June 11, 2009

TO: Interested Parties

FROM: Anthony Marple, Director, MaineCare Services


These emergency rules amend language that describes the one-time payment reimbursement methodology for nursing facility services for SFY 09 rebasing. Specifically, the one-time payment will be based on the service dates beginning January 1, 2009, as opposed to July 1, 2008. In addition, the Department has included a more detailed methodology for calculation of these payments. This is necessary because the Centers for Medicare and Medicaid Services (CMS) has informed the Department that its state plan must be modified to clarify the one time supplemental payment. These emergency rules will be in effect for ninety (90) days from the effective date of the rule.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at http://www.maine.gov/dhhs/bms/rules/provider_rules_policies.htm 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 1-800-423-4331.

A copy of the public comments and Department responses can be viewed at and printed from the Office of MaineCare Services website or obtained by calling 207-287-9368 or TTY: (207) 287-1828 or 1-800-423-4331.

If you have any questions regarding the policy, please contact your Provider Relations Specialist at 624-7539, option 8 or 1-800-321-5557, extension option 8 or TTY: (207)287-1828 or 1-800-423-4331.
Notice of Agency Rule-making EMERGENCY Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: Chapter 101, MaineCare Benefits Manual, Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities

ADOPTED RULE NUMBER:

CONCISE SUMMARY: In this emergency rule making, the Department is implementing changes in the one-time payment methodology. Since March 15, 2009, the Centers for Medicare and Medicaid Services (CMS) has informed the Department that its state plan must be modified to clarify the one time supplemental payment. Specifically, the dates of service on which the payment will be based will begin January 1, 2009 instead of July 1, 2008. In addition, the Department was required to add more specific language that describes the methodology that will be used for the calculation of the one-time payment. These emergency rules will be in effect for ninety (90) days.

STATUTORY AUTHORITY: 22 M.R.S.A. §§42, §3173
5 M.R.S.A. §8054


EFFECTIVE DATE: June 11, 2009

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Establishment of Prospective Per Diem Rate

Principle. For services provided on or after July 1, 2008, 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.

Nursing facilities will receive a one time payment from SFY 09 rebasing funding for the period between July 1, 2008 and December 15, 2008. This payment will not be subject to cost settlement. The one time payment is based on the facility’s December 16, 2008 rebased case mix adjusted direct care cost component multiplied by the facility’s total Medicaid days for dates of service between July 1, 2008 and December 15, 2008, which results in a facility specific case mix adjusted MaineCare direct care cost. The facility’s percentage of the total amount of the one time payment available equals the facility specific case mix adjusted MaineCare direct care cost, as calculated in the previous sentence, divided by the total MaineCare direct care cost for all nursing facilities, as calculated in the previous sentence. The amount of the one time payment is calculated by multiplying the total amount appropriated for all nursing facilities by this facility specific percentage.

If CMS approves, a one-time supplemental payment shall be paid to each qualifying nursing facility to distribute the remaining balance of the 2009 nursing facility rebasing appropriation. Payment will be made to each qualifying nursing facility whose base year 2005 costs inflated to January 1, 2009, is greater than the facility’s rate effective January 1, 2009, prior to the rebasing. The one-time supplemental payment will be allocated based on the percentage of Medicaid incremental cost increase for each qualifying nursing facility. The Medicaid incremental cost increase is calculated by subtracting the facility’s rate effective January 1, 2009, prior to the rebasing, from the rebased rate, using the Skilled Nursing Facility Total Market Basket published in the Healthcare Cost Review first quarter 2008 to inflate base year 2005 cost through June 30, 2008. The resulting difference is multiplied by the facility’s latest Medicaid days. Each qualifying nursing facility’s relative share of the Medicaid incremental cost increase is multiplied by the remaining balance of the 2009 nursing facility rebasing appropriation, to determine the facility’s one-time supplemental payment. The payment will be made in June 2009.

The base year direct and routine cost component costs will be trended forward using the guidelines as described in Section 91. (See Section 80.3 for a complete description of the rate setting process for the direct care component and inflation guidelines from the base year through June 30, 2008.) 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.