MaineCare Services

An Office of the
Department of Health and Human Services

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Paul R. LePage, Governor *Mary C. Mayhew, Commissioner*

DATE: February 27, 2012

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Adopted Rule - MaineCare Benefits Manual, Chapter III, Section 67

This letter gives notice of adopted rule: Chapter 101, MaineCare Benefits Manual, Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities. This adopted rulemaking, if CMS approves, will raise the Cost of Living Adjustment (COLA) for Nursing Facilities to 2% beginning on October 1, 2011. This is prompted by changes to P.L. 2011, ch. 411. The retroactive application of this rule is permitted under 22 MRSA 42(8).

Rules and related rulemaking documents may be reviewed at and printed from MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html or, for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-606-0215.

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

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, Office of MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities

ADOPTED RULE NUMBER:

CONCISE SUMMARY: This adopted rulemaking, if CMS approves, raises the Cost of Living Adjustment (COLA) for Nursing Facilities to 2% beginning on October 1, 2011. This is prompted by changes to P.L. 2011, ch. 411. The retroactive application of this rule is permitted under 22 MRSA 42(8).

See http://www.maine.gov/dhhs/oms/rules/index.shtml **for rules and related rulemaking documents.**

EFFECTIVE DATE: March 3, 2012

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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)
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SECTION 67 **PRINCIPLES OF REIMBURSEMENT FOR NURSING FACILITIES** Established 3-13-79
LAST UPDATED 2-27-12

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LAST UPDATED 2-27-12

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.

44.3 Purchase, Rental, Donation and Lease of Capital Assets

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

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.

(6) 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 nonrevenue - 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.

SECTION 67 **PRINCIPLES OF REIMBURSEMENT FOR NURSING FACILITIES** Established 3-13-79
LAST UPDATED 2-27-12

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 - 182.484
EXTENSIVE 2/ADL	7-18/Head Injury – ADL	10 - 142.057
EXTENSIVE 1/ADL	7-18/Head Injury – ADL	7 - 91.910

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 bedbanking 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.