been submitted to the designated planning agency as required, or has been determined to be consistent with health facility planning requirements.

44 **FIXED COSTS COMPONENT** (cont.)

44.3 **Purchase, Rental, Donation and Lease of Capital Assets**

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

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

(1)(B) Where a facility is purchased after April 1, 1980 by an individual related to the seller as:

(a) a child
(b) a grandchild
(c) a brother or sister
(d) a spouse of a child, grandchild, or brother or sister, or
(e) an entity controlled by a child, grandchild, brother, sister or spouse of child, grandchild or combination brother or sister thereof; or

(2) Accumulated depreciation of the seller under the program shall be considered as incurred by the purchaser for purposes of computing gains and applying the depreciation recapture rules in Subsection 44.2.9 to subsequent sales by the buyer. There will be no recapture of depreciation from the seller on a sale between stipulated related parties since no set-up in the basis of depreciable assets is permitted to the buyer.

(3) One-time exception to subsection 44.3.1(2). At the election of the seller, subsection 44.3.1(1) will not apply to a sale made to a buyer defined in subsection 44.3.1(2) if:

(a) the seller is an individual or any entity owned or controlled by individuals or related individuals who were selling assets to a "related party" as defined in subsection 44.3.1(1) or 44.3.1(2), and

(b) the seller has attained the age of fifty-five (55) before the date of such sale or exchange; and

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

(d) the seller has inherited the facility as property of a deceased spouse to satisfy the holding requirements under subsection 44.3.1(3)(c)

44 **FIXED COSTS COMPONENT** (cont.)

(e) if the seller makes a valid election to be exempted from the application of 44.3.1(2) the allowable basis of depreciable assets for reimbursement of interest and depreciation expense to the buyer will be determined in accordance with the historical cost as though the parties were not related. This transaction is subject to depreciation recapture if there is a gain on the sale.

(4) The one (1) exception to subsection 44.3.1(2) applies to individual owners and not to each facility. If an individual owns more than one (1) facility he must make the election as to which facility he wished to apply this exception.

(5) Limitation in the application of subsection 44.3.1(3)

a. Subsection 44.3.1(3) shall not apply to any sale or exchange by the seller if an election by the seller under subsection 44.3.1(3) with respect to any other sale or exchange has taken place.

b. Subsection 44.3.1(3) shall not apply to any sale or exchange by the seller unless the seller:

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

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

iii agrees to file an agreement with the Department of Health and Human Services to notify the Department that any acquisition as defined by the subsection 44.3.1(5)b, ii has occurred.

(6) If subsection 44.3.1(5)b is satisfied, subsection 44.3.1(1) and subsection 44.3.1(2) will also be satisfied.

(7) If the seller acquires any interest defined by subsection 44.3.1(5)b, ii, then pursuant to the agreement the basis will revert to what the seller's basis would be if the seller had continued to own the facility, the amounts paid by the Title XIX program for depreciation, interest and return of owner's equity from the increase in basis will be immediately recaptured, and an interest rate of nine percent (9%) per annum on recaptured moneys will be paid to the Department for sellers' use of Title XIX moneys. A credit against this, of the original amount of depreciation recapture from the seller, will be allowed, with any

44 **FIXED COSTS COMPONENT** (cont.)

remaining amount of the original depreciation recapture becoming the property of the Department.

44.3.2 **Basis of assets used under the program and donated to a provider**. Where an asset that has been used or depreciated under the program is donated to a provider, the basis of depreciation for the asset shall be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program. The net book value of the asset is defined as the depreciable basis used under the program by the asset's last participating owner less the depreciation recognized under the program.

44.3.3 Allowances for depreciation on assets financed with Federal or Public Funds. Depreciation is allowed on assets financed with Hill Burton or other Federal or Public Funds.

44.4 **Leases and Operations of Limited Partnerships**

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

(1) A copy of the signed lease agreement is required.

(2) An annual copy of the federal income tax return of the lessee will be made available to Representatives of the Department and of the U.S. Department of Health and Human Services in accordance with Section 27.

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

(4) If the lease is for the use of a building and/or fixed equipment, the annual federal income tax return of the lessor will be made available to representatives of the Department and the U.S. Department of Health and Human Services in accordance with Section 27.

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

(5) The lease must be for a minimum period of five (5) years if an unrelated organization is involved. If the lessor was to sell the property within the five (5) year period to a nursing home operator or the lessee, the historical cost for the new owner would be determined in accordance with the definition of historical costs, and the portion of the lease payment made in lieu of straight line depreciation will be

45 **FIXED COSTS COMPONENT** (cont.)

(6) (cont.) recaptured in accordance with subsection 44.2.9. This change will become effective when and if CMS approves this new language in the state plan.

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

44.4.3 **Leased Arrangement Between Individuals or Organizations Not Related by Common Control or Ownership**. A provider may lease a facility from an unrelated organization within the meaning of the Principles of Reimbursement. The allowable cost between two (2) unrelated organizations is the lesser of: (Sections 44.4.3(1) or 44.4.3(2).

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

(2) The actual lease payments made by the lessee to the lessor.

(3) The above principle applies unless either of the following limitations of the general rule applies:

(a) the lessor refinances and reduces the cost of ownership below the cost of lease payments and the lessee remains legally obligated to make the same lease payment despite the refinancing. This limitation of the general rule shall not apply to any lease entered into, renewed, or renegotiated after January 1, 1990;

(b) for all fiscal periods ending after June 30, 2007, for any lease entered into previous to January 1, 1990, the landlord and tenant renegotiate the amount of the lease payments due under the lease, without extending the lease term, such that the aggregate rental amounts due through the end of the lease term (taking into account any scheduled escalators and the obligation to pay any replacement reserve) are reduced by a reasonably projected amount of at least 15 %.

If either the limitation in (a) or the limitation in (b) applies, the allowable cost shall be the actual lease payments made by the lessee to the lessor. In applying limitation (b) above, the amount of any additional rent that is conditioned on profitability of the tenant shall be disregarded both in computing allowable cost and in determining the percentage reduction in projected, aggregate lease costs.

45 **FIXED COSTS COMPONENT** (cont.)

The determination of whether limitation (b) applies shall be made upon request of the provider based on proposed lease terms. If the applicability of limitation (b) is approved by the Department, it shall continue to apply for the remaining lease term.

(4) If the cost as defined in subsection 44.4.3(2) are less than the costs as defined in subsection 44.4.3(1), then the difference can be deferred to a subsequent fiscal period. If in a later fiscal period, costs as defined in subsection 44.4.3(2) exceed costs as defined in subsection 44.4.3(1), the deferred costs may begin to be amortized. Amortization will increase allowable costs up to the level of the actual lease payments for any given year. These deferred costs are not assets of the provider for purposes of calculating allowable costs of interest or return of owners equity and, except as specified, do not represent assets that a provider or creditor of a provider may claim is a monetary obligation from the Title XIX program.

(5) A lease payment to an unrelated party for moveable furnishings and equipment is an allowable cost, but it shall be limited to the cost of ownership on vehicles only.

(6) For facilities entering into, renewing, or renegotiating a lease on or after September 1, 1999, where the provider/lessee leases a nursing facility from an unrelated party and subsequently the lessor sells to another unrelated party, Sections 44.4.3(6)(a) and (b) shall apply.

(a) In cases where the original lessor sells, the lease payment and the terms of the original lease agreement, which have been prior approved by the Department, will be allowed. Should the lessee enter into, renew, extend, or renegotiate the original lease agreement, any terms of that lease agreement or payments related to it must be prior approved by the Department. Otherwise, the lesser of Principle 44.4.3(1) or 44.3.3(2) shall apply.

(b) For the provider/lessee entering into, renewing, or renegotiating a lease on or after September 1, 1999, the following four (4) conditions must be met:

i. Financing existing on September 1, 1999 must be through the Maine Health and Higher Educational Facilities Authority; and

ii. Approval is necessary in order for the Provider to obtain favorable refinancing, as determined by the Department; and

44 **FIXED COSTS COMPONENT** (cont.)

iii. In the Department's judgment, failure to approve may adversely affect resident care; and

iv. In the Department's judgment, approval will further the Department's goal of ensuring that public funds are only expended for services that are necessary for the well being of the citizens of Maine.

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

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

44.5 **Interest Expense**

44.5.1 **Principle**. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

44.5.2 **Interest**. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the costs incurred for funds borrowed for a relatively short term, usually one (1) year or less, but in no event more than fifteen (15) months. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans. Except as provided in subsection 44.5.4(6), interest does not include interest and penalties charged for failure to pay accounts when due.

44.5.3 **Necessary**. In order to be considered "necessary", interest must:

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

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

(3) **Proper**. Proper requires that interest:

44 FIXED COSTS COMPONENT (cont.)

a. Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

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

(4) **Refinancing**. Any refinancing of property mortgages or loans on fixed assets must be prior approved by the Department. If prior approval is not obtained any additional interest costs or finance charges will not be allowed.

44.5.4 **Borrower-lender relationship**

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

(2) **Exceptions** to the general rule regarding interest on loans from controlled sources of funds. Where the general fund of a provider borrows from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money borrowed from the funded depreciation account of the provider. In addition, if a provider of a facility operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost. Interest paid by the provider cannot exceed interest earned by the above subject funds.

(3) Where **funded depreciation** is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to resident care, or payment of long-term debt principle

44 FIXED COSTS COMPONENT (cont.)

once the principle payment exceeds the straight-line depreciation allowed under the Principles of Reimbursement, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation.

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

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

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

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

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

c. The late payment of property taxes results from the financial needs of the provider and does not result in excess funds; and

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

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

44.5.5 The Department will make adjustments to the nursing facility's fixed cost component of the per diem rate to reflect the effect of refinancing which results in lower interest payments.

44 **FIXED COSTS COMPONENT** (cont.)

44.7 **Insurance**. Reasonable and necessary costs of insurance involved in operating a facility are considered allowable costs (real estate insurance including liability and fire insurance are included as fixed costs - see subsection 44.1.4). Premiums paid on property not used for resident care are not allowed. Life insurance's premiums related to insurance on the lives of key employees where the provider is a direct or indirect beneficiary are not allowable costs. A provider is a direct beneficiary where, upon the death of the insured officer or key employee the insurance proceeds are payable directly to the provider. An example of a provider as an indirect beneficiary is the case where insurance on the lives of officers is required as part of a mortgage loan agreement entered into for a building program, and, upon the death of an insured officer the proceeds are payable to the lending institution as a credit against the loan balance. In this case, the provider is not a direct beneficiary because it does not receive the proceeds directly, but is, nevertheless, an indirect beneficiary since its liability on the loan is reduced.

44.7.1 Workers' Compensation Insurance premiums paid to an admitted carrier; application fees, assessments and premiums paid to an authorized fully-funded trust; and premiums paid to an individual self-insured program approved by the State of Maine for facility fiscal years that began on or after October 1, 1992, and deductibles paid by facilities related to such cost are allowable fixed costs. Estimated amounts for workers compensation insurance audit premiums will not be accepted as an allowable cost. The Department will require the facility to be a prudent and cost conscious buyer of Workers' Compensation Insurance. In those instances where the

Department finds that a facility pays more than the usual and customary rate or does not try to minimize costs, in the absence of clear justification, the Department may exclude excess costs in determining allowable costs under MaineCare. Allowable costs are subject to an experience modifier of 1.4; that is, cost associated with an experience modifier of 1.4 or under are allowable. Workers' Compensation costs incurred above the experience modifier of 1.4 shall be considered unallowable and will be settled at time of audit.

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

44 **FIXED COSTS COMPONENT** (cont.)

(2) The wages and fringes paid to workers engaged in formal Modified or Light-Duty Early-Return-To-Work Programs are allowable costs only to the extent that they cause a nursing facility to exceed its staffing pattern. Rehabilitation eligibility assessments are a cost to a limit of $300.00 per indemnity claimant. (Rehabilitation services provided to eligible injured workers are to be paid for by their employers insurer.)

44.8 **Administrator in Training**. The reasonable salary of an administrator in training will be accepted as an allowable cost for a period of six (6) months provided there is a set policy, in writing, stating the training program to be followed, position to be filled, and provided that this individual obtain an administrator's license and serve as an administrator of a facility in the State of Maine. Prior approval in writing, from the Department, must be issued in advance of the date of any salary paid to an administrator in training. A request for prior approval must be received by the Department at least two (2) weeks prior to the desired effective start date of the administrator in training program. Failure to receive approval from the Department for the Administrator in Training salary will deem that salary an unallowable cost at time of audit. Failure to become an administrator within one (1) year following completion of the examination to become a licensed administrator will result in the Department recovering one hundred percent (100%) of the amount allowed of the administrator in training. If the administrator in training discontinues the training program for any reason or fails to take the required examination to become a licensed administrator, one hundred percent (100%) of the amount allowed will be recovered by the Department.

44:9 **Acquisition Costs**. Fifty percent (50%) of the acquisition cost of the rights to a nursing facility license shall be approved as a fixed cost in those situations where the purchaser acquires the entire existing nursing facility license of a provider and delicenses all or a significant portion {at least fifty percent (50%)} of the beds associated with that license. This amount will be amortized over a ten (10) year period, beginning with the subsequent fiscal year after completion of the acquisition and delicensing. If any beds will be replaced as part of a Certificate of Need project, the amortization will begin as approved in the applicable Certificate of Need. This acquisition cost will not include any fees (e.g.: accounting, legal) associated with the acquisition.

44.10 **Occupancy Adjustment**

Facilities with Greater than Sixty (60) Beds. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of ninety percent (90%). For all new providers coming into the program, the ninety percent (90%) occupancy adjustment will not apply for the first ninety (90) days of operation. It will, however, apply to the remaining months of their initial operating period. The occupancy rate adjustment will be applied to fixed costs and shall be cost settled at the time of audit. Facilities With Sixty (60) or Fewer Beds. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than eighty-five percent (85%). The adjustment to the

44 **FIXED COSTS COMPONENT** (cont.)

44.10 **Occupancy Adjustment.** (cont.)

fixed cost component shall be based upon a theoretical level of occupancy of eighty-five percent (85%). For all new providers of sixty (60) or fewer beds coming into the program, the eighty-five percent (85%) occupancy adjustment will not apply for the first ninety (90) days of operation. It will, however, apply to the remaining months of their initial operating period. The occupancy rate adjustment will be applied to fixed costs and shall be cost settled at the time of audit.

44.11 **Start Up Costs Applicability**

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

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the Department need not be capitalized, but rather will be charges to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the Department, these costs need not be capitalized, but will be charged to operations in the periods incurred.

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

Where a provider prepares all portions of its facility for resident care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratable over a period of sixty (60) consecutive months beginning with the month in which the first resident is admitted for treatment.

44 **FIXED COSTS COMPONENT** (cont.)

Where a provider prorates portions of its facility for resident care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for resident care services during different periods of time.

44.12 **Nursing Facility Health Care Provider Tax.** Nursing facilities subject to the Health Care Provider Tax defined in state law 36 MRSA, Chapter 373 will have the tax treated as an allowable fixed cost. Only taxes actually collected by the Maine Revenue Services will be considered allowable.

50 **PUBLIC HEARING**

The State of Maine will provide for public hearings as necessary in our State Plan, according to State procedures.

60 **WAIVER**

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

70 **SPECIAL SERVICE ALLOWANCE**

70.1 **Principle.** A special ancillary service is to be distinguished from a service generally provided in the nursing facility.

70.1.1 A special ancillary service is that of an individual nature required in the case of a specific resident. This type of service is limited to professional services such as physical therapy, occupational therapy, and speech and hearing services. Special services of this nature must be billed monthly to the Department as separate items required for the care of individual members.

70.1.2 For eligible members, including those with other related conditions, the Department will reimburse community support services for persons with Development Disabilities in accordance with Chapter III, Section 21, Home and Community Benefits for Members with Mental Retardation or Autistic Disorder. The costs associated with community support are not included in the nursing facility per diem rate.

71 **OMNIBUS RECONCILIATION ACT OF 1987 (OBRA 87)**

OBRA 1987 has eliminated the distinction between ICFs and SNFs and the method of payment by such classifications. The statute provides for only one (1) type of nursing facility. All nursing homes are now classified as a "nursing facility" with a single payment methodology.

80 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE

80.1 **Principle.** For services provided on or after July 1, 2009, the Department will establish a prospective per diem rate to be paid to each facility until the end of its fiscal year. Each nursing facility's cost components for the fiscal year ending in 2005, as determined from the audited cost report (or as filed cost report) will be the basis for the base year computations (subject to upper limits). Allowable costs are separated into three (3) components - direct, routine and fixed costs.

The base year direct and routine cost component costs will be trended forward using the guidelines as described in Section 80.3 and 80.5, respectively. Thereafter, inflation will be based on Section 91. The prospective rate shall consist of three (3) components: the direct care cost component as defined in Section 41, the routine cost component as defined in Section 43, and the fixed cost component as defined in Section 44.

80.2 **Fixed Cost Component**

The fixed cost component shall be determined from the most recent audited or, if more recent information is approved by the Department, it shall be based on that more recent information using allowable costs as identified in Section 44. As described in Section 44, fixed costs will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to fixed costs shall be based upon a theoretical level of occupancy of ninety percent (90%). For all new providers coming into the program, the ninety percent (90%) occupancy adjustment will not apply for the first ninety (90) days of operation. It will, however, apply to the remaining months of their initial operating periods. To the extent that fixed costs are allowable, such cost will be adjusted for providers with sixty (60) or fewer beds whose annual level of occupancy is less than eighty-five percent (85%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of eighty-five percent (85%). The eighty-five percent (85%) occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after July 1, 1997, and shall be cost settled at the time of audit. For all new providers of sixty (60) or fewer beds coming into the program, the eighty-five percent (85%) occupancy adjustment will not apply for the first thirty (30) days of operation. It will, however, apply to the remaining months of their initial operating period.

80.3 **Direct Care Cost Component**

80.3.1 **Case Mix Reimbursement System**

(1) The direct care cost component utilizes a case mix reimbursement system. Case mix reimbursement takes into account the fact 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 form - MDS as specified in Section 41.2;

(b) the classification of residents into groups which are similar in resource utilization by use of the case mix resident classification groups as defined in Section 80.3.2;

80 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE (cont.)

(c) a weighting system which quantifies the relative costliness of caring for different classes of residents by direct care staff to determine a facility's case mix index.

80.3.2 **Case Mix Resident Classification Groups and Weights**

There are a total of forty-five (45) case mix resident classification groups, including one (1) resident classification group used when residents can not be classified into one (1) of the forty-four (44) clinical classification groups.

Each case mix classification group has a specific case mix weight as follows:

RESIDENT CLASSIFICATION GROUP CASE MIX WEIGHT

REHABILITATION

REHAB ULTRA HI/ADL	16 - 18	1.986
REHAB ULTRA HI/ADL	9 - 15	1.426
REHAB ULTRA HI/ADL	4 - 8	1.165
REHAB VERY HI/ADL	16 - 18	1.756
REHAB VERY HI/ADL	9 - 15	1.562
REHAB VERY HI/ADL	4 - 8	1.217
REHAB HI/ADL	13 - 18	1.897
REHAB HI/ADL	8 - 12	1.559
REHAB HI/ADL	4 - 7	1.260
REHAB MED/ADL	15 - 18	2.051
REHAB MED/ADL	8 - 14	1.635
REHAB MED/ADL	4 - 7	1.411
REHAB LOW/ADL	14 - 18	1.829
REHAB LOW/ADL	4 - 13	1.256

EXTENSIVE

EXTENSIVE 3/ADL	7-18/Head Injury – ADL	15 - 18	2.484
EXTENSIVE 2/ADL	7-18/Head Injury – ADL	10 - 14	2.057
EXTENSIVE 1/ADL	7-18/Head Injury – ADL	7 - 9	1.910

SPECIAL CARE

SPECIAL CARE/ADL	17 - 18	1.841
SPECIAL CARE/ADL	15 - 16	1.709
SPECIAL CARE/ADL	4 - 14	1.511

CLINICALLY COMPLEX

CLIN. COMP W/DEP/ADL	17 - 18D	1.826
CLIN. COMP/ADL	17 - 18	1.663
CLIN. COMP W/DEP/ADL	12 - 16D	1.503
CLIN. COMP/ADL	12 - 16	1.389
CLIN. COMP W/DEP/ADL	4 - 11D	1.331
CLIN. COMP/ADL	4 - 11	1.149

80 **ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE** (cont.)

IMPAIRED COGNITION

COG. IMPAIR W/RN REHAB/ADL	6 - 10	1.199
COG. IMPAIR/ADL	6 - 10	1.152
COG. IMPAIR W/RN REHAB/ADL	4 - 5	0.945
COG. IMPAIR/ADL	4 - 5	0.888

BEHAVIOR PROBLEMS

BEHAVE PROB W/RN REHAB/ADL	6 - 10	1.180
BEHAVE PROB/ADL	6 - 10	1.123
BEHAVE PROB W/RN REHAB/ADL	4 - 5	0.905
BEHAVE PROB/ADL	4 - 5	0.759

PHYSICAL FUNCTIONS

PHYSICAL W/RN REHAB/ADL	16 - 18	1.454
PHYSICAL/ADL	16 - 18	1.421
PHYSICAL W/RN REHAB/ADL	11 - 15	1.323
PHYSICAL/ADL	11 - 15	1.281
PHYSICAL W/RN REHAB/ADL	9 - 10	1.219
PHYSICAL/ADL	9 - 10	1.088
PHYSICAL W/RN REHAB/ADL	6 - 8	0.833
PHYSICAL/ADL	6 - 8	0.854
PHYSICAL W/RN REHAB/ADL	4 - 5	0.776
PHYSICAL ADL	4 - 5	0.749

UNCLASSIFIED 0.749

80.3.3 **Base Year Direct Care Cost Component**

(1) **Source of Base Year Cost Data.** The source for the direct care cost component of the base year cost data is the audited cost report (as filed cost report if an audit has not been completed) for the nursing facility's fiscal year ending in calendar year 2005, except for facilities whose MaineCare rates are determined in accordance with Sections 80.6 and 80.7. The total audited allowable direct care costs are divided by the total actual audited days. Recalculation of the upper limits shall not occur until subsequent rebasing of all components occurs.

(2) **Case Mix Index**

The Office of MaineCare Services shall compute each facility's case mix index for the base year as follows:

(a) For non-hospital based facilities, the number of MaineCare resident days in each case mix classification group shall be determined from the most recent MDS completed for all residents on each day during calendar year 2005 and received in the MDS CORE system by May15, 2008. For hospital based

80 **ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE** (cont.)

facilities, the number of MaineCare resident days in each case mix classification group shall be determined from the most recent MDS completed for all residents on each day during calendar year 2005 and received in the MDS CORE system by May 15, 2008. For new facilities, see 80.6.5.

(b) For each facility, the Office of MaineCare Services will multiply the number of MaineCare resident days in each case mix classification group excluding the resident days in the unclassified group by the case mix weight for the relevant classification group.

(c) The sum of these products divided by the total number of MaineCare resident days excluding the resident days in the unclassified group equals the facility's base year case mix index.

(d) **Direct Care Regional Index**

Each region's cost index shall be determined as follows:

i) The average case mix adjusted cost per day shall be calculated for each region from base year adjusted costs per day inflated to July 1, 2008.

ii) The lowest cost region shall be provided an index of 1.00. The other regional indices are computed by determining 50% of the percentage difference in cost between that region and the lowest cost region.

iii) The regional cost indices are as follows:

Region I – 1.10
Region II – 1.06
Region III – 1.02
Region IV – 1.00

(3) **Base year case mix and regionally adjusted MaineCare cost per day**

Each facility's direct care case mix adjusted cost per day will be calculated as follows:

(a) The facility's direct care cost per day, as specified in Section 80.3.3(1), is divided by the facility's base year case mix index and regional cost index to yield the case mix adjusted cost per day.

(4) **Array of the base year case mix and regionally adjusted cost per day**

If CMS approves, the direct care cost component is inflated from the end of the facility's base year to July 1, 2008 using the CMS Nursing

80 **ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE** (cont.)

Home without Capital Market Basket Index, Table 6.7, published in the IHS Global Insight HealthCare Cost Review, 1st Quarter Edition Index, 2009.

For each peer group (hospital based facilities, non-hospital based facilities with less than or equal to sixty (60) beds, and non-hospital based facilities with greater than sixty (60) beds), the Office of MaineCare Services shall array all nursing facilities case mix adjusted costs per day inflated to July 1, 2008 from high to low and identify the median.

b. If CMS approves, limits on the base year case mix and regionally adjusted cost per day. Within each peer group, the upper limit on the base year case mix and regionally adjusted cost per day shall be the median multiplied by 88.73%.

(6) Each facility's case mix adjusted direct care rate shall be the lesser of the limit in Section 80.3.3(5). or the facility's base year case mix and regionally adjusted cost per day multiplied by the regional cost index.

80.3.4 (A) **Calculation of the Direct Care Component**

Effective until MIHMS go-live, the Office of MaineCare Services shall compute the direct resident care cost component for each facility on a quarterly basis.

(1) **Calculation of the quarterly case mix index**

The Office of MaineCare Services shall compute each facility's quarterly case mix index for the rate period as follows:

For each facility the number of MaineCare residents in each case mix classification group shall be determined from the most recent MDS on all MaineCare residents in the facility as of the fifteenth (15th) day of the prior quarter (e.g. For an October 1 rate, the facility's case mix index would be computed using the most recent assessments of MaineCare residents with an assessment date of June 15.) In calculating the quarterly rate the Department will exclude those MaineCare residents in the nursing facility who have been approved by the Department for assisted living facility placement but who are "awaiting placement" into an assisted living facility.

For each facility, the Office of MaineCare Services will multiply the number of MaineCare 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 equals the facility's quarterly case mix index. The roster provided to the nursing facility for confirmation of residents in the nursing facility is relied upon by the Department in determining the residents in the nursing facility. It is the nursing

80 **ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE** (cont.)

facility's responsibility to check the roster and make corrections within one (1) week of the availability of the roster and submit such corrections to the Department or its designee. MDS Corrections for assessments used in the calculation of a facility's quarterly case mix index will not be considered in the calculation of the index when received in the MDS CORE system after the calculation of the rate by the Office of MaineCare Services. For purposes of this Section, resident assessments that are incomplete due to the death, discharge, or hospital admission of the resident during the time frame in which the assessment must be completed will not be included in the unclassified group or used to compute the case mix index. (Note: For MaineCare residents, the facility would be paid the facility rate for the number of days the resident is at the facility.)

(2) **Direct Care rate per day**

The direct care rate per day shall be computed by multiplying the allowable base year case mix and regionally adjusted cost per day by the applicable case mix and regional wage index.

(3) **Direct Care Add-on**

If CMS approves, the direct care rate shall be increased by twenty-five percent (25%) of the excess of the base year direct care cost inflated to July 1, 2008 over the direct care rate, as determined in 80.3.4(2) using the case mix index for the quarter beginning July 1, 2008 as the applicable case mix index for this calculation and limited to a maximum of fifteen dollars ($15.00) per day.

(4) **Hold Harmless Provision**

If CMS approves, the direct care rate as determined in 80.3.4(2) and 80.3.4 (3) may be further increased if the rate for quarter beginning July 1, 2010 is less than the direct care rate issued for July 1, 2008. If the July 1, 2010 rate is lower, the rate shall be increased by the smaller of the following two differentials:

1. the differential between the July 1, 2010 and July 1, 2008 direct care rates, as adjusted by the wage index and the case mix index for the quarter beginning July 1, 2008; or

2. the differential between the July 1, 2010 direct care rate and the allowable base year direct care cost per day inflated to July 1, 2008, as adjusted by the wage index and the case mix index for the quarter beginning July 1, 2008.

(5) **Staffing Ratios**

All facilities are responsible for meeting the minimum staffing ratios as outlined in 10-144, Chapter 110, Regulations Governing the Licensing

80 **ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE** (cont.)

and Functioning of Skilled Nursing Facilities and Nursing Facilities, Chapter 9.

(B) Effective upon MIHMS implementation the Office of MaineCare Services shall compute the direct resident care cost component for each facility as follows:

(1) **Direct Care rate per day**

The total direct care rate per day shall be computed by multiplying The inflated direct care rate by the applicable case mix index for the RUG group on the residents active assessment (OBRA assessment).

(2) **Direct Care Add-on**

If CMS approves, the direct care rate shall be increased by twenty-five percent (25%) of the excess of the base year direct care cost inflated to July 1, 2008 over the direct care rate, as determined in 80.3.4(2) using the case mix index for the quarter beginning July 1, 2008 as the applicable case mix index for this calculation and limited to a maximum of fifteen dollars ($15.00) per day. This direct care add-on is calculated one time and is included as a direct care add-on to the direct care rate.

(3) **Hold Harmless Provision**

If CMS approves, the direct care rate as determined in 80.3.4(2) and 80.3.4 (3) may be further increased if the rate for quarter beginning July 1, 2010 is less than the direct care rate issued for July 1, 2008. If the July 1, 2010 rate is lower, the rate shall be increased by the smaller of the following two differentials:

1. the differential between the July 1, 2010 and July 1, 2008 direct care rates, as adjusted by the wage index and the case mix index for the quarter beginning July 1, 2008; or

2. the differential between the July 1, 2010 direct care rate and the allowable base year direct care cost per day inflated to July 1, 2008, as adjusted by the wage index and the case mix index for the quarter beginning July 1, 2008.

(4) **Staffing Ratios**

All facilities are responsible for meeting the minimum staffing ratios as outlined in 10-144, Chapter 110, Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities, Chapter 9.

80 **ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE** (cont.)

80.3.5 Direct Care Cost Settlement

For dates of service beginning on or after July 1, 2009 facilities that incur allowable direct care costs during their fiscal year that are less than their average prospective rate for direct care will receive their actual cost.

Facilities, which incur allowable direct care costs during their fiscal year in excess of their average prospective rate for direct care, will receive no more than the amount allowed by the prospective rate.

80.4 Routine Cost Component

Routine Cost component base year rates shall be computed as follows:

80.5.1 Using each facilities base year (year ending in calendar year 2005) audited cost report, the provider's base year total allowable routine costs shall be determined in accordance with Section 43.

80.5.2 The base year per diem allowable routine care costs for each facility shall be calculated by dividing the base year total allowable routine care costs by the total Base Year resident days.

80.5.3 If CMS approves, the routine cost component is inflated from the end of the facility's base year to July 1, 2008 using the CMS Nursing Home Without Capital Market Basket Index, Table 6.7, published in the IHS Global Insight Healthcare Cost Review, 1st Quarter Index, 2009. In lieu of the Staff Enhancement Payment (SEP), formerly outlined in principle 101, an additional inflation of 12.37% will be applied through SFY 2011. For each peer group (hospital based facilities, non-hospital based facilities with less than or equal to sixty (60) beds, and non-hospital based facilities with greater than sixty (60) beds), the Office of MaineCare Services shall array all nursing facilities base year costs per day inflated to July 1, 2011 from high to low and identify the median.

80.5.4 If CMS approves, for each peer group, the upper limit on the base year cost per day shall be the median multiplied by 88.73%.

80.5.5 Each facility's Base Year Routine Care cost per diem rate shall be the lesser of the limit set in Subsection 80.5.4 or the facility's base year per diem allowable routine care costs inflated to July 1, 2011.

80.5.6 **Routine Hold Harmless Provision**

If CMS approves, the routine rate may be further increased if the rate for the quarter beginning July 1, 2010 is less than the rate issued July 1, 2008. If the July 1, 2010 rate is lower, then the rate shall be increased by the smaller of the following two differentials:

1. the differential between the July 1, 2010 and July 1, 2008 routine rates; or

2. the differential between the July 1, 2010 routine rate and the allowable base year routine costs per day inflated to the July 1, 2011.

80 **ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE** (cont.)

80.5.7 **Routine Cost Settlement.** Effective for fiscal years beginning on or after October 1, 2001, facilities that incur allowable routine costs less than their prospective rate for routine costs may retain any savings as long as it is used to cover direct care costs. Facilities that incur allowable routine costs during their fiscal year in excess of the routine cost component of the prospective rate will receive no more than the amount allowed by the prospective rate.

80.6 **Rates for Facilities Recently Sold, Renovated or New Facilities**

80.6.1 A nursing home project that proposes renovation, replacement or other actions that will increase MaineCare costs and for which an application is filed after March 1, 1993 may be approved only if appropriations have been made by the Legislature expressly for the purpose of meeting those costs. The basis for establishing the facility's rate through the certificate of need review is the lesser of the rate supported by the costs submitted by the applicant or the statewide base year median for the direct and routine cost components inflated to the current period. The fixed costs determined through the Certificate of Need review process must be approved by the Office of MaineCare Services (also see Section 44.2.5(2).

(1) For a facility sold after October 1, 1993, the direct and routine rate shall be the lesser of the rate of the seller or the rate supported by the costs submitted by the purchaser of the facility. The fixed cost component recognized by the MaineCare Program will be determined through the Certificate of Need review process. Fixed costs determined through the certificate of need review process must be approved by the Office of MaineCare Services.

80.6.2 Nursing facility's not required to file a certificate of need application, currently participating in the MaineCare Program, that undergo replacement and/or renovation will have their appropriate cost components adjusted to reflect any change in allocated costs. However, the rates established for the affected cost components will not exceed the state median rates for facilities in its peer group. In those instances that the data supplied by the nursing facility to the Department indicates that any one (1) component rate should be less than the current rate the Department will assign the lower rate for that component to the nursing facility.

80.6.3 The reimbursement rates set, as stated in Sections 80.6.1 and 80.6.2, will remain in effect for the period of three (3) years from the date that they are set under these Principles.

80.6.4 At the conclusion of the three (3) years, the reimbursement rate will be rebased to the fiscal year stated in Sections 41.3.1 and 43 or the most recent audited fiscal year occurring after the opening of the new facility, the completion of the new renovation, or the sale of the facility, whichever is the most current.

80 **ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE** (cont.)

80.7 **Nursing Home Conversions**

80.7.1 In reference to Public Law 1981, c. 705, Pt. V, § 304, the following guidelines have been established in relation to how nursing facilities that convert nursing facility beds to residential care beds will be reimbursed. As required by §90.4, the savings incurred as a result of delicensing nursing facility beds must be returned to the MaineCare funding pool.

(1) A pro forma step down cost report for the year in which the bed conversion will take place or the first full fiscal year in which the facility will operate with both nursing facility and residential care facility levels of care will be submitted to the Office of Elder Services and to the Division of Reimbursement and Financial Services of the Office of MaineCare Services.

(2) Based on an analysis of the cost report by the Department, the allowable costs will be determined based on the Principles of Reimbursement for Nursing Facilities contained herein.

(3) The occupancy level that will be used in the calculation of the rate will be set at the days included on the pro forma cost report submitted at the time of the conversion or at the ninety-five percent (95%) occupancy level, whichever is greater.

(4) The case mix index will be determined as stated in Sections 41.2, 80.3.1, 80.3.2, and 80.3.3(2).

(5) The upper limits for the direct and routine care cost components will be inflated forward to the end of the fiscal year of the pro forma cost report submitted as required in Section 80.7.1(1).

(6) The reimbursement rates set, as stated in Sections 80.7.1(1) and 80.7.1(5), will remain in effect for the period of three (3) years from the date that they are set under these Principles. The direct and routine components will be inflated to the current year, subject to the peer group cap. Reimbursement rates and all rate letters will have an effective date of the first day of the subsequent month after the date of the licensure change.

(7) At the conclusion of the three (3) years, the reimbursement rate will be rebased to the fiscal year stated in Sections 41.3.1 and 43 or the most recent audited full fiscal year occurring after the conversion of nursing facility beds to residential care beds, whichever is the most current.

(8) Section 80.7 is effective for nursing facilities with the effective date of conversion of nursing facility beds to residential care facility beds occurring on or after January 1, 1996.

81 **INTERIM AND SUBSEQUENT RATES**

81.1 **Interim Rate and Subsequent Year Rates.** Fifteen (15) days prior to the beginning of the State fiscal year, an interim rate will be established by using the fixed cost component of the latest audited cost report and adding to it the inflated routine cost components of the base year. The interim rate in subsequent fiscal years will be determined in the same manner as outlined above. The direct cost component is computed as specified in Section 80.3.4.

81.2 **Fixed costs** may be adjusted upon request of the provider when sufficient documentation (determined by the DHHS) has been provided to the Department. These adjustments will be effective with the next issuance of an interim rate.

82 **FINAL PROSPECTIVE RATE**

Upon final audit of all nursing facility's base year cost reports, the Department will determine a final prospective rate.

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

84 **FINAL AUDIT OF FIRST AND SUBSEQUENT PROSPECTIVE YEARS**

84.1 **Principle.** All facilities will be required to submit a cost report in accordance with Section 32 at the end of their fiscal year on cost report forms approved by the Department. The Department will conduct a final audit of each facility's cost report, which may consist of a full scope examination by Department personnel and which will be conducted on an annual basis.

84.2 Upon final audit of a facility's cost report for the first and subsequent prospective years, the Department will:

84.2.1 Determine the actual allowable fixed costs incurred by the facility during the cost reporting period,

84.2.2 Determine the occupancy levels of the nursing facility,

84.2.3 Determine reimbursable direct care costs incurred by the facility during the reporting period per Section 80.3.5.

84.2.4 Determine the actual allowable routine costs incurred by the facility during the cost reporting period per Section 80.5.6.

84.2.5 Calculate a final rate.

84.2.6 Determine final settlement by calculating the difference between the audited final rate and the interim rate(s) paid to the provider times the MaineCare utilization.

84 **FINAL AUDIT OF FIRST AND SUBSEQUENT PROSPECTIVE YEARS** (cont.)

Nursing facilities that transfer a cost center from one (1) cost component to another cost component resulting in increased MaineCare costs will have the affected cost components adjusted at time of audit.

Upon final audit of a facility's cost report, the Department will calculate a final prospective rate and determine the lump sum settlement amount either due to or from the nursing facility.

The Office of Audit final audit adjustment to the nursing facility's annual cost report will consider the impact of days waiting placement as specified in the Principles of Reimbursement for Residential Care Facilities. Fixed cost reimbursement for the nursing facility will not be affected by days waiting placement reimbursement to the nursing facilities.

85 **SETTLEMENT OF FIXED EXPENSES**

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

85.2 Federal regulations state that during the first year of implementing the nursing home reform requirements, the new costs that a facility must incur to comply with these requirements will be treated as a fixed cost. The facility must maintain the appropriate documentation in order for these costs to be identified at the time of the facility's final audit.

The cost associated with meeting the Nursing Home Reform Act of 1987 requirements will continue to be treated as a fixed cost through the facility's first full fiscal year after September 30, 1991 and will not be included in the determination of incentive payments which the facility might be entitled to receive as a result of its performance during that year. Thereafter, the cost associated with implementing the Nursing Home Reform Act of 1987 will be considered in the appropriate cost component and will be added to the facility's final prospective rate.

Upon final audit of a facility's cost report, if the Department's share of the allowable OBRA costs actually incurred by the facility is greater than the amount paid by the Department, the Department will pay the facility the difference. If on the other hand, the Department's appropriate share of the allowable OBRA costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.

86 **ESTABLISHMENT OF PEER GROUP**

86.1 **Establishment of Peer Group**. All Nursing care facilities will be included in one (1) of three (3) peer groups. Hospital based nursing facilities (excluding governmental institutions) will comprise one (1) peer group, non-hospital based facilities with sixty (60) or fewer beds will compose a second peer group, and non-hospital based facilities with more than sixty (60) beds will compose the third peer group. Please refer to Section 13 for a description of a hospital-affiliated nursing facility. For determining the Medicare upper limit, it should be noted that the establishment of these three (3) peer groups in developing a payment model is not an accepted model in determining the upper limits as established by Federal Statute. The Federal Statute recognizes free standing nursing facilities in determining the upper limit. The upper limit for hospital-based facilities is based on one-half the routine costs of freestanding facilities and one-half the costs of hospital based facilities. Therefore, the appropriate Medicare upper limit test will be applied to all nursing facilities.

88 **CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS**

Upon determination of the final rate as outlined in Section 84 above, the Department will calculate the net amount of any overpayments or underpayments made to the facility.

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

If a facility appeals a determination of overpayment, the facility must repay within sixty (60) days of the notice of overpayment all portions of the determined overpayment except those that are expressly disputed and for which specific dollar values are identified. Repayment of each such specifically disputed portion and identified amount shall be stayed pending resolution of the dispute with respect thereto. The amount of money in dispute must be identified in the manner outlined in Section 152.

The net amount of any over or underpayment made to the facility will be based on 1) the calculation of actual fixed expenses incurred in the prior year and 2) the estimated difference in amount due or paid based on the interim versus final prospective rate.

89 **BEDBANKING OF NURSING FACILITY BEDS**

89.1 Any bed-banking request must be submitted to the Department for review by the Office of Elder Services and the Office of MaineCare Services. Nursing facilities are permitted to bank nursing facility beds, according to the guidelines contained in Title 22, Chapter 103A, Section 333, providing the space left vacant in the facility is not used for the creation of private rooms. In addition to those guidelines, a floor plan must be submitted

89 **BEDBANKING OF NURSING FACILITY BEDS** (cont.)

to the Office of Elder Services that describes the intended use of the banked bed spaces. This floor plan will be reviewed by the Department. Reimbursement of costs associated with the banked beds will be allowed to the extent that such costs have been approved by the Department. Reasons that the Department may deny the space as reimbursable under these Principles includes, but is not limited to, the following:

89.1.1 the use of the space is not reimbursable under the criteria contained in these Principles,

89.1.2 the proposed purpose of the use of the space has already been designated by other space within the facility and this would constitute duplication of use,

89.1.3 the proposed use of the space is not deemed to be in the best interest of the physical, emotional, and safety needs of the residents (In this case, a recommendation by the Department may be made for an alternative use of the space).

89.2 Pursuant to Title 22, Chapter 103A, Section 333, the following cost components shall be decreased by a percentage equal to the percentage of bed days decreased by the banking of the beds. Total bed days used to calculate this percentage will be the audited days (as filed if audited days are not available) from the base year cost report. (e.g. If a facility decreased the number of beds by twenty-five percent (25%), and the total bed days in the base year equals 40,000 and the facility was at ninety percent (90%) occupancy = 36,000 days, then the bed days used in the calculation of the rate after the bedbanking would equal ninety percent (90%) of 30,000 days or 27,000 days.) This percentage decrease would be used in the calculation of the new rate for the following cost components based on what the total audited costs (as filed, if audited costs are not available) in the base year:

89.2.1 **Routine Cost Component**

(1) Administrative and Management Ceiling.
(2) Housekeeping Supplies
(3) Laundry Supplies
(4) Dietary Supplies
(5) Patient Activity Supplies
(6) Food Costs

89.3 **Direct Care Cost Component** - The Direct Care Cost Component will be decreased, subject to Licensing and Certification Regulations, by a percentage equal to fifty percent (50%) of the total percentage decrease based on the audited costs (as filed, if audited costs are not available) in the base year for the following areas:

89.3.1 RNs

89.3.2 LPNs

89.3.3 CNAs, CNAs-M

89 **BEDBANKING OF NURSING FACILITY BEDS** (cont.)

89.3.4 Contract Nursing

89.3.5 Payroll Benefits and taxes for 89.31 through 89.34

89.3.6 Medical Supplies/Medicine and Drugs

(e.g. Using the example in Section 89.2 of a twenty-five percent (25%) decrease, if the total audited costs (as filed, if audited costs are not available) of the RNs, LPNs, CNAs, CNAs-M, Contract Nursing, and benefits and taxes and medical supplies/medicine and drugs were $400,000 in the base year, the allowable costs for this component would be reduced by $50,000 or twelve and one half percent (12.5%). The ratio of labor costs to benefits and taxes as contained in the base year cost report would be used in the determination of the amounts decreased in each of those areas.) Reimbursement rates and all rate letters will have an effective date of the first day of the subsequent month after the date of the licensure change.)

90 **DECERTIFICATION/DELICENSING OF NURSING FACILITY BEDS**

90.1 Any request for delicensing/decertification of nursing facility beds must be submitted to the Department for review by Office of MaineCare Services. In addition to those guidelines, a floor plan must be submitted to the Office of MaineCare Services that describes the intended use, if any, of the space that the beds previously occupied. This floor plan will be reviewed by the Department. Reasons that the Department may deny the space as reimbursable under these Principles includes, but is not limited to, the following:

90.1.1 the use of the space is not reimbursable under the criteria contained in these Principles,

90.1.2 the proposed purpose of the use of the space has already been designated by other space within the facility and this would constitute duplication of use,

90.1.3 the proposed use of the space is not deemed to be in the best interest of the physical, emotional, and safety needs of the residents (In this case, a recommendation by the Department may be made for an alternative use of the space

90.2 The following cost components shall be decreased by a percentage equal to the percentage of bed days decreased by the delicensing/decertification of the beds. Total bed days used to calculate this percentage will be the audited days (as filed if audited days are not available) from the base year cost report. The example used in Section 89.2 to also applicable to this Section. This percentage decrease would be used in the calculation of the new rate for the following cost components based on what the total audited costs (as filed, if audited costs are not available) in the base year:

90.2.1 **Routine Cost Component**

(1) Administrative and Management Ceiling.
(2) Housekeeping Supplies

90 **DECERTIFICATION/DELICENSING OF NURSING FACILITY BEDS** (cont.)

(3) Laundry Supplies
(4) Dietary Supplies
(5) Patient Activity Supplies
(6) Food Costs

90.3 **Direct Care Cost Component** - The Direct Care Cost Component will be decreased, subject to Licensing and Certification Regulations, by a percentage equal to fifty percent (50%) of the total percentage decrease based on the audited costs (as filed, if audited costs are not available) in the base year for the following areas:

90.3.1 RNs

90.3.2 LPNs

90.3.3 CNAs, CNAs-M

90.3.4 Contract Nursing

90.3.5 Payroll Benefits and taxes for 90.31 through 90.34.

90.3.6 Medical Supplies/Medicine and Drugs

(e.g. Using the example in Section 89.2 of a twenty-five percent (25%) decrease, if the total audited costs (as filed, if audited costs are not available) of the RNs, LPNs, CNAs, CNAs-M, Contract Nursing, and benefits and taxes were $400,000 in the base year, the allowable costs for this component would be reduced by $50,000 or twelve and one half percent (12.5%). The ratio of labor costs to benefits and taxes as contained in the base year cost report would be used in the determination of the amounts decreased in each of those areas.) Reimbursement rates and all rate letters will have an effective date of the first day of the subsequent month after the date of the licensure change.)

90.4 MaineCare savings derived from the delicensing of nursing facility beds must be credited to the MaineCare funding pool, in accordance with 22 MRSA §333-A. Pursuant to 22 MRSA §329(6), the nursing facility savings are not available to fund new MaineCare residential care beds.

91 **INFLATION ADJUSTMENT** – Cost of Living Adjustment (COLA)

The Department will notify the nursing facilities, through rule change, of what the COLA will be, for what applicable fiscal period, and will specify the COLA in terms of a percentage change.

Effective 3/3/12

91.1 If CMS approves, the COLA will be 2% effective October 1, 2011. For those applicable fiscal periods where a COLA will be made, and the Department has sent forth the above notice, the following will apply:

91.1.1 Total wages, as set forth in Principle 24.5, and benefits, as set forth in Principle 1.1.7, for "front line employees," as defined in the Definitions subsection of this Section, be divided by total worked hours to determine the average wage and

91 **INFLATION ADJUSTMENT** – Cost of Living Adjustment (COLA) (cont.)

benefit rate per hour for front line employees for the applicable fiscal period in which a COLA has been made.

91.1.2 This average wage and benefit rate per hour will be compared to the average wage and benefit rate per hour for the fiscal period immediately prior to the period of the COLA in order to determine a percentage change in the average wage and benefit rate per hour.

91.1.3 Nursing facilities must demonstrate a percentage change in the average wage and benefit rate per hour for front line employees that is equal to or greater than the COLA as specified in the Department's notice.

91.1.4 If the percentage change in the average wage and benefit rate per hour is less than the COLA as specified within this rule, the Department will recoup, at time of audit, the difference between what the average wage and benefit rate per hour for front line employees was for the applicable fiscal period, and what it should have been if it had exactly matched the COLA as specified within this rule.

92 **REGIONS**

The regions, for DHS analysis purposes, are:

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

93 **DAYS WAITING PLACEMENT**

Reimbursement to nursing facilities for days waiting placement are governed by the regulations specified in the Principles of Reimbursement for Residential Care Facilities.

120 **EXTRAORDINARY CIRCUMSTANCE ALLOWANCE**

Facilities which experience unforeseen and uncontrollable events during a year that result in unforeseen or uncontrollable increases in expenses may request an adjustment to a prospective rate in the form of an extraordinary circumstance allowance. Extraordinary circumstances include, but are not limited to:

* events of a catastrophic nature (fire, flood, etc.)
* unforeseen increase in minimum wage, Social Security, or employee retirement contribution expenses in lieu of social security expenses
* changes in the number of licensed beds
* changes in licensure or accreditation requirements

120 **EXTRAORDINARY CIRCUMSTANCE ALLOWANCE (cont.)**

If the Department concludes that an extraordinary circumstance existed, an adjustment will be made by the Department in the form of a supplemental allowance.

The Department will determine from the nature of the extraordinary circumstance whether it would have a continuing impact and therefore whether the allowance should be included in the computation of the base rate for the succeeding year.

130 **ADJUSTMENTS**

130.1 **Adjustment for Unrestricted Grants or Gifts**. Unrestricted Federal or State grants or gifts received by a facility and which have been deducted from operating costs for purposes of reimbursement will be added back to the direct resident care and routine cost component for purposes of calculating a base rate.

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

130.3 **Adjustments for Capital Costs**. The Department will adjust the fixed cost component of an interim or final prospective rate to reflect increases or decreases in capital costs. For example costs which have been approved under the Maine Certificate of Need Act or refinancing.

140 **APPEAL PROCEDURES-START UP COSTS-DEFICIENCY RATE - RATE LIMITATION**

140.1 **Appeal Procedures**

140.1.1 A facility may administratively appeal any of the following types of Office of Audit determinations:

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

140.1.2 An administrative appeal will proceed in the following manner:

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

(2) The Director or his/her designee shall notify the facility in writing of the decision made as a result of the informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer

140 **APPEAL PROCEDURES-START UP COSTS-DEFICIENCY RATE - RATE LIMITATION (cont.)**

140.1 Appeal Procedures (cont.)

140.1.2 An administrative appeal will proceed in the following manner: (cont.)

designated by the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within thirty (30) days of receipt of the decision made as a result of the informal review.

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

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

152 **DEFICIENCY PER DIEM RATE**

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

152.1 Staffing over a period of two (2) weeks or more does not meet the Federal Certification and State Licensing requirements, except where there is written documentation of a good faith effort to employ licensed nurses to meet the licensed nurse requirements over and above the full time director of nursing;

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

152.3 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 thirty (30) days from written notification that such deficiencies exist;

152.4 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;

152.5 Failure to submit a cost report, financial statements, and other schedules as requested by the Office 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. The deficiency per diem rate for these items will go into effect immediately upon receipt of written notification from the Department.

152.6 Failures to correct MDS, as requested in writing, and submit within the specified time outlined in Section 41.2.1 of these Principles of Reimbursement. A reduction in rate because of deficiencies shall remain in effect until the deficiencies have been corrected, as verified by representatives of the Department, following written notification by the provider that the deficiencies no longer exist. No retroactive adjustments to the full rate shall be made for the 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.

160 **INTENSIVE REHABILITATION NF SERVICES FOR BRAIN INJURED INDIVIDUALS (BI)**

It has been determined that the reasonable cost of comprehensive rehabilitative services of brain injury is an allowable cost. This requires that the facility possess characteristics, both in terms of staffing and physical design, which meet the requirements of providing comprehensive rehabilitative BI services. The Department will require that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with the BI unit from the Office of MaineCare Services. In the event a facility believes that the needs of the residents it serves have increased or decreased, the facility must request prior approval from the Office of MaineCare Services authorizing such a change to its staffing pattern/reimbursement rate.

The Department will recognize NF-BI services when they are a distinct part of a dual licensed nursing facility. The facility will be reimbursed for the average annual per diem cost for BI rehabilitative services, for individuals classified as eligible for BI services in accordance with Chapter II, Section 67 of the MaineCare Benefits Manual. There can be no duplication of services with other providers if clinical and therapy services are included in the facility's staffing/reimbursement rate.

160.1 **Principle.** A nursing facility which has a recognized BI unit will be reimbursed for services provided to members covered under MaineCare based upon the actual cost of services provided. The Department will establish the rate and determine that the cost is reasonable and adequate to be 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.

160.2 **Cost.** The Department's payments made for allowable BI services provided will be based on the actual cost of services provided. The allowable per diem cost for BI services will include a direct care price, a routine service component, a rehabilitative ancillary service component, and a fixed cost component.

160.2.1 The direct care price will be determined by the Office of MaineCare Services. It will be increased annually by the rate of inflation, as defined in Section 91, at the beginning of a facility's fiscal year. This direct care price is not subject to audit. The Direct Care price times the number of Brain Injury days of service will be removed from the total Direct Care Cost in determining the allowable cost for the NF level of care.

160.2.2 The Routine Cost component rate will be increased annually by the rate of inflation, as defined in Section 91, at the beginning of a facility's fiscal year. These routine costs will be cost settled on an annual basis at the end of the facility's fiscal year. They will be based on actual costs allocated to Brain Injury services in accordance with the allocations defined in Section 22.10 of these Principles.

160.2.3 Rehabilitative ancillary services included in the care of a brain injured individual residing in a recognized BI unit shall be considered an allowable cost. Covered ancillary services must meet the requirements and definitions under Medicare regulations. These rehabilitative costs will be increased annually by the rate of inflation, as defined in Section 91, at the beginning of a facility's fiscal year.

160 **INTENSIVE REHABILITATION NF SERVICES FOR BRAIN INJURED INDIVIDUALS (BI)** (cont.)

These costs will be cost settled on an annual basis at the end of the facility's fiscal year. They will be based on actual costs allocated to Brain Injury services in accordance will the allocations defined in Section 22.10 of these Principles.

160.2.4 **Fixed Costs.** Fixed Costs are an allowable cost as defined in Section 44 of these Principles. These costs will be cost settled on an annual basis at the end of the facility's fiscal year. They will be based on actual costs allocated to Brain Injury services in accordance will the allocations defined in Section 22.10 of these Principles.

160.3 **Rehabilitative ancillary services** are not subject to the routine service cost limitations.

Rehabilitative ancillary services include:

- Physical Therapy Services
- Occupational Therapy Services
- Speech Pathology Services
- Respiratory Therapy Services
- Recreational Therapy Services
- Physiatry Evaluation and Consultation Services
- Neuropsychology Evaluation and Consultation Services
- Psychology Evaluation and Consultation Services

160.4 **Cost Reporting.** Costs will be reported on forms provided by the Department that will segregate NF-BI routine costs and BI ancillary costs from standard NF costs.

For the purpose of calculating a separate NF-BI rate, whether interim or final, a facility that has been granted a special NF-BI rate for a distinct part shall allocate its costs to the distinct part as the distinct part were licensed as a separate level of care. All other principles pertaining to that allowability, recording and reporting of costs shall apply.

171 **COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS**

Community-based specialty nursing facility units providing services under contract with the Department to former residents of the Riverview Psychiatric Center (formerly Augusta Mental Health Institute) and the Bangor Mental Health Institute (BMHI). The Department may designate specialty nursing facility units that provide special services under contract with the Department to former residents of the Riverview Psychiatric Center and the Bangor Mental Health Institute. It has been determined that the reasonable cost of services for these residents, who have multiple medical needs that make them eligible for nursing facility level of care and have a primary diagnosis of mental illness that requires the ongoing supervision of trained professionals, is an allowable cost. This requires the nursing facility unit to possess characteristics, both in terms of staffing and physical design, for providing services to these residents.

Such designated specialty units shall be subject to the provision of these rules, except for the rate limitations contained in Sections 80 - 86.

171 **COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS** (cont.)

The Department will require that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with these facilities from the Office of MaineCare Services. In the event a facility believes that the needs of the residents it serves have increased or decreased, the facility must request prior approval from the Office of MaineCare Services authorizing such a change to its staffing pattern.

171.1 **Principle.** A nursing facility that is recognized as a specialty unit under this Section will be reimbursed for services provided to residents covered under the Title XIX program based upon the actual cost of services provided. The Department will establish the rate and determine that the cost is reasonable and adequate to be 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.

171.2 **Cost.** The Department's payments made for allowable services provided will be based on the actual allowable cost of services provided to such residents. The allowable per diem cost for the services will be increased annually by the rate of inflation at the beginning of each facility's fiscal year based on Section 91. This per diem rate is subject to audit and will be adjusted to the actual allowable costs of providing services to such residents in these units at year end.

171.3 **Cost Reporting.** Costs will be reported in a manner that will segregate the costs of such residents in the specialty unit from the costs of other residents in the unit and the standard nursing facility's costs as apply under these Principles.

For the purpose of calculating the reimbursement rate for such residents in the specialty unit, whether interim or final, a facility that has been designated as a specialty unit under this Section of the Principles for a distinct part shall allocate the costs of such residents in the distinct part as if the distinct part were licensed as a separate level of care.
All other sections of theses Principles pertaining to the allowability, recording, and reporting of costs shall apply.

172 **PUBLICLY OWNED NURSING FACILITIES**

172.1 For publicly owned nursing facilities, as defined in Section 13 of this Section, the total MaineCare per diem funds must not exceed the lesser of the facility's Medicaid allowable costs as reflected on the Medicare cost report or the Medicare rate of reimbursement. Such designated publicly owned nursing facilities shall be subject to the provisions of the rules contained in the Principles of Reimbursement for Nursing Facilities.

173 **REMOTE ISLAND NURSING FACILITIES**

The following is subject to CMS approval:

173.1 In order to qualify as a remote island nursing facility, a nursing facility must meet all of the following criteria:

1. The nursing facility must be located on an island, and
2. must have less than 30 licensed NF beds, and
3. must not be physically located within a hospital, and
4. must not have any licensed residential care beds, and
5. must maintain Medicaid (MaineCare) utilization of 95% or greater.

173 REMOTE ISLAND NURSING FACILITIES (cont.)

173.2 **Principle**. A nursing facility that qualifies as a remote island nursing facility under this section will be reimbursed for services provided to residents covered under the Title XIX program based upon the actual allowable cost of services provided.

173.3 **Rate setting**. Annually, at the beginning of each facility's fiscal year, the Department will establish the rate based on the latest audited cost report. The allowable per diem cost for the services will be inflated to the beginning of the facility's fiscal year based on Section 91. If the facility experiences cost increases in excess of the current interim rate, the provider can request to have the interim rate adjusted. The written request along with the supporting documentation for the rate adjustment should be submitted to:

Department of Health and Human Services
Director, Rate Setting Unit
11 State House Station
Augusta, ME 04333

The Director will review the request and determine if a rate adjustment is necessary.

173.4 **Audit**. The per diem rate is subject to year-end audit and will be adjusted to the actual allowable costs of providing services to eligible residents during the year.

Except for Sections 43.4.2(A), (B), (C), 80-86 and 101, all other sections of these principles pertaining to the allowability, recording, and reporting of costs shall apply.

APPENDIX A:

CERTIFIED NURSES AIDE TRAINING PROGRAMS

Principle. Effective for CNA training programs beginning on or after January 1, 2001, the median plus ten percent (10%) of costs per student paid by the Department for state fiscal year ending in 1998 to qualify individuals as certified nurses aides is reimbursable under the MaineCare Program. These programs must be conducted in accordance with the requirements of the Maine Board of Nursing for education programs for nurse's aides. To be allowable these programs must be conducted within a licensed nursing facility within the State of Maine or under contract with an educational institute whereby the classroom instruction may be provided in the educational facility, but the supervised clinical experience must be within the licensed nursing facility receiving reimbursement under the "Principles of Reimbursement for Long-Term Care Facilities".

Definitions

1. **Allowable Programs**. All CNA programs must be approved by the Department of Education in order for a nursing facility to be reimbursed for a CNA training program.

   The Department will reimburse for the number of courses needed to meet the facility's needs, or the needs of a group of facilities on a prorated basis, which is expected to be no more than three (3) CNA courses per year, unless it is found that three (3) courses in not enough to meet the facility's needs. However, costs for classes of four (4) or fewer students will be allowed no more than twice a year.

2. **Allowable Costs**

   a) qualified instructor for classroom instruction and clinical instruction, not to exceed one hundred-fifty (150) hours.
   b) instructor preparation time, not to exceed fifteen (15) hours.
   c) additional clinical instructor time when number of students in program exceeds ten (10).
   d) one (1) "Train the Trainer Program" per facility per year.
   e) training materials, books and supplies necessary for providing the CNA program.
   f) liability insurance
   g) competency examinations, if Department of Education no longer provides the competency examinations.
   h) administrative overhead expenses shall be limited to ten percent (10%) of the total allowable CNA training budget.

   The cost per student cannot exceed the cost of tuition in a program offered through the Department of Education that is reasonably accessible. If it is determined that any of the CNA training programs offered by a facility has not met or does not presently meet the requirements of the Maine Board of Nursing or is not an approved program through the Department of Education and the Department of Professional and Financial Regulation, the Department will initiate action to recoup all reimbursement.

   All income received from these programs must be used to reduce the overall cost of the programs.

APPENDIX A: (cont.)

Reimbursement. In order for a nursing facility to be reimbursed for conducting an approved CNA training program, the facility must submit a formal request for reimbursement to the Director of the Office of MaineCare Services, 11 State House Station, Augusta, Maine, 04333-0011. All requests must be received by the Department before the end of the facility's current fiscal year in which the CNA program began.

Any request that is not received before the end of the facility's current fiscal year in which the CNA program begins will not be considered as an allowable cost under the MaineCare Program.

All requests must include:

1. A completed schedule "Request for Budget Approval" available from the Office of MaineCare Services.

2. Copies of the letters of intent to employ for non-employees participating in the training program.

3. Copy of the Department of Education "Notice of Status" letter.

The Department will reimburse a nursing facility the median plus ten percent (10%) of costs per student paid by the Department for state fiscal year 1998 for CNA training. The allowable cost of approved CNA training programs conducted at a nursing facility will not be included in the calculation of the facility's prospective rate, but will be reimbursed in a lump sum payment upon approval by the Office of MaineCare Services.

The Office of Audit will audit all CNA training costs at the time of the facility's final audit. Therefore it is very important that the facility maintain accurate records of the CNA training programs conducted by the nursing facility.

10-144

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chapter 101

MAINECARE BENEFITS MANUAL

Chapter II

Section 67

NURSING FACILITY SERVICES

Note: Language in this policy that relates to assessment practices for person with Alzheimer's disease and other dementia have been deemed major substantive rules per Public Law 1995, Chapter 687 and Title 22 §3174-I.

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MAINECARE BENEFITS MANUAL
CHAPTER II
SECTION 67 NURSING FACILITY SERVICES ESTABLISHED 7/1/91
LAST UPDATED 8/27/13 (Emergency)

67.01 DEFINITIONS

67.01-1 **Nursing Facility** (NF) means, a Skilled Nursing Facility (SNF) in the Medicare program or a Nursing Facility (NF) in the MaineCare program which meets State licensing and Federal certification requirements for nursing facilities and has a valid agreement with the Department of Health and Human Services (**the Department**).

"Nursing facility" may include a distinct part of an institution which meets the above requirements.

A NF may not be an institution for mental diseases, nor an institution for the mentally retarded or persons with related conditions.

67.01-2 **Nursing Facility Services** means services that are:

- primarily professional nursing care or rehabilitative services for injured, disabled, or sick persons;
- needed on a daily basis and as a practical matter can only be provided in a nursing facility;
- ordered by and provided under the direction of a physician; and
- less intensive than hospital inpatient services.

67.01-3 **Dually-Certified Facility** is a facility that is certified to participate in both the Medicare and MaineCare programs. Dually-certified facilities are not limited to distinct parts since all of the beds in the facility are dually-certified.

67.01-4 **Swing-Bed** is a skilled Medicare certified hospital bed that may be used interchangeably as an acute care bed or a skilled nursing facility bed. For additional information pertaining to swing-beds refer to Chapter II, Section 45, of this Manual regarding Hospital Services.

67.01-5 **Utilization Review** is the evaluation of the necessity, appropriateness, and efficiency of the use of services, procedures, and facilities by each participating nursing facility. It includes a review of the appropriateness of admissions, services ordered and provided, continued stays, and discharge practices.

67.01-6 **Mental Illness** (MI) or a mental disorder is: (a) schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder;

67.01 **DEFINITIONS** (cont.)

personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but (b) not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in Section 67.01-6(a).

67.01-7 **Mental Retardation** (MR) means a condition of an individual as defined in the most current version of the American Psychiatric Association's Diagnostic and Statistical Manual.

67.01-8 **Resident Assessment Instrument** (RAI) is the assessment tool approved by the Department to provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. It is comprised of the Minimum Data Set (MDS) and the Resident Assessment Protocols (RAPs). The RAI is not an assessment tool for determination of medical eligibility.

67.01-9 **Plan of Care** (or care plan) includes measurable objectives and timetables related to meeting a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident assessment. The care plan must describe the following: 1) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and 2) Any services that would otherwise be required but are not provided due to the resident's exercise of his or her rights, including the right to refuse treatment. A copy of the Plan of Care is included in the member's medical record.

67.01-10 **Limited Assistance** is a term used to describe an individual's self-care performance in activities of daily living, as defined by the Minimum Data Set (MDS) assessment process. It means although the individual was highly involved in the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:

- Guided maneuvering of limbs or other non-weight-bearing assistance three (3) or more times, or
- Limited assistance (three (3) or more times,) **plus** weight-bearing support provided only one (1) or two (2) times.

67.01-11 **One-person Physical Assist** requires one (1) person to provide either weight-bearing or non-weight-bearing assistance for an individual who cannot perform the activity independently over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting. This does not include cueing.

67.01 **DEFINITIONS** (cont.)

67.01-12 **Extensive Assistance** means although the individual performed part of the activity over the last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital setting, help of the following type(s) was provided:

- Weight-bearing support three (3) or more times, or
- Full staff performance during part (but not all) of the last seven (7) days.

67.01-13 **Total Dependence** means full staff performance of the activity during the entire last seven (7) day period across all shifts. Complete non-participation by the resident in all aspects of the Activities of Daily Living (ADLs).

67.01-14 **Specialized Services for People with Mental Retardation or Other Related Conditions** are continuous active treatment programs that include aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services.

67.01-15 **Specialized Services for People with Mental Illness** are mental health services developed by an interdisciplinary team and include specific therapies and activities that are directed at diagnosing conditions, reducing symptoms, and achieving a level of functioning that permits reduction in the intensity of mental health services.

67.01-16 **Unstable**: A medical condition is unstable when it is fluctuating in an irregular way and/or is deteriorating and affects the resident's ability o function independently. These changes must require medical treatment and professional nursing observation assessment and management at least once every eight (8) hours. The change or decline in physical health requires increased physician involvement and should result in communication with the physician for adjustments in treatment and medication. Evidence of fluctuating vital signs, lab values, and physical symptoms and plan of care adjustments must be documented in the medical record. The loss of function resulting from a temporary disability from which full recovery is expected does not qualify as instability as defined under this Section.

67.01-17 **Assessment Form**: The form approved by the Department for medical eligibility determination or advisory assessments required in this Section. The definitions, scoring mechanisms and time-frames included in this form are outlined in Section 67.02-3. This form is also known as the Medical Eligibility Determination (MED) form. The Assessment Form does not include the Minimum Data Set (MDS).

67.01 **DEFINITIONS** (cont.)

67.01-18 **Residence**: means an individual's permanent dwelling. If the individual does not have a permanent dwelling, the nursing facility shall be considered his/her residence.

67.01-19 **Cognition** is the ability to recall what is learned or known and the ability to make decisions regarding tasks of daily life. Cognition is evaluated in terms of:

1. Memory: short-term and long-term memory;
2. Memory/recall ability during last seven (7) days, or twenty-four (24) to forty-eight (48) hours if in a hospital; and
3. Cognitive skills for daily decision making on a scale including: independent; modified independence; moderately impaired; severely impaired.

A "threshold" score for "cognition" on the eligibility Assessment Form is equal to a score of one (1) for loss of short term memory and one (1) or two (2) of items A-D or E, no items for memory/recall ability, and a score of two (2) or three (3) for cognitive skills for decision making.

67.01-20 **Problem Behavior** refers to wandering with no rational purpose; verbal abuse; or physical abuse; or socially inappropriate/disruptive behavior. A "threshold" score for problem behavior on the eligibility Assessment Form is equal to a score of two (2) or three (3) in one (1) of these four (4) criteria and occurs at least four (4) days per week.

67.01-21 **Authorized Agent** shall mean the organization authorized by the Department to perform specified functions pursuant to a signed contract or other approved signed agreement.

67.01-22 **Brain Injury (BI)** is an insult to the brain resulting directly or indirectly from trauma, infection, anoxia, or vascular lesions, and not of a degenerative or congenital nature, but which may produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities and/or physical or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment.

67.01-23 **Frequent Change in Care Setting** shall mean three (3) or more moves from one care setting to another care setting, including the following settings: home, residential care facility, nursing facility or other specialized facility, excluding hospitals, within a nine (9) month period. Hospital admissions/discharges are not counted as a change in care setting or move. Each change in care setting counts as one (1) move, e.g. - moving from home

67.01 **DEFINITIONS** (cont.)

to NF counts as one (1) move; - moving from home to NF and back home counts as two (2) moves. (A change in the "level of care" within a facility is not a "change in care setting" under this Section.)

67.01-24 **Member** in this Section is an individual who meets financial and other eligibility requirements set forth in the MaineCare Eligibility Manual and has also been determined to meet the eligibility requirements of this Section and is prior authorized to receive services. For purposes of making health care decisions, a member may be represented by his or her "guardian," "agent" or "surrogate," as these terms are defined in 18-A MRSA Sec. 5-801.

67.01-25 **Significant Change** means a major change in the member's status that is not self-limiting, impacts on more than one (1) area of functional or health status, and requires multi-disciplinary review or revision of the authorized plan of care. A significant change assessment is appropriate if there is a consistent pattern of change with either two (2) or more areas of improvement, two (2) or more areas of decline, or would impact the member's NF level of care.

67.01-26 **Rehabilitation Potential** is the documented expectation by a physician of measurable, "functionally significant improvement" (the demonstrable, measurable increase in the individual's ability to perform specific tasks or motions that contribute to independence outside the therapeutic environment) in the individual's condition in a reasonable, predictable period of time as the result of the prescribed treatment plan. The physician documentation of rehabilitation potential must include the reasons used to support the physician expectation and must follow guidelines detailed in MaineCare Benefits Manual (MBM), Chapter II, Section 90, Physician Services.

67.01-27 **Other Related Conditions(ORC)** means (i) cerebral palsy or epilepsy or (ii) any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for those persons. Further, the condition must manifest before the person reaches age 22 years, be likely to continue indefinitely, and result in functional limitations in three (3) or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

67.02 **ELIGIBILITY FOR CARE**

67.02-1 **General and Specific Requirements**

MaineCare coverage of NF services requires prior approval from the Department or its Authorized Agent. NF services are covered for an approved eligibility period for each MaineCare member. Beginning and end dates of the individual's eligibility period correspond to beginning and end dates for MaineCare reimbursement. MaineCare coverage shall end on the eligibility end date unless a new eligibility period has been authorized. A person is

67.02 **ELIGIBILITY FOR CARE** (cont.)

eligible to receive covered services if he or she meets: general MaineCare financial eligibility requirements and other eligibility requirements set forth in the MaineCare Eligibility Manual, medical eligibility requirements, as set forth in Section 67.02-3 and as documented on the MED form completed by the Department or its Authorized Agent, and other specific requirements for NF services.

67.02-2 **General Requirements**. A person must meet the MaineCare financial eligibility requirements and other eligibility requirements set forth in the MaineCare Eligibility Manual, as determined by the Office of Integrated Access and Support.

67.02-3 **Medical Requirements**

In order to receive services under this Section applicants must meet the eligibility requirements as set forth in this Section and as documented on the MED form. An applicant for services or a resident under this Section meets the medical eligibility requirements for admission to a nursing facility if he or she requires the services specified in 67.02-3(A) OR (B) OR (C), as determined or otherwise verified by the Department or its Authorized Agent and documented on the approved MED form. The timeframes used to determine medical eligibility are incorporated in the MED form. If an applicant or member is placed in a NF facility out of state, then the MED form that is completed by the Department or its Authorized Agent must be submitted as part of the out of state prior authorization process that is described in Chapter I, Section 1.14-2 of the MBM.

A. A person meets the medical eligibility requirements for NF services if he or she needs at least one (1) of the following services seven (7) days per week (unless otherwise specified) that are or otherwise would be performed by or under the supervision of a registered professional nurse:

1. intraarterial, intravenous, intramuscular, or subcutaneous injection, or intravenous feeding, all for treatment of unstable conditions requiring medical or nursing intervention. Daily insulin injections for an individual whose diabetes is under control do not meet the requirements of this Section;

2. nasogastric tube, gastrostomy, or jejunostomy feeding, for a new/recent (within past thirty (30) days) or unstable condition;

3. nasopharyngeal suctioning or tracheostomy care; however, care of a tracheostomy tube must be for a recent or unstable condition;

4. treatment and/or application of dressings when the physician has prescribed irrigation, the application of prescribed medication, or

67.02 **ELIGIBILITY FOR CARE** (cont.)

sterile dressings of stage III and IV decubitus ulcers, other widespread skin disorders (except psoriasis and eczema), or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, second or third degree burns, open surgical sites, fistulas, tube sites, and tumor erosions);

5. administration of oxygen on a regular and continuing basis when the person's medical condition warrants professional nursing observation, for a new or recent (within past thirty (30) days) condition;

6. professional nursing assessment, observation and management of an unstable medical condition (observation must, however, be needed at least once per shift throughout the twenty-four (24) hours);

7. insertion and maintenance of a urethral or suprapubic catheter as an adjunct to the active treatment of a disease or medical condition may justify a need for skilled nursing care.

   In such instances, the need for a catheter must be documented and justified in the person's medical record;

8 physical, speech/language, occupational, or respiratory therapy provided at least five (5) days per week as part of a planned program that is designed, established by, and provided by, and requires the professional skills of, a licensed or registered therapist. (Therapy services may be delivered by a qualified licensed or certified therapy assistant under the direction of a qualified professional therapist.) The findings of an initial evaluation and periodic reassessments must be documented in the person's medical record. Skilled therapeutic services must be ordered by a physician and be designed to achieve specific goals within a given time frame. With the exception of speech/language criteria outlined under 67.05-13 (E), maintenance or preventative therapy does not meet the requirements of this Section. A Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BIPAP) system or the wearing of an airway clearance system vest does not meet the requirements of this Section;

9. services to manage a comatose condition;

10. care to manage conditions requiring a ventilator/ respirator at least three (3) days per week;

67.02 **ELIGIBILITY FOR CARE** (cont.)

11. direct assistance from others is required for the safe management of an uncontrolled seizure disorder, (i.e.: grandmal) at least weekly; or

12. extensive assistance or total dependence with three (3) of the following five (5) activities of daily living: a) bed mobility; (b) transfer; (c) locomotion; (d) eating; and (e) toilet use (refer to 67.02-3(B)(2) below).

B. A person meets the medical eligibility requirements for NF services if he or she needs a combination of at least three (3) of the following services described in 67.02-3(B) below, including at least one (1) of the nursing services described in 67.02-3(B)(1), that are or otherwise would be performed by or under the supervision of a registered professional nurse.

1. **Nursing Services**

Nursing services include any of the following on a frequent basis of a minimum of three (3) days a week unless otherwise specified:

a. any physician-ordered services specified in 67.02-3(A) but provided on a frequent rather than daily basis;

b. professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability;

i. If an individual meets the threshold for deficits in cognition as defined in Sec. 67.01-19, but otherwise does not require professional nursing intervention at least three (3) days per week, then the individual shall be assessed in accordance with Section 67.02-3 (C) below.

c. professional nursing assessment, observation, and management for problems including wandering, physical abuse, verbal abuse or socially inappropriate behavior;

i. If an individual meets the threshold for deficits in behavior as defined in Section 67.01-20, but otherwise does not require professional nursing intervention at least three (3) days per week, then the individual shall be assessed in accordance with Section 67.02-3 (C) below.

67.02 **ELIGIBILITY FOR CARE** (cont.)

d. physician-ordered occupational, physical, or speech-language therapy provided at least three (3) days a week as part of a planned program that is designed by, established by, provided by, and requires the professional skills of, a licensed or registered therapist. (Therapy services may be delivered by a qualified licensed or certified therapy assistant, under the direction of a qualified professional therapist.) The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Therapeutic services must be ordered by a physician for individuals twenty-one (21) years of age or older.

Rehabilitation potential (see Section 67.01-26) must be documented by the physician for these speech-language services for individuals twenty-one (21) years of age or older.

With the exception of speech/language criteria outlined under 67.05-13 (E), maintenance or preventative services do not meet the requirements of this Section.

e. administration of treatments (excluding: nebulizers, CPAP or BIPAP systems, and airway clearance system vest), procedures, or dressing changes which involve prescription medications, for post-operative or chronic conditions according to physician orders, that require nursing care and monitoring; or

f. professional nursing for physician ordered radiation therapy, chemotherapy, or dialysis.

2. **Activities of Daily Living**

At least "limited assistance" (defined in 67.01) and a "one person physical assist" (defined in 67.01) is needed with the following activities of daily living:

a. **Bed Mobility**: how person moves to and from lying position, turns side to side, and positions body while in bed;

b. **Transfer:** how person moves between surfaces to/from: bed, wheelchair, standing position (excluding to/from bath/toilet and dressing);.

c. **Locomotion:** how person moves between locations on the same floor, in room and other areas. If in wheelchair, self-sufficiency once in chair;

67.02 **ELIGIBILITY FOR CARE** (cont.)

d. **Eating**: how person eats and drinks (regardless of skill); and

e. **Toilet Use**: how person uses the toilet room (or commode, bedpan, urinal): transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

C. An individual who meets the threshold for deficits in criteria 67.02-3 (B)(1)(b) cognition and/or (B)(1)(c) behavior, as defined in Section 67.01-19 and 67.01-20 respectively, but otherwise does not require professional nursing intervention at least three (3) days per week, then the individual shall be assessed using the criteria below. The individual shall be eligible for NF services if he or she has a qualifying score on the Cognitive Screen and/or Behavioral Screen, in combination with a need for at least "limited assistance" with an activity(ies) of daily living described in Section (B)(2), for a total of three (3) service needs. (e.g. Cognitive score =thirteen (13) points and two (2) ADL's; OR Cognitive score = thirteen (13) points and Behavioral score = fourteen (14) points and one (1) ADL; OR Behavioral score = fourteen (14) points and two (2) ADL's)

1. **Cognition Screen** Sixteen (16) points available, thirteen (13) required

a. **Memory for Events**

0 Can recall details and sequences of recent experiences and remember names of meaningful acquaintances.
1 Cannot recall details or sequences of recent events or remember names of meaningful acquaintances.
2 Cannot recall entire event or names of close friends or relatives (e.g., recent outings, visits of relatives or friends) without prompting.
3 Cannot recall entire event or name of spouse or other living partner even with prompting.

b. **Memory and Use of Information**

0 Does not have difficulty remembering and using information. Does not require directions or reminding from others.
1 Has minimal difficulty remembering and using information. Requires direction and reminding from others one (1) to three (3) times per day. Can follow written instructions.
2 Has difficulty remembering and using information. Requires direction and reminding from others four (4) or more times per day. Cannot follow written instructions.
4 Cannot remember or use information. Requires continual verbal reminding.

67.02 **ELIGIBILITY FOR CARE** (cont.)

c. **Global Confusion**

0 Appropriately responsive to environment.
1 Nocturnal confusion on awaking.
2 Periodic confusion during daytime.
3 Nearly always confused.

d. **Spatial Orientation**

0 Oriented, able to find and keep his/her bearings.
1 Spatial confusion when driving or riding in local community.
2 Gets lost when walking in neighborhood.
3 Gets lost in own home or present environment.

e. **Verbal Communication**

0 Speaks normally.
1 Minor difficulty with speech or word-finding difficulties.
2 Able to carry out only simple, uncomplicated conversations.
3 Unable to speak coherently or make needs known.

2. **Behavior Screen** Twenty (20) points available, fourteen (14) required

a. **Sleep Patterns**

0 Unchanged from "normal" for the individual.
1 Sleeps, noticeably more or less "normal".
2 Restless, nightmares, disturbed sleep, increased awakenings.
4 Up wandering for all or most of the night, inability to sleep.

b. **Wandering**

0 Does not wander.
1 Does not wander. Is chair bound or bed bound.
2 Wanders within the facility or residence and may wander outside, but does not jeopardize health and safety.

67.02 **ELIGIBILITY FOR CARE** (cont.)

3 Wanders within the facility or residence. May wander outside; health and safety may be jeopardized. Does not have history of getting lost and is not combative about returning.

4 Wanders outside and leaves grounds. Has a consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the use of psychotropic drugs for management and safety.

c. Behavioral Demands on Others

0 Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions.

1 Attitudes, habits and emotional states limit the individual's type of living arrangement and companions.

3 Attitudes, disturbances and emotional states create consistent difficulties that are modifiable to manageable levels. The individual's behavior can be changed to reach the desired outcome through respite, in-home services, or existing facility staffing.

4 Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels. The individual's behavior cannot be changed to reach the desired outcome through respite, in-home services, or existing facility staffing, even with training for the caregiver.

d. Danger to Self and Others

0 Is not disruptive or aggressive, and is not dangerous.

1 Is not capable of harming self or others because of mobility limitations (is bed bound or chair bound).

2 Is sometimes (one (1) to three (3) times in the last seven (7) days) disruptive or aggressive, either physically or verbally, or is frequently extremely agitated or anxious, even after proper evaluation and treatment.

3 Is frequently (four (4) or more times during the last seven (7) days) disruptive or aggressive, or is frequently extremely agitated or anxious, and professional judgment is required to determine when to administer prescribed medication.

5 Is dangerous or physically abusive, and even with proper evaluation and treatment, may require physician's orders for appropriate interventions.

67.02 **ELIGIBILITY FOR CARE** (cont.)

e. Awareness of Needs/Judgment

0 Understands those needs that must be met to maintain self care.

1 Sometimes (one (1) to three (3) times in the last seven (7) days) has difficulty understanding those needs that must be met, but will cooperate when given direction or explanation.

2 Frequently (four (4) or more times during the last seven (7) days) has difficulty understanding those needs that must be met, but will cooperate when given direction or explanation.

3 Does not understand those needs that must be met for self care and will not cooperate even though given direction or explanation.

67.02-4 **Other Specific Requirements**

Nursing facility services are covered under the MaineCare program if an applicant is determined to be medically eligible, according to 67.02-3(A) OR (B) OR (C), and when all of the following conditions are met:

A. An applicant who meets the NF medical eligibility criteria in 67.02-3 has been informed of, and offered the choice of, available, appropriate, and cost-effective home and community-based services and alternatives to NF placement. The relative costs to the applicant of each option must be explained.

B. The Assessment Form and the preadmission screening (PASARR) for mental illness and mental retardation have been completed, or the applicant is otherwise exempt (see Section 67.05-1).

C. The applicant (or applicant's guardian, or applicant's agent or surrogate, as defined in 18-A MRSA Sec. 5-801 and evidenced by a valid, signed document on file at the NF, available upon request) selected placement in the nursing facility as documented by a signed choice letter.

D. The nursing facility to be reimbursed has the signed orders for NF services by the physician responsible for the care of the resident. The medical care of each resident must be supervised by a physician.

E. No Medicare or other third-party payment is available for the services, in accordance with Chapter I, MaineCare Benefits Manual.

67.02 **ELIGIBILITY FOR CARE** (cont.)

67.02-5 **Medical Requirements for Brain Injury (BI) Services**

A person meets the medical eligibility requirements for NF BI services if he or she has been determined to meet the NF eligibility requirements of Sections 67.02-3 and 67.02-4 AND meets the following BI criteria as determined or otherwise verified by the Department or its Authorized Agent.

A. The individual has sustained a brain injury as defined in Section 67.01-22; and

B. The individual has been assessed by the Disability Rating Scale(DRS) (See Appendix 1) administered by the Department or its Authorized Agent, and has received a score between seven (7) and twenty-one (21) inclusive; and

C. The individual has received an assessment by a qualified neuropsychologist (as defined in the MBM, Rehabilitative Services, Section 102.08-5 B) and/or a licensed physician who is Board certified, or otherwise Board eligible in Physical Medicine and Rehabilitation. The assessment must at least:

1. positively indicate the individual: is not in a persistent vegetative state, is able to demonstrate potential for physical and/or behavioral and/or cognitive rehabilitation; and shows evidence of moderate to severe behavioral and/or cognitive and/or functional disabilities; and

2. result in specific rehabilitation goals, based upon the findings of the assessment, describing types and frequencies of therapies and expected outcomes and timeframes.

In order for services to be covered under the BI rate of reimbursement, the assessment as described in 67.02-5(C) must be completed and a rehabilitation plan of care based upon the findings of the assessment must be in place. An assessment conducted up to no more than three (3) months prior to admission will be accepted. If the individual meets the requirements of Section 67.02-3 and 67.02-4, he or she may be classified and reimbursed for NF level of care. The individual will be classified NF-BI when the additional requirements of Section 67.02-5 are met.

67.02-6 **Extraordinary Circumstances (EC)**

A. A nursing facility must request and receive written approval for a member's continued stay under "extraordinary circumstances." (Please refer to 67.05-4.). A NF MaineCare member whose length of stay has been reimbursed by MaineCare for more than one hundred-twenty (120) consecutive days may continue to stay in the NF due to "extraordinary circumstances" if it has been determined after documented discharge planning that:

67.02 **ELIGIBILITY FOR CARE** (cont.)

1. There is no available, appropriate placement within a sixty (60) mile radius of the member's residence; AND

2. Discharge from the NF would pose serious risk to the individual's health, welfare, or safety.

The counting of one hundred-twenty (120) consecutive days may include short-term hospital stays (ten (10) or fewer days), but may not

include any days accrued during an appeal process, which begins on the day the member requests an appeal with the Department (see Section 67.05-18).

B. MaineCare coverage for "extraordinary circumstances" shall be for a specified period approved by the Department. For coverage to continue beyond the approved period, the NF must submit a completed request form to the Department at least five (5) calendar days prior to the end date of the member's approved EC period. If appropriate, the Department will approve a new EC certification period. When a member is admitted to a hospital, the EC period ends on the date of admission. A member must be assessed by the Department or its Authorized Agent prior to the member's return to the NF as required under Section 67.05-2(B).

67.02-7 **Frequent Change in Care Settings**

A. In order to promote the health and well-being of a member who has experienced frequent changes in health status, resulting in frequent changes in care settings (defined in 67.01-23), coverage for NF services may continue even though the member's health status has improved such that he or she no longer meets the Section 67.02-3 medical eligibility requirements for NF level care, and would otherwise be discharged, if the following additional criteria are met:

1. The member has lost medical eligibility for NF services at least twice, while receiving covered services in the NF, during the past nine (9) month period; and

2. The member has a chronic or unstable medical condition that would likely result in re-admission to the NF within three (3) months of discharge; and

3. The various settings (including home), within the last nine (9) months, must be listed, each facility identified with admission and discharge dates documented; and

4. The member (or member's guardian, or member's agent or surrogate, as defined in 18-A MRSA Sec. 5-801 and evidenced

67.02 **ELIGIBILITY FOR CARE** (cont.)

by a valid, signed document on file at the NF, available upon request) chooses to continue to stay in the NF, as documented by a signed Choice Letter.

B. The member will be determined eligible pursuant to the requirements of this Section by the Department. The NF shall submit the above required information to the Department with a request for classification under this Section. If approved, a classification period will be established. The member must be reassessed within five (5) calendar days prior to the end date of the member's approved classification period, if an additional classification period is requested under this Section. The Department shall consider the member's recent history of frequent changes in care settings, as well as health status, and may continue to classify him/her for NF coverage under this Section as appropriate.

67.02-8 **Significant Change Assessment**

A. If the NF believes the member has become medically eligible for NF services during a certified EC period, during an appeal or while awaiting placement for residential care, then the NF shall request a significant change eligibility assessment from the Department or its Authorized Agent. A significant change (see Section 67.01-25) MDS assessment and the most recent quarterly MDS assessment, prior to this change, must be submitted to the Department or its Authorized Agent. In order for the Department or its Authorized Agent to complete an Assessment Form, the significant change areas must impact on this Section's eligibility.

B. The significant change assessment process applies to current residents, whom the facility believes meet the medical eligibility criteria and are under appeal for denial of medical eligibility or have within the past year had an Assessment Form appealed and upheld as accurate by the Commissioner's final ruling in the appeal. It also applies to members receiving extraordinary circumstances or frequent change eligibility as exceptions to medical eligibility.

67.02-9 **Days Awaiting Placement for Residential Care Facility**

Current nursing facility residents who have no federal third party coverage or long term care insurance coverage and who have been determined not medically eligible for MaineCare nursing facility benefits may continue to stay in the nursing facility subject to all of the following conditions:

A. The resident has received notice that he/she is not medically eligible for NF MaineCare benefits, the facility has initiated the discharge process, and has determined that there is no safe and appropriate placement currently available.

67.02 **ELIGIBILITY FOR CARE** (cont.)

B. The individual meets the medical and financial eligibility requirements for MaineCare coverage in a cost reimbursed residential care facility, as determined by the regional Office of Integrated Access and Support.

C. The member met the MaineCare medical eligibility criteria for NF in effect at the time of admission to the nursing facility.

D. The nursing facility continually pursues discharge of the member. The nursing facility shall continue to document in the member's record all efforts to locate appropriate placement.

E. The member accepts the first available, appropriate placement within a sixty (60) mile radius of the facility or the member's home, if applicable. The member may accept a placement beyond the sixty (60) mile radius. However, this is not required. The nursing facility must notify the Department if a member refuses a placement meeting these criteria. If the member refuses this placement, the Department will issue a thirty (30) day notice to the nursing facility that reimbursement will terminate.

67.03 **DURATION OF CARE**

Eligible Title XIX and XXI members are entitled to receive as many days of NF services as are medically necessary as long as the member meets the eligibility for care requirements set forth under Section 67.02, or otherwise meets the exception specified under 67.05-1 (G). MaineCare coverage of NF services requires prior approval from the Department or its Authorized Agent. Beginning and end dates of an individual's eligibility period corresponds to the beginning and end dates for MaineCare reimbursement. The Department, or its Authorized Agent may grant eligibility for NF services on a short or long term basis, based upon the complexity, frequency and length of time that services are needed.

The Department, or its Authorized Agent may, at any time, review an individual's need for NF services.

67.04 **STANDARDS OF CARE**

All nursing facilities must meet the following standards to qualify for MaineCare reimbursement:

67.04-1 **General Regulatory Compliance**

A. In order to qualify for reimbursement under this Section, NFs, including those operated by the State of Maine, must meet the requirements contained in the Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities as are currently in effect. NFs must also comply with the Principles of Reimbursement for Nursing Facilities; and all requirements of Title XIX of the Social Security Act and the CFR, Subpart B, Requirements for Long Term Care Facilities, 42 CFR 483 issued pursuant thereto, as are most currently in effect. These standards are incorporated into this Section by reference as if set out fully herein.

67.04 **STANDARDS OF CARE** (cont.)

B. All NFs including those operated by the State of Maine, must obtain a license from the Department of Health and Human Services in order to qualify for Title XIX reimbursement. However, the license shall not be considered valid evidence that the facility meets all requirements for certification under MaineCare regulations if the Secretary of Health and Human Services has established, on the basis of an on-site monitoring survey or other federal review, that the Department's certification agency has failed to properly apply Federal certification standards or procedures.

C. Each NF must obtain Medicare certification for a minimum of twenty percent (20%) of its licensed bed capacity. Additionally, any NF that participates in the MaineCare program must follow required Federal procedures for certification and become certified following the Department's recommendation for certification; submit an annual application for Medicare participation at the same time applications for licenses and MaineCare certification are due; and participate in the Medicare program by billing Medicare for care provided to eligible members prior to billing MaineCare.

D. Sanctions. Failure to comply with any of the provisions in Section 67.04-1(C) may result in the imposition of a penalty of one hundred dollars ($100) per bed. This penalty must be imposed for each day a NF fails to comply with the requirement that the NF participate in the Medicare program by billing Medicare for care provided to eligible members prior to billing MaineCare. A repeated failure to comply with any provision in Section 67.04-1(C) will result in fines of two hundred dollars ($200) per bed. The imposition and collection of these sanctions are governed by 22 M.R.S.A. §7946.

E. In order to qualify for reimbursement for laboratory services by nursing facilities, those laboratory services must be in compliance with the rules implementing the Clinical Laboratory Improvement Amendments (CLIA) of 1988, and any amendments thereto, or otherwise have a waiver. CLIA regulations are located at following website: http://www.phppo.cdc.gov/clia/regs/toc.aspx .

67.04-2 **Training Requirements for Alzheimer's and Dementia Services**

Nursing facilities that admit members or have members determined eligible based in part on the supplemental dementia screen in Section 67.02-3 (C) will be reimbursed with MaineCare funds for those members if the NF can document that it meets the following training standards:

67.04 **STANDARDS OF CARE** (cont.)

A. The NF must document six (6) hours of classroom training on Alzheimer's and other dementia for all licensed staff, CNA, social work, activities and housekeeping staff. In addition, the NF must be able to document six (6) hours of clinical experience for licensed staff, CNA, social work and activities staff. In addition, four (4) of the twelve (12) contact hours required for CNA certification in-service must be in the area of managing residents with cognitive impairments.

B. Training shall be provided by individuals qualified by education or experience and must include, but is not limited to the following topics:

- diseases and conditions that cause dementia;
- behavior management;
- communication with resident and family;
- creating a therapeutic environment;
- promoting functional independence;
- legal and ethical issues; and
- mandatory reporting of abuse, neglect and exploitation.

67.05 **POLICIES AND PROCEDURES**

All nursing facilities must establish and maintain policies and practices regarding transfer, discharge, and the provision of services that are the same for all individuals regardless of source of payment.

67.05-1 **Preadmission Screening (PAS) and Change In Condition (CIC) Reviews for Mental Illness and Mental Retardation**

A. Nursing facilities must not admit any new resident who has:

Mental Illness (MI), unless the State mental health authority, has determined, based on an independent evaluation performed by a person or entity other than the Department, prior to admission, that the individual requires the level of services provided by a NF and, if so, whether the individual requires specialized services for MI; or Mental Retardation (MR) or other related conditions (ORC), unless the State mental retardation authority has determined prior to admission that the individual requires the level of services provided by a NF, and, if so, whether the individual requires specialized services for MR or ORC. Determinations made by the State mental health or mental retardation authorities (Office of Adult Mental Health Services and Office of Adults with Cognitive and Physical Disability Services) cannot be countermanded by the State Medicaid agency (Maine Care Services) per 42 CFR 483.108, with the exception of appeal determinations made through the system specified in subpart E of 42 CFR 483.204. The mental health and mental retardation authorities and the State Medicaid Agency are part of the Department of Health and Human Services.

67.05 **POLICIES AND PROCEDURES** (cont.)

B. NF's may not admit any individual who has not had preadmission screening for mental illness, mental retardation, or other related condition. All applicants to a NF, regardless of payment source (private pay, Medicare, MaineCare or other third-party payor) must be screened with the Level I screen:

1. Preadmission screening is not required in the case of the readmission to a NF of an individual who, after being admitted to the NF, was transferred for care in a hospital. However, such readmissions are subject to a change in condition (CIC) review when indicated.

2. A Level II screen is not required for an individual admitted to a NF directly from a hospital (after receiving acute inpatient care) if the individual requires NF services for the condition for which care was received in the hospital, and the attending physician certifies, before admission to the NF, that the individual is likely to require a NF stay of less than thirty (30) days.

   If an individual who enters a NF as an exempted hospital discharge is later found to require more than thirty (30) days of NF care, a Level II assessment must be conducted if indicated within forty (40) calendar days of admission.

3. A Level II screen may be deferred or waived, as appropriate, for an individual who is likely to require a NF stay of less than thirty (30) days, and if the individual qualifies for an advance categorical determination, as determined by the State Mental Health Authority.

   If an individual who enters a NF as an advance categorical determination and is later found to require more than thirty (30) days of NF care, a Level II assessment must be conducted, if indicated, within forty (40) calendar days of admission.

4. Interfacility transfers are subject to change in condition (CIC) review when indicated. An interfacility transfer occurs when an individual is transferred from one NF to another NF, with or without an intervening hospital stay. In cases of transfer of a resident with MI ,MR or ORC from a NF to a hospital or another NF, the transferring NF is responsible for ensuring that all PAS CIC records and resident assessment reports accompany the transferring resident.

C. For each resident who has mental illness, mental retardation, or other related condition, a change in condition (CIC) review must be conducted promptly after a significant change in physical or mental condition occurs, in order to determine whether the resident requires

67.05 **POLICIES AND PROCEDURES** (cont.)

the level of services provided by a NF and, if so, whether the individual requires specialized services for MI ,MR, or ORC.

D. The Level I and Level II screening procedures and time frames are described in the Manual issued by the mental health and mental retardation authorities This Manual can be accessed on line at: http://www.maine.gov/dhhs/mh/PASRR/Contents.htm

   Any NF applicant known or suspected to have a serious mental illness, as identified by the Level I screen, shall be referred to the mental health authority for a Level II assessment. The applicant shall be notified in writing that the need for specialized services will be determined through a Level II assessment.

   Any NF applicant known or suspected to have mental retardation or a related condition, shall be notified in writing and referred to the nearest mental retardation authority Regional Office for a Level II assessment.

   The findings of a Level II assessment shall be submitted to the State Medicaid Agency within six (6) to eight (8) working days of the referral.

E. An applicant or resident has the right to appeal the finding of need for specialized services. He/she may request a hearing by submitting a verbal or written request within ten (10) days of receipt of the notification letter or of the final determination decision by writing to the Director, MaineCare Services, #11 State House Station, Augusta, ME 04333-0011.

F. A NF or an entity that has a direct or indirect affiliation or relationship with a NF, may not conduct PAS CIC activities, with the exception of a Level I screen.

G. MaineCare will not cover NF services for any individual found not to require NF services, with the following exception:

   Any long term resident who has continuously resided in a NF for at least thirty (30) months before the date of determination, and who requires only specialized services for MI or MR, will be offered the choice of remaining in the NF or of receiving services in an alternate appropriate setting.

H. MaineCare will only reimburse for services furnished after preadmission screening for MI, MR, or ORC has been completed.

I. Failure to implement preadmission screening, in accordance with established procedures, for all NF applicants, regardless of payment

67.05 **POLICIES AND PROCEDURES** (cont.)

source (e.g.: MaineCare, Medicare, private pay, or other third-party payor), shall result in sanctions from MaineCare Services.

67.05-2 **Notice and Preadmission Long Term Care Assessment (MED)**

A. NFs shall provide all applicants for NF services a copy of the Department's official notice that indicates that a Long Term Care assessment is required. The notice shall also indicate that, if the applicant depletes the applicant's resources and applies for MaineCare in the future, the applicant may need to leave the NF if an assessment conducted at that time finds that the applicant is not medically eligible for NF services.

B. Except as specified in C and D below, a preadmission Long Term Care assessment (MED) is required for each applicant, regardless of source of payment, including private pay individuals. The Department or its Authorized Agent shall conduct the assessment using the approved eligibility Assessment Form.

1. The Assessment Form must be completed prior to admission, or, if necessary for reasons of the person's health or safety, following communication with the Office of Elder Services to receive approval for deferral of the mandated assessment, as soon after admission as possible.

2. An applicant shall be informed of available, appropriate, and cost-effective home and community-based services and alternatives to NF placement. The relative costs to the applicant, of each option, shall be explained.

C. For a consumer transferring from a hospital to the NF under Medicare or any other private insurance coverage, the long term care assessment (MED) may be delayed until the exhaustion of their Medicare/private insurance covered NF stay. To ensure MaineCare reimbursement, it is the responsibility of the NF to track each Medicare, Medicare managed care, and private insurance covered admission, and to notify the Department or its Authorized Agent and request an assessment five (5) calendar days prior to the last day of coverage. The Department or its Authorized Agent will conduct an assessment and issue a MaineCare eligibility decision.

The eligibility for MaineCare coverage shall start with the date the eligibility Assessment Form is completed. In a situation where the first twenty (20) day period is reimbursed one hundred percent (100%) by Medicare or other third party insurance, retroactive MaineCare coverage may be granted back to the first day of the end of that period,

67.05 **POLICIES AND PROCEDURES** (cont.)

if an assessment was requested by the Office of Integrated Access and Support prior to the twentieth (20th) day.

D. For a consumer admitted under a Hospice Medicare or MaineCare benefit the PAS screen shall be exempt and the long term care assessment (MED) may be waived for up to the five (5) day benefit period. If the person is receiving the general inpatient care hospice benefit and it is the person's intention to remain in a NF setting, then the assessment can be done prior to the benefit period ending.

If the consumer chooses to stay in the NF beyond the benefit period, the NF must request the Department or its Authorized Agent to conduct an assessment, regardless of the consumer's payment source. For MaineCare coverage, medical eligibility shall start the date the assessment is completed.

67.05-3 **Determination of Eligibility**

A registered nurse trained in conducting assessments with the Department's approved MED form, shall conduct the medical eligibility assessment. The assessment must be performed by the Department or its Authorized Agent. In the process of completing an assessment the nurse assessor shall use professional nursing judgment. The assessor shall, as appropriate within the exercise of professional nursing judgment, consider documentation, perform observations and conduct interviews with the applicant/member, family members, direct care staff, the applicant's/member's physician, and other individuals, and document in the record of the assessment all information considered relevant in the professional judgment of the assessor.

A. **Eligibility from a Hospital**

1. If the applicant is not a MaineCare member, the discharge planner or other designated person shall explore MaineCare financial eligibility and refer the applicant, family member, or guardian to the regional office of the Office of Integrated Access and Support.

2. MaineCare coverage of NF services shall begin only after an applicant is determined medically eligible by the Department or its Authorized Agent using the Assessment Form. Except for Medicare and/or other private insurance covered NF admissions described in Sec. 67.05-2 (C) and (D), the assessment shall be conducted prior to admission to a NF. The hospital shall request an assessment by submitting a complete referral form to the Department or its Authorized Agent. An incomplete form will be returned to the hospital and the assessment delayed until receipt of a complete form. Forms may be faxed. The Department or its Authorized Agent shall complete the medical eligibility Assessment Form within twenty-four (24) hours of the request

67.05 **POLICIES AND PROCEDURES** (cont.)

for an assessment and the eligibility assessment shall not be conducted sooner than twenty-four (24) hours prior to the denial of acute level of care or discharge from a hospital.

3. Applicants who meet the NF medical eligibility criteria, according to the Assessment Form, shall be informed of, and offered the choice of, available, appropriate, and cost-effective home and community-based services and alternatives to NF placement. The relative costs to the consumer of each option must be explained.

4. The applicant (or applicant's guardian, agent or surrogate, as defined in 18-A MRSA Sec. 5-801) shall sign a "choice letter" indicating his or her selection of community-based services or NF placement.

5. If the applicant does not select community-based services, he/she must accept the first available appropriate nursing facility placement within a sixty (60) mile radius of his or her home, or MaineCare reimbursement will cease. If the applicant refuses to accept the placement, the hospital discharge planner must notify the Department, and the Department will issue a ten (10) day notice of intent to terminate services.

   The applicant may accept a placement beyond the sixty (60) miles from home radius, however, this cannot be required. The discharge planner shall document in the medical record all efforts to obtain an appropriate placement.

   If the applicant is a MaineCare and a Medicare member and is eligible for Medicare NF services, he/she shall be admitted to a Medicare certified NF bed, except in the following circumstances:

   a. If the applicant has been a resident in a NF and desires to return to that NF and can receive appropriate care; or

   b. An appropriate Medicare certified NF bed is not available within a sixty (60) mile radius of the applicant's home.

B. **Eligibility from a Nursing Facility**

1. If the resident is not a MaineCare member the NF will explore MaineCare financial eligibility and refer the applicant, family member or guardian to the regional office of the Office of Integrated Access and Support.

2. The NF shall request an eligibility assessment by submitting a complete referral form to the Department or its Authorized

67.05 **POLICIES AND PROCEDURES** (cont.)

Agent. An incomplete form will be returned to the NF and the assessment delayed until receipt of a complete form. The Department or its Authorized Agent shall conduct the medical eligibility assessment with the Department's approved Assessment Form. A Registered Nurse (RN) must conduct the medical eligibility assessment. Applicants who meet the NF medical eligibility criteria, according to the Assessment Form, shall be informed of, and offered the choice of, available, appropriate, and cost-effective home and community-based services and alternatives to NF placement. The relative costs to the patient, of each option, must be explained. The Assessment Form must be completed within five (5) calendar days of the request for an assessment. Faxed forms are acceptable.

3. The applicant (or applicant's guardian, agent or surrogate, as defined in 18-A MRSA Sec. 5-801) shall sign a "choice letter" indicating his or her selection of community based services or NF placement as part of the assessment process and again with each reassessment that follows.

4. For individuals who are expected to remain in the facility following their conversion from Medicare, private pay, or other third-party coverage, to MaineCare coverage, the NF shall request a NF medical eligibility assessment up to five (5) calendar days prior to the exhaustion of their current coverage. A copy of the facility's third-party denial letter indicating the last day of covered services, must be submitted to the Department, or its Authorized Agent. In order to receive MaineCare reimbursement back to the day of exhaustion of benefits, the NF must request a NF medical eligibility assessment no later than five (5) calendar days after the exhaustion of benefits.

5. In the event a non-MaineCare covered resident depletes his or her resources and does not notify the NF in a timely manner to allow compliance with Section 67.05-2 above, (that is to request an assessment within five (5) calendar days before or five (5) calendar days after the qualifying event), MaineCare shall reimburse covered services back to the date of financial eligibility so long as the member is determined medically eligible at the time the MED assessment is completed by the Department or its Authorized Agent and if the NF meets the following conditions:

   a. Provides documentation which demonstrate quarterly efforts to inform the consumer or responsible party of the availability of MaineCare funding if private resources are exhausted; and

67.05 **POLICIES AND PROCEDURES** (cont.)

b. Provides documentation of ongoing offers of NF staff to work with and assist the consumer or responsible party to submit a MaineCare financial application; and

c. The NF makes a request for an assessment to the Department or its Authorized Agent within five (5) calendar days before or five (5) calendar days after receipt of notice from the consumer or responsible party that all private funds are depleted.

Requests must be submitted for approval to the Department and include a description of the chronology of events and required documentation from the medical record. Submit request to:

Director, Office of Elder Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

C. **Eligibility from Other Settings**

1. Concurrent with the financial eligibility determination process, the Department or its Authorized Agent shall arrange for a medical eligibility assessment at the applicant's residence.

2. The Department or its Authorized Agent shall conduct the medical eligibility assessment with the Department's approved Assessment Form. A Registered Nurse (RN) must conduct the medical eligibility assessment. Applicants who meet the NF medical eligibility criteria, according to the Assessment Form, shall be informed of, and offered the choice of available, appropriate, and cost-effective home and community-based services and alternatives to NF placement. The relative costs to the applicant of each option, must be explained. The Department or its Authorized Agent must complete the Assessment Form within five (5) calendar days of receipt of a request for an assessment.

D. **Eligibility for Home Care for Certain Disabled Children (Katie Beckett)**

The following criteria are to be used for the determination of home care for certain disabled children age eighteen (18) and under who would be eligible for MaineCare if in a nursing facility:

1. The child meets the medical eligibility requirements for NF services described in Section 67.02-3. The child shall be

67.05 **POLICIES AND PROCEDURES** (cont.)

evaluated in the context of age appropriate development for the "activities of daily living" under Section 67.02-3(B)(2).

2. It is appropriate to provide such care for the child outside an institution;

3. The estimated amount to be expended for medical assistance for the child for such care outside an institution is not greater than the estimated amount expended for medical assistance for the individual within an appropriate institution; and

4. The child meets the criteria described in the Department's MaineCare Eligibility Manual regarding disabled children.

A child's medical eligibility, as defined in Section 67.02-3, for NF level services, is subject to periodic reviews by the Department.

67.05-4 **Continued Stay Review**

A. The NF must submit a complete referral form to the Department or its Authorized Agent to request a reassessment at least five (5) calendar days prior to the end date of the resident's current approved eligibility period in order for a new eligibility period to be established and MaineCare coverage to continue. A resident who continues to meet the eligibility requirements for NF services shall sign a "choice letter" indicating his or her selection of community-based services or continued stay in the NF.

B. An individual who is classified for NF-BI level of care must continue to meet the eligibility requirements set forth in Section 67.02-5, in addition to the other requirements in Section 67.02, in order for a new NF-BI eligibility period to be approved. The NF must submit a complete referral form to the Department or its Authorized Agent to request a reassessment at least five (5) calendar days prior to the end date of the resident's current approved eligibility period in order for a new eligibility period to be established and MaineCare coverage to continue. Upon reassessment for NF-BI level of care, the assessment required in Section 67.02-5(C) may be waived at the discretion of the Department or its Authorized Agent; however, a current rehabilitation plan of care with specific goals and timeframes must be in place, and there must be evidence indicating the potential for continued improvement.

C. The reassessment required in Section 67.05-4(A) may be deferred by the Department or its Authorized Agent if: 1) it is the clinical judgment of the assessor that the resident is likely to continue to meet the medical eligibility requirements in Section 67.02-3; and 2) the resident has been in a nursing facility receiving MaineCare coverage for

67.05 **POLICIES AND PROCEDURES** (cont.)

nursing facility services for at least ninety (90) days (excluding resident-days in the facility under an appeal).

Reassessments cannot be deferred for members eligible under Section 67.02-5 NF-BI or members classified under Section 67.02-6, Extraordinary Circumstances.

D. The NF is responsible for implementing a systematic review process to monitor the service needs of each resident and to determine whether the resident continues to require a Nursing Facility level of care to the eligibility requirements set forth under Section 67.02. This review process shall be conducted in conjunction with the multidisciplinary team process.

E. The NF is responsible for notifying a resident who no longer requires a Nursing Facility level of care, as defined by the requirements set forth under Section 67.02. The NF shall request the Department or its Authorized Agent to conduct an eligibility assessment to document whether a resident continues to meet the eligibility requirements. See Section 67.05-9 regarding discharge procedures.

F. At the Department's or its Authorized Agent's request, an individual may be referred to the specialized "Geriatric Evaluation Team" for an assessment of his/her cognitive and physical health status. The team shall provide findings and recommendations to the Department or its Authorized Agent and the individual's physician for care plan development.

G. The Department may review at any time a member's eligibility for continued MaineCare reimbursement for NF, NF-BI services or "extraordinary circumstances" pursuant to Section 67.02-6.

67.05-5 **Physician Services**

A physician must personally approve in writing a recommendation that an individual be admitted to a NF. Stamped signatures are unacceptable. The resident must be seen by a physician at least once every thirty (30) days, during the first ninety (90) days after admission to the NF, and at least once every sixty (60) days thereafter.

67.05-6 **Resident Case Mix Assessment**

A. Each resident of a NF, regardless of payment source, shall have a resident assessment that will enable facility staff to develop a plan of care designed to assist the resident to reach their highest practicable level of physical, mental, and psychosocial functioning.

67.05 **POLICIES AND PROCEDURES** (cont.)

The Minimum Data Set (MDS) and matching Resident Assessment Protocols (RAPs) is the Department's approved Resident Assessment Instrument.

B. **Accuracy of Assessments**

1. Each assessment must be conducted or coordinated with the appropriate participation of health professionals.

2. Certification. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the Assessment Form.

3. Penalty for falsification. An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties pursuant to CFR Subpart B - Requirements for Long Term Care Facilities, 42 CFR §483.20(j) in addition to possible criminal liability.

4. Use of independent assessors. If the Department determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph B(3) above, the Department may require (for a period specified by the Department) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the Department.

C. The Department may review all forms used for resident assessments at any time. Quality reviews will be undertaken by the Department for the following reasons:

1. To ensure that assessments are completed accurately, correctly and on a timely basis.

2. To review the need for NF care for any resident.

67.05-7 **Resident Case Mix Classification**

All residents admitted to a NF, regardless of payment source, shall be assessed using the Minimum Data Set (MDS). The MDS provides the basis for resident classification into one of the case mix groups. The MDS does not meet the definition of Assessment Form in Section 67.01-17. An additional group is assigned when assessment data are determined to be incomplete or in error.

Refer to the Principles of Reimbursement for Nursing Facilities for the case mix classification categories.

67.05 **POLICIES AND PROCEDURES** (cont.)

67.05-8 **Admissions Discrimination and Preferential Admission**

Each facility shall have and implement a written policy consistent with State licensing and Federal certification requirements, which shall define the medical services that may be provided in the facility.

Each facility shall have and implement a written antidiscrimination policy consistent with State licensing and Federal certification requirements, which shall include the following:

A. **Provisions for Resident Acceptance**

All NF's shall have written policy stating that the facility will accept residents regardless of race, color, national origin, or reimbursement source. The written policy shall also identify the following: members of the admission committee; medical treatments that cannot be performed by facility staff; and criteria used to determine incompatibility with current residents. In addition:

1. Nursing facilities may not require any third-party payment as a condition of admission, expedited admission or continued stay in a nursing facility.

2. Nursing facilities may not charge, solicit, accept or receive any gift, money, donation or other consideration as a condition of admission, or expedited admission or continued stay.

B. **Preferential Admission**

NFs may preferentially admit residents under the following conditions and shall give preference in the following order:

1. Any resident whose hospitalization exceeds the approved bed hold period that is paid by MaineCare shall be permitted to be readmitted to the facility immediately upon the first availability of a bed in a semiprivate room in the NF, as long as the resident requires the level of care provided by the facility, and as long as the facility can provide the level of care required by the resident.

2. A facility may preferentially admit anyone who is referred by the Authorized Agent, the Department or the Department's Office of Adult Mental Health Services (also see Sec. 67.05-1, PAS CIC requirements) if the individual's physical health and safety is at risk and he or she is NF level of care.

3. A NF may also preferentially admit residents under the following conditions (without any specific order of preference):

67.05 **POLICIES AND PROCEDURES** (cont.)

a. A facility that is owned and operated by a religious group or for veterans may preferentially admit all members of that religion or denomination or veteran status.

b. A facility may preferentially admit all persons who have a long-time residence in the area where the facility is located.

c. A facility may preferentially admit anyone referred by a specific hospital with which the facility has a written transfer agreement.

d. A facility may preferentially admit anyone who has a spouse residing in that facility.

e. A facility may preferentially admit anyone who has a signed agreement between their insurance company and the NF.

f. A facility may preferentially admit anyone needing specialized covered services (i.e.: care for a brain injury) provided by that facility or in a distinct part of the facility.

g. A facility may preferentially admit anyone who has a written life-care-contract with the facility or with a continuing care retirement community that has entered into a written agreement with the facility.

C. **Waiting List**

A waiting list for facility admissions must be utilized in admitting residents and must also meet the requirements contained in the Regulations Governing the Licensing and Functioning of Nursing Facilities. Residents shall be admitted on a first-come first-served basis, subject to the exceptions outlined in Section 67.05-8(A) and (B).

1. The waiting list must contain the names of all referrals for admission, regardless of payment source, must be updated as necessary and must indicate the reason(s) why a person was not admitted, or was removed from the list. A facility's decision to admit out of order must be justified with reference to policies established pursuant to Section 67.05-8. A facility's decision not to admit must be justified with reference to a written policy defining the scope of medical services provided.

2. The list must indicate when a resident was admitted and must be maintained in one bound book and be available for public review.

67.05 **POLICIES AND PROCEDURES** (cont.)

3. Facilities may not require verbal or written assurance that potential residents are not eligible, or will not apply for Medicare or MaineCare benefits.

4. Once a person's name has been entered on the waiting list, a facility may require the completion of a reasonable application or interview but may not require any additional activity by the potential resident in order to maintain his/her place on the waiting list.

D. **Continuing Care Retirement Communities**

Any facility which is subject to guidelines contained in 24-A M.R.S.A., §6201 *et seq.* is exempt from compliance with this rule.

67.05-9 **Discharges**

A. **Discharge Tracking Forms**

When a resident is discharged from a nursing facility with no expectation of return, discharged with return anticipated, or discharged prior to completing a MDS, a Discharge Tracking Form is to be completed within seven (7) days of the event. Completion of the discharge tracking form is required upon discharge from a facility, admission to another health care facility, or for hospital stays of twenty-four (24) hours or more. The form is not required for therapeutic or social leaves or for observational stays of less than twenty-four (24) hours. Discharge tracking forms must be electronically submitted at least monthly to the Department or its Authorized Agent.

B. **Reentry Tracking Forms**

Following submission of a discharge tracking form coded as discharged with return anticipated or discharged prior to completion of initial assessment, a reentry tracking form must be completed within seven (7) days of the reentry to the facility. The reentry tracking forms must be electronically submitted at least monthly to the Department or its Authorized Agent.

C. **Discharge Planning Procedure**

1. Each participating NF shall maintain written discharge planning procedures that describe which staff members of the facility will have operational responsibility for discharge planning; and, the manner and methods by which such staff members will function, including their relationship with the facility staff.

67.05 **POLICIES AND PROCEDURES** (cont.)

2. At the time of the resident's discharge, the facility shall provide to those persons responsible for post-discharge care such information as will insure the optimal continuity of care. Examples of such information are: current information relative to diagnosis, prior treatment, rehabilitation potential, physician advice concerning immediate care, and pertinent social information.

3. Nursing facilities must notify the Department, Office of Elder Services, of all MaineCare discharges by submitting the Member Transfer form on the day of discharge. This notification is not required for Medicare discharges where MaineCare covers the co-pay, deductible and/or coinsurance. However, notification is required if a member is enrolled in a Medicare managed care plan and Medicare will be paying the member's daily rate of reimbursement for a period of time. The NF must also notify the Department's Office of Elder Services when the member's Medicare benefits discontinue and MaineCare will again be responsible for the daily rate.

4. If the resident is transferring to another NF, copies of the current MDS assessment, the most recent MED form and all PAS CIC records (Level I, Level II and Annual Resident Reviews) shall be sent along.

5. Individuals who are discharged from a NF to their home or community setting shall be made aware of community resources prior to discharge. A referral may be submitted to the Department or its Authorized Agent for an assessment for long term care services.

D. **Resident Transfer and Discharge Rights**

A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

1. the transfer or discharge is necessary to meet the resident's welfare or medical needs and the resident's welfare or medical needs cannot be met in the facility;

2. the transfer or discharge is appropriate because the resident's health and/or functional abilities has improved sufficiently so the resident no longer needs the services provided by the facility; as determined by the resident's physician or a third party payor including Medicare and/or MaineCare;

3. the safety of individuals in the facility is endangered;

67.05 **POLICIES AND PROCEDURES** (cont.)

4. the health of individuals in the facility would otherwise be endangered as determined by the resident's physician;

5. the resident has failed, after reasonable and appropriate notice, to pay or have paid on his or her behalf (including MaineCare, Medicare) for the stay at the facility. Conversion from private pay rate to payment at the MaineCare rate does not constitute non-payment. For a resident who becomes eligible for MaineCare after admission to a facility, the facility may charge a resident only allowable charges under MaineCare; or

6. the facility ceases to operate. In the event a NF ceases to operate and the member is to be transferred to another NF, the member must accept the first available placement that is appropriate to meet his or her medical care needs within a sixty (60) miles radius of the member's home, (or the NF, if this is considered home) or MaineCare reimbursement will cease. The member may accept a placement beyond the sixty (60) miles radius, however, this cannot be required.

The resident's clinical record shall contain documentation describing the basis for the transfer or discharge. When a resident is transferred or discharged for reasons described in 67.05-9(D)(1) or (2), the resident's clinical record shall contain documentation by the resident's physician that identifies the need for transfer or discharge and Interdisciplinary Care Team planning. The member's clinical record must be documented by a physician if the resident is being discharged for the reasons described in 67.05-9(D)(4). Documentation by a physician is not required if the discharge is based upon the reasons described in 67.05-9(D)(3), (5) or (6).

The facility must demonstrate that appropriate multidisciplinary interventions have been tried and have failed before discharging a resident because of violent behavior.

E. **Pre-transfer and Pre-discharge Notice**

1. **In General** - Before transferring or discharging of a resident, a nursing facility must -

   a. notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reason(s);

   b. record the reason(s) in the resident's clinical record, including any documentation required in Section 67.05-9(D)(1-6) above; and

67.05 **POLICIES AND PROCEDURES** (cont.)

   c. include in the notice the items described in Section 65.05-9(E)(3) below.

2. **Timing of Notice** - Written notice must be made at least thirty (30) days in advance of the resident's transfer or discharge except:

   a. in a case described in Section 67.05-9(D) (3)and (4),

   b. in a case described in Section 67.05-9(D)(2) where the resident's health and/or functional abilities improve sufficiently to allow a more immediate transfer or discharge;

   c. in a case described in Section 67.05-9(D)(1) where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

   d. in a case where a resident has not resided in the facility for thirty (30) days.

   In the case of such exceptions, written notice must be given as many days before the date of the transfer or discharge as is practicable.

   In addition, oral notice shall be provided immediately to the resident, his/her legal representative, or a family member (if they are able to be contacted) unless the discharge meets the exceptions. (67.05-9(E)(2)(a - d).

3. **Items included in notice** - Each notice must include:

   a. the reason for the transfer or discharge including events that are the basis for such action;

   b. the effective date of the transfer or discharge;

   c. the location to which the resident is transferred or discharged;

   d. notice of the resident's right to appeal the transfer or discharge as set forth in Section 67.05-9(G);

   e. the mailing address and telephone number of the State Long-term Care Ombudsman Program which is: P.O. Box 2723, Augusta, Maine 04333, 1-800-499-0229 (in-state only) and (207) 621-1079 (local and out-of state);

67.05 **POLICIES AND PROCEDURES** (cont.)

f. in the case of resident's with developmental disabilities, the mailing address and telephone number of the Office of Advocacy Services, Department of Health and Human Services, Office of Adults with Cognitive and Physical Disabilities, which is: 40 State House Station, Augusta, Maine 04333-0040, 287-4228; and for residents with mental illness, the advocacy office is "Disability Rights Center of Maine", Office of Adults with Mental Illness, 40 State House Station, Augusta, Maine 04333-0040, 626-2774 or 1-800-452-1948.

g. the resident's right to be represented by him or herself or by legal counsel, a relative, friend or other spokesperson.

F. **Orientation for Transfer or Discharge**

A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility as defined in the Department's "Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities."

1. Sufficient preparation and orientation shall include, a discharge summary that includes -

   a. a recapitulation of the resident's stay;

   b. a final summary of the resident's status to include an assessment of the resident's current functional and physical abilities at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

   c. a post-discharge plan of care developed with the participation of the resident and his or her family (if available), that will assist the resident to adjust to his or her new living environment.

2. Sufficient preparation may include trial visits by the resident to a new location, working with family to ask their assistance in assuring the resident that valued possessions are not left.

G. **Hearings**

A notice of intent to transfer or discharge (see Section 67.05-9(E)) shall include a statement that any resident has the right to appeal a decision to transfer or discharge to the Office of Administrative

67.05 **POLICIES AND PROCEDURES** (cont.)

Hearings, Department of Health and Human Services. To challenge the transfer or discharge, submit a request in writing to the:

The Office of Administrative Hearings
Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

Hearings will be held on an expedited basis and a written decision will be rendered within three (3) working days. The decision by The Office of Administrative Hearings is enforceable following two (2) working days of the written decision, unless the resident has appealed the decision in court. The appeal must be submitted within two (2) working days. A facility decision to transfer or discharge will be upheld if consistent with the standard set forth in Section 67.05-9(D), (E), and (F). The hearing officer may consider violations, by the facility, of federal or state statutes or regulations that may have contributed to the basis for discharge.

A facility may not transfer or discharge a resident until a decision is rendered if that resident has requested a hearing within ten (10) days of receipt of notice unless:

1. the health or safety of individuals is in immediate risk and cannot be otherwise protected until a decision is rendered (see Section 67.05-9(D) (3) and (4));

2. immediate transfer or discharge is necessitated by the resident's urgent medical need (see Section 67.05-9(D)(1)).

Hearings will be held as described in Chapter I of this Manual unless inconsistent with this Section in which case this Section shall govern.

67.05-10 **Quality Assurance**

Each nursing facility shall have in effect a written quality assurance plan that includes, but is not limited to:

1. Utilization Review

2. Infection Control

3. Discharge Planning

As part of utilization review a NF is required to review the necessity for continued stay and discharge planning in accordance with Section 67.

The Department will monitor the NF's compliance with Section 67.

67.05 **POLICIES AND PROCEDURES** (cont.)

67.05-11 **Prior Approval for Payment of Bed Holds During a Hospitalization**

A. All nursing facilities must provide written information to the member and a family member or legal representative that specifies the Department's bed hold policy and the facility's bed hold policy before the member is transferred to a hospital and at the time of transfer.

B. A NF shall provide a member with the opportunity for readmission following hospitalization, if the individual remains a MaineCare member. The NF must request prior approval on the day of admission to the hospital or the first working day after admission, if admission is on a non-working day by submitting the Department's member transfer form to the Office of Elder Services. If the NF fails to do so, reimbursement will be granted only for the remainder of the allowed days. If the NF fails to notify the Office of Elder Services, the patient shall not be billed for non-reimbursed days.

Emergency Effective 8.27.13

C. Effective March 25, 2013, payment of bed holds for a semi-private room for a short-term hospitalization of the member shall be granted up to four (4) days (midnights) absence through March 31, 2013, as long as the member is expected to return to the nursing facility.

If CMS approves, effective April 1, 2013, payment for bed holds shall be granted up to seven (7) days (midnights) absence per inpatient hospitalization absence, as long as the member is expected to return to the nursing facility.

If a member leaves the hospital and does not return to the NF, MaineCare reimbursement for the bed hold will stop as of the date of discharge from the hospital.

If the member's hospitalization exceeds the applicable limit on the number of bed hold days, the resident must receive a medical eligibility assessment prior to continued MaineCare coverage of nursing facility services.

MaineCare eligible members who are admitted to a NF from their home or community living situation and their expected stay is to be less than thirty (30) days in the NF, would not qualify for bed hold days. MaineCare members authorized under extraordinary circumstances (see Section 67.06) or awaiting placement for residential care (see Section 67.06-9) are not eligible for bed hold days. The facility must notify the Office of Elder Services by faxing the member transfer form.

D. Upon a resident's readmission to a NF, following a hospital stay, the NF must FAX or mail a completed copy of the Member Transfer Form to the Office of Elder Services.

E. If at any point it is determined that the resident will not return to the NF, the Office of Elder Services must be notified and reimbursement for the bed hold will cease.

67.05 **POLICIES AND PROCEDURES** (cont.)

F. Family or friends of a MaineCare-eligible resident may make payment for bed holds in excess of the maximum number of days allowed under MaineCare regulations. This payment may not exceed the usual and customary rate for a bed in a semi-private room.

67.05-12 **Leave of Absence for a MaineCare Member**

Emergency Effective 8/27/13

Effective March 25, 2013, all nursing facilities are responsible for informing residents in writing of their right to one (1) overnight leave of absence through March 31, 2013. If CMS approves, all nursing facilities must inform patients who are in days awaiting NF placement, in writing, of their right to twenty (20) overnight leaves of absence from April 1, 2013 through June 30, 2013; and twenty (20) overnight leaves of absence from July 1, 2013 through June 30, 2014 and subsequent state fiscal years. A leave of absence may not be used to extend a bed hold during a hospital stay.

Payment may be made to a facility to reserve a bed for a resident on an overnight leave of absence if the following conditions are met:

A. The resident's plan of care provides for such an absence;
B. The resident takes no more than one (1) overnight leave of absence from March 25, 2013 through March 31, 2013;
C. If CMS approves, the member takes no more than a total of twenty (20) overnight leaves of absence from April 1, 2013 through June 30, 2013;
D. If CMS approves, the member takes no more than a total of twenty (20) overnight leaves of absence from July 1, 2013 through June 30, 2014 and subsequent state fiscal years;
E. If at any point it is determined that the resident will not return to the NF, the Department must be notified and reimbursement for the bed will cease.

67.05-13 **Services, Supplies and Equipment**

A. **Routine Services, Supplies and Equipment Included in Regular Rate for Reimbursement**

1. Routine services, supplies, and equipment shall be supplied by the facility as part of the regular rate of reimbursement. Routine services means regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment. (See Chapter II, Section 60, Medical Supplies and Durable Medical Equipment for a list of supplies and equipment provided to members in a NF as part of the regular rate of reimbursement.)

2. Facilities which serve a special group of the disabled are expected to furnish the equipment and services normally used in their care (e.g., children's wheelchairs) as part of their reasonable cost.

B. **Supplies and Equipment for Which Department May Be Billed by a Supplier or Pharmacy**

Equipment and supplies which, when ordered by a physician, may be payable to a supplier or pharmacy in accordance with the policies established under Section 60 and Section 80 of Chapter II of this Manual.

67.05 **POLICIES AND PROCEDURES** (cont.)

2. For purposes of reimbursement, acute care general hospitals that are affiliated with the facility through the same corporate structure, or have a NF as a distinct part of a larger institution, may be considered a supplier of these items and must bill the Department as a provider of medical supplies and durable medical equipment for patients who are residents of the hospital-based NF.

C. **Services, Supplies and Equipment Costs Charged to Residents' Personal Funds**

1. **Personal Funds**

Charges may not be imposed against the personal funds of a resident for any item or service for which payment is made under MaineCare. In addition, residents shall not be required to supplement MaineCare payments for items or services that are covered.

2. **Member Cost of Care**

a. A member's cost of care is determined by OIAS under MaineCare eligibility rules.

b. Routine supplies and personal care items that are provided by the NF under 67.05-13(A), may not be purchased by a member and then deducted from his or her client cost of care.. If a resident has a therapeutic need for a particular brand name item, or product, as documented by the physician, then the NF must provide that brand name item or product to the resident as part of the NF regular rate of reimbursement.

c. The cost of "Less-Than-Effective" drug products, identified under the FDA's Drug Efficacy Study Implementation (DESI) program, may not be deducted from a resident's client cost of care. These drug products are not covered under MaineCare.

d. Drugs of manufacturers not participating in the Rebate Program may not be deducted from a resident's client cost of care. Reimbursement for these drug products is not covered under MaineCare.

e. Some items are covered by MaineCare only for individuals under the age of twenty-one (21). In cases where an individual age twenty-one (21), **or over**, requires an item or service covered by MaineCare only for individuals

67.05 **POLICIES AND PROCEDURES** (cont.)

under age twenty-one (21), the amount to be charged to the client assessment or to the responsible party, shall be limited to the MaineCare rate for that item or service.

f. Eyeglasses for individuals residing in a nursing facility, who are age twenty-one (21), or over, must be obtained through the Vision Care Volume Purchase Contract.

D. **Physical Therapy (PT) and Occupational Therapy (OT) Services**

Physical and occupational therapy services must be directly and specifically related to an active written treatment regimen designed by the physician after any needed consultation with the qualified physical or occupational therapist, and the services must be included in the written plan of care. To constitute physical or occupational therapy, a service furnished to a member must be reasonable and necessary for the treatment of his or her illness or condition. The services must be of such a level of complexity and sophistication, or the condition of the member must be such, that the judgment, specialized knowledge, and skills of a qualified physical or occupational therapist are required.

See Section 68, Occupational Therapy Services and Section 85, Physical Therapy Services of the MaineCare Benefits Manual for licensing criteria of the practitioner and covered services.

1. **Limitations**

a. MaineCare will not reimburse for more than two (2) hours each of PT and OT per day.

b. PT or OT services can be provided by a home health agency certified as a Medicare provider, or an outpatient department of an acute care hospital, or a licensed independent therapist as defined in Chapter II, Sections 68 and 85 of the MaineCare Benefits Manual.

c. NFs may bill for services of PT and/or OT on their staff or under a contract with them. Reimbursement for services provided by a licensed independent physical or occupational therapist will be limited to the maximum allowance as defined in Chapter III, Sections 68 and 85 of the MaineCare Benefits Manual.

d. For purposes of reimbursement, acute care general hospitals that are affiliated with the facility through the same corporate structure, or have a NF as a distinct part of a larger institution, must bill the Department as a provider of physical or

67.05 **POLICIES AND PROCEDURES** (cont.)

occupational therapy services on the NF's billing form for patients who are residents of the hospital-based NF.

2. **Reimbursement for PT and OT Consultations**

a. Consultation provided to a NF must be reimbursed at a reasonable cost.

b. Types of consultation that may be approved include:

1. In-service education programs for staff members who have not been trained to carry out procedures that may be delegated by a physical or occupational therapist; and

2. Professional consultation provided to administrators with respect to purchasing equipment or modification of a physical plant to meet the needs of individuals.

E. **Speech and Hearing Services**

1. All covered services provided under Section 109 of the MaineCare Benefits Manual must be ordered or requested in writing by a physician, physician assistant, or advanced practice registered nurse as allowed by the respective licensing authority and his or her scope of practice.

2. Covered speech-language pathology services for members aged twenty-one (21) or older are also limited to those members who have been assessed to have rehabilitation potential as defined in Section 67.01-26 or to those who have demonstrated medical necessity for speech therapy to avoid a significant deterioration in ability to communicate orally, safely swallow or masticate. A member's rehabilitation potential must originate from a physician or primary care provider.

3. Adult members (age twenty-one (21) and over), must have an initial assessment by a physician or primary care provider that documents that the member has experienced a significant decline in his/her ability to communicate orally, safely swallow or masticate, and that the member's condition is expected to improve significantly in a reasonable, predictable period of time as a result of the prescribed treatment plan.

4. One initial evaluation of the member is covered per provider per year. The member must receive an initial evaluation by a speech-language pathologist annually that supports the physician or

67.05 **POLICIES AND PROCEDURES** (cont.)

primary care provider's determination that rehabilitation potential exists.

5. If speech-language pathology services are to be continued beyond a period of six (6) months, a re- evaluation by a speech-language pathologist must be completed every sixth month from the initial determination of eligibility, in order to determine that eligibility continues to exist. A report of the results of the speech-language pathologist's six-month re-evaluation must be sent to the member's physician or primary care provider, who will use that information to decide if eligibility continues to exist. If the physician or primary care provider agrees in writing that eligibility continues to exist, the member may continue to receive speech-language pathology services for an additional six (6) month period.

6. **Limitations**

a. Speech and hearing services when provided in a NF setting, will be reimbursable to the following types of providers only: a home health agency certified as a Medicare provider, or a speech and hearing clinic certified as a Medicare provider, or a licensed speech-language pathologist, or audiologist, or a speech and hearing agency as defined in Section 109 of the MaineCare Benefits Manual.

b. NFs may bill for services of a speech-language pathologist or audiologist on their staff or under a contract with them. Reimbursement for services provided by a speech-language pathologist or audiologist will be limited to the maximum allowance as defined in Chapter III, Section 109 of the MaineCare Benefits Manual.

c. For purposes of reimbursement, acute care general hospitals that are affiliated with the facility through the same corporate structure, or have a NF, as a distinct part of a larger institution, must bill the Department as a provider of speech and hearing services on the NF's billing form for members who are residents of the hospital-based NF.

7. **Reimbursement for Consultation Services**

Types of consultation that may be approved include: In-service education programs for staff members who have not been trained to carry out procedures and principles developed by the licensed speech pathologist and/or audiologist.

67.05 **POLICIES AND PROCEDURES** (cont.)

F. **Mental Health Services**

Mental Health Services are covered when those services meet all the following conditions:

1. The services must be of a level of less intensity than those defined as specialized services;

2. The services must be specifically designed by a plan of care developed in response to the findings and recommendations of PAS CIC and approved by the NF interdisciplinary team or, for individuals exempt from PAS, the services must be specifically designed by a plan of care developed in response to the findings and recommendations of, and approved by, the NF interdisciplinary team;

3. The service must be reasonable and necessary for the treatment of the individual's mental illness;

4. The services must be of a level that the skills and expertise of a mental health professional are required;

5. The services must be provided by an individual appropriately licensed or certified in the State or province in which he or she practices and practicing within the scope of that licensure or certification. A clinician includes the following: licensed clinical professional counselor (LCPC); licensed clinical professional counselor-conditional (LCPC-conditional); licensed clinical social worker (LCSW); licensed master social worker conditional clinical (LMSW-conditional clinical); licensed marriage and family counselor (LMFT); licensed marriage and family counselor-conditional (LMFT-conditional); physician; psychiatrist; advanced practice registered nurse psychiatric and mental health nurse practitioner (APRN-PMH-NP); advanced practice registered nurse psychiatric and mental health clinical nurse specialists (APRN-PMH-CNS); psych examiner, RNC, or licensed clinical psychologist.

6. The services must be provided with the expectation that there will be improvement in mental, psychosocial and functional abilities;

7. Mental health services will include consultation with and education of staff in the implementation of the treatment plan recommendations;

8. Mental health services in a NF setting will be reimbursed when ordered by a physician; and

67.05 **POLICIES AND PROCEDURES** (cont.)

9. Mental health services must be provided and reimbursed in accordance with the relevant sections of the MBM and Chapter III of this Section, Principles of Reimbursement for Nursing Facility Services.

G. **Services for Individuals with Mental Retardation or Other Related Condition**

Community support services are covered for those members residing in the NF who meet the eligibility criteria under Section 21 or have an "other related condition" as defined in 67.01-27 above. The services must meet all the requirements outlined below:

1. The community support services are designed to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well being. These services focus on community inclusion, personal development, and support in areas of daily living skills if necessary.

2. The services are provided by individuals who have successfully completed the Direct Support Professional (DSP) curriculum or the Maine College of Direct Support.

3. All services delivered are written and documented in the member's plan of care.

4. The services must be provided and reimbursed in accordance with Chapter III, Section 67, Principles of Reimbursement for Nursing Facility Services, Subsection 70, Special Service Allowance.

H. **Services for Individuals with a Brain Injury (BI)**

1. A nursing facility that has Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation may be designated by the Department as a provider of service for individuals with a brain injury.

2. The Department or its Authorized Agent will review each individual's need for BI services at least annually, based upon the criteria set forth in 67.02.

   Additionally, the member must show measurable improvement in a reasonable, and generally predictable, period of time. Once it is established that the restorative potential has been reached, and maintenance rehabilitation is required, the member shall be transferred to an appropriate setting.

67.05 **POLICIES AND PROCEDURES** (cont.)

3. A nursing facility providing BI Services shall provide a program of goal-oriented, comprehensive, interdisciplinary and coordinated services directed at restoring an individual to the optimal level of physical, cognitive, and behavioral functioning. Covered services include medical, rehabilitative, and social services provided by appropriately licensed or qualified staff as defined in the Principles of Reimbursement for Nursing Facilities.

Reimbursement for all NF-BI services will be included in the per diem rate, as described in the Principles of Reimbursement for Nursing Facilities. Members classified for NF-BI are prohibited from receiving coverage for services under Section 102, Rehabilitative Services, as long as the member is a NF-BI resident.

H. **Pharmaceutical Services**

All nursing facilities shall comply with State and Federal regulations that govern obtaining, dispensing and administering drugs and biologicals. Refer to the "Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities" for rules regarding pharmaceutical services.

A pharmacy affiliated through common ownership or control with a hospital and/or nursing facility is allowed to dispense covered MaineCare prescription drugs to MaineCare members in that facility. The drugs must be dispensed by a registered pharmacist, according to dispensing regulations. Drugs are to be billed in accordance with the Department's billing guidelines and drug claim processing system, at Average Wholesale Price (AWP) without professional fee. (Also see Section 80, Pharmacy Services.)

I. **Respiratory Therapy Services**

1. The following respiratory therapy services are included in the facility's per diem rate and shall not be billed separately:

   a. Maintenance of artificial airways;

   b. Therapeutic administration and monitoring of medical gases (especially oxygen), pharmacological active mists and aerosols;

   c. Bronchial hygiene therapy, including deep breathing and coughing exercises, IPPB, postural drainage, chest percussion and vibration, and nasotrachael suctioning; and

67.05 **POLICIES AND PROCEDURES** (cont.)

   d. periodic assessment and monitoring of acute and chronically ill members for indications for respiratory therapy services.

2. The following services shall not be provided by the direct care staff of the facility, but rather by the appropriate professional and shall be billed separately:

   a. diagnostic tests for evaluation by a physician (e.g.: pulmonary function tests, spirometry, and blood gas analysis); and

   b. pulmonary rehabilitation that includes exercise conditioning, breathing retraining, and patient education regarding the management of the member's respiratory problem.

J. **Other Services**

The attending physician's order is required for all other types of services provided in a NF (e.g.: psychological services, podiatric services, etc.). The individual providing the service shall bill in accordance with the policies and procedures in the section of this Manual that apply to his or her specialty.

67.05-14 **Transportation to Services Outside of the Nursing Facility**

A. **Arranging or Providing Transportation**

NF's are required to assist members in gaining access to vision, hearing, or other medically necessary MaineCare services by making appointments, and providing or arranging for transportation. To enable a NF to provide transportation, the reasonable costs of operating one (1) motor vehicle is an allowable cost in the facility's reimbursement rate (as set forth in this Section, Chapter III, Principles of Reimbursement for Nursing Facilities). NF's must use their agency vehicle to transport members whenever possible. Each time a member is transported by someone other than a family member/friend, or the NF's agency vehicle, and for which MaineCare reimbursement will be sought, the member's record must document why the NF vehicle was not used.

B. **Transportation Agency**

If approved by CMS, effective August 1, 2013, or such later date as determined by the Department, when a member requires transportation to a MaineCare covered service, and the NF or a family member/friend is unable to provide it and the NF has documented why the transportation cannot be provided, then the MaineCare Non-Emergency Transportation (NET) Broker must be called to make travel arrangements. NF staffing shortages should not be an ongoing reason for NET services. It is the expectation that the NF is fully staffed and a need to use a transportation agency due to unavailable staff would not occur frequently.

67.05 **POLICIES AND PROCEDURES** (cont.)

The only exception is when the services of a wheelchair van are medically necessary, in which case, the NF must call the NET Broker and the NET Broker will arrange for this transportation as needed, if the NF does not own a vehicle that can accommodate a wheelchair. (e.g. the member is not able to transfer from a wheelchair to a car or van that is owned by the NF) The NF must document in the member's medical record if this situation occurs.

The NET Broker must work with the NFs to coordinate member appointments to utilize the available resources in the most cost effective manner.

67.05-15 **Flu and Pneumonia Vaccinations**

Upon admission, and annually every fall, each resident's immunization status shall be updated, regardless of payor. Unless medically contraindicated or refused, the standard of care is to administer an annual flu (influenza) vaccination in the fall; and a pneumonia (pneumococcal) vaccination, that may be repeated no more than every five (5) years (other immunizations should also be reviewed and updated as necessary). As with any treatment, the resident has the right to refuse the vaccination. Each vaccination must be documented in the resident's medical record. Each vaccination refusal by the resident (or guardian, agent or surrogate, as defined in 18-A MRSA Sec. 5-801) must also be documented in the resident's record. Annually, the NF shall report to the Department, in a format specified by the Department, the number of residents, number and type of vaccinations administered, and the number of refusals for the reporting period.

67.05-16 **Respite Services**

A MaineCare waiver member may be admitted to a NF in order to receive "waiver" respite services for no more than thirty (30) days annually. The Medical Eligibility Determination (MED) assessment and the PAS screen are **NOT** required for a respite admission reimbursed by waiver funds. Respite services for a MaineCare home and community based waiver services member will be authorized and reimbursed through Section 19, Home and Community Based Benefits for the Elderly and for Adults with Disabilities, of the MaineCare Benefits Manual. If the member applies to remain in the NF, MaineCare coverage for NF services shall begin only after all of the requirements in Sec. 67.02 have been met and a classification period has been authorized by the Department or its Authorized Agent.

67.05-17 **Non-Covered Services**

A. Payment by a relative of an additional amount to enable a member to obtain non-covered services such as a private room (single bed), telephone, television, and authorized bed reservation days is permitted. However, the additional charge for noncovered services shall not exceed the charge to private pay residents. The supplement for a private room shall be no more than the difference between the private pay rate for a

67.05 **POLICIES AND PROCEDURES** (cont.)

semi-private room and a private room. There shall be a signed statement by the relative making the additional payment that he/she was notified and agreed to the payment for non-covered services before those services were provided.

B. A private room is a noncovered service under the MaineCare program, but if there is a medical necessity for a private room, the nursing facility must make one available. However, reimbursement will be made only at the MaineCare semi-private room rate.

C. Specialized services, as determined by a PAS CIC assessment, for NF residents diagnosed with mental illness, mental retardation, or other related condition, are noncovered services under Section 67, Nursing Facility Services. (Also see Section 67.05-13(F)and (G) for covered MI/MR services).

D. PT and OT therapy services related to activities for the general good and welfare of resident, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute physical therapy for MaineCare purposes.

E. Maintenance therapy (repetitive services not requiring the skills of a qualified physical or occupational therapist or the use of complex and sophisticated physical or occupational therapy procedures) is not a covered service, except as provided in Section 67.05-13(D).

F. Services provided in the absence of a valid MED form completed by the Department or its Authorized Agent.

G. Services that are provided outside an approved classification period.

67.05-18 **Right of Appeal**

The following individuals may request an administrative hearing if aggrieved by a decision of the Department as set forth in this section.

A. **The Member, His or Her Family or Responsible Person**

An appeal may be made by the member, his or her family, or responsible person or the attending physician on behalf of the member, for any classification decision. In order to appeal, the member should state by letter his or her reasons for disagreement with the classification and any other pertinent information. This letter shall be addressed to the Director of the Office of Elder Services, Department of Health and Human Services, 11 State House Station, Augusta, Maine 04333-0011.

B. **The Provider**

Providers may request a hearing when aggrieved by a decision of the Department as set forth in Chapter I of this Manual. The procedure for administrative hearings is more specifically set forth in Chapter I of this Manual.

67.05 **POLICIES AND PROCEDURES** (cont.)

67.05-19 **Freedom of Choice**

If a nursing facility contracts with or utilizes a single source of qualified outside resources such as pharmacy services, members must be given a choice of using this particular service or another qualified resource.

67.05-20 **Program Integrity**

All providers are subject to the Department's Program Integrity activities. See Chapter I, General Administrative Policies and Procedures, Section 1.18 of the MBM for rules governing these functions.

67.05-21 **Confidentiality**

The disclosure of information regarding individuals participating in the MaineCare program is strictly limited to purposes directly connected with the administration of the MaineCare program. Providers shall maintain the confidentiality of information regarding these individuals in accordance with 42 CFR §431.300 *et seq.* and other applicable sections of State and Federal law and regulation.

67.06 **REIMBURSEMENT**

A. Nursing facilities are reimbursed in accordance with this Section, Chapter III, Principles of Reimbursement for Nursing Facilities.

1. Except for nursing facilities which provide brain injury services, reimbursement for ancillary services, including those provided by a NF that is a distinct part of a larger institution, such as medical supplies, physical therapy, occupational therapy, speech and hearing services, respiratory therapy, and pharmacy services is based upon reasonable cost or the maximum allowance.

2. Brain Injury (BI) services shall be reimbursed pursuant to the "Intensive Rehabilitation NF Services for Brain Injured Individuals" section of the Principles of Reimbursement only when: a) the member is classified, by the Department or its Authorized Agent, NF-BI level pursuant to Section 67.02-5 and all relevant requirements; b) the services were provided during an approved NF-BI classification period; and c) the BI services were delivered in a CARF accredited facility (unless waived by the Department for an authorized out-of-state placement).

3. Nursing facilities will be reimbursed under Chapter 115, Principles of Reimbursement for Residential Care Facilities, for those members qualifying for continued NF stay under Section 67.02-9.

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

C. Nursing Facilities may not accept or receive payment for covered services in addition to the MaineCare payment.

Appendix 1

Assessment Scales		
	Disability Rating Scale (DRS)	
Category	**Item**	**Instructions**
Arousability, Awareness and Responsivity	Eye Opening	0 = *spontaneous* 1 = *to speech* 2 = *to pain* 3 = *none*
	Communication Ability	0 = *oriented* 1 = *confused* 2 = *inappropriate* 3 = *incomprehensible* 4 = *none*
	Motor Response	0 = *obeying* 1 = *localizing* 2 = *withdrawing* 3 = *flexing* 4 = *extending* 5 = *none*
Cognitive Ability for Self Care Activities	Feeding	0 = *complete* 1 = *partial* 2 = *minimal* 3 = *none*
	Toileting	0 = *complete* 1 = *partial* 2 = *minimal* 3 = *none*
	Grooming	0 = *complete* 1 = *partial* 2 = *minimal* 3 = *none*
Dependence on Others	Level of Functioning	0 = *completely independent* 1 = *independent in special environment* 2 = *mildly dependent* 3 = *moderately dependent* 4 = *markedly dependent* 5 = *totally dependent*
Psychosocial Adaptability	Employability	0 = *not restricted* 1 = *selected jobs* 2 = *sheltered workshop (non-competitive)* 3 = *not employable*
	Total DR Score	

1

Rappaport et al., (1982). Disability rating scale for severe head trauma patients: coma to community. Archives of Physical Medicine and Rehabilitation, 63: 118-123

Appendix 1 (cont.)

Total DR Score	Level of Disability
0	None
1	Mild
2-3	Partial
4-6	Moderate
7-11	Moderately Severe
12-16	Severe
17-21	Extremely Severe
22-24	Vegetative State
25-29	Extreme Vegetative State

Rappaport et al., (1982). Disability rating scale for severe head trauma patients: coma to community. Archives of Physical Medicine and Rehabilitation, 63: 118-123