DATE: December 12, 2018

TO: Interested Parties

FROM: Stefanie Nadeau, Director, Office of MaineCare Services


PUBLIC HEARING: January 2, 2019

COMMENT DEADLINE: January 12, 2019

This letter gives notice of proposed rule: 10-144 C.M.R. ch. 101, MaineCare Benefits Manual, Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities.


This rulemaking makes a number of changes to the reimbursement methodology for Nursing Facilities pursuant to the Act. These changes include a change in the Occupancy Adjustment to allow for reduced occupancy percentages, an increase in the utilization payment, and the addition of a special supplemental allowance to account for wage increases. The Legislature further required that, for state fiscal year beginning July 1, 2018, the base year for each facility is its fiscal year that ended in calendar year 2016; for state fiscal years beginning on or after July 1, 2019, subsequent rebasing must be based on the most recent cost report filings available. Further, for the state fiscal year beginning July 1, 2018, the rates for each rebasing year must include an inflation adjustment for a cost-of-living percentage change in nursing facility reimbursement each year in accordance with the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index – medical care services index from the prior December for professional services, nursing home, and adult day care services. Finally, the Department added an aggregate hold harmless provision to reflect that the revised method of rebasing a nursing facility’s base year may not result in a rate of reimbursement for direct and routine costs that is lower than the rate in effect June 30, 2018.

Additional changes include:

- Uniform desk review completion is extended from one hundred eighty days to one calendar year;
- Clarification is added to describe the conditions required for interest expense to be allowable. Similarly, the Department elaborated upon when refinancing expenses may be allowable;
• Principle 39 – Community-Based Specialty Nursing Facility Units states services provided are medical-psychiatric services and removes “under contract” with the Department;
• Throughout the policy “if CMS approves” language has been removed, where applicable, based on approved State Plan Amendment status.

Because the Act involves MaineCare reimbursement, these rule changes are also governed by federal Medicaid law. 42 C.F.R. § 447.205(d) requires that public notice of changes in reimbursement for State Plan services must “be published before the proposed effective date of the change.” The Department published its notice of reimbursement methodology change for the Section 67 rates on August 1, 2018. Upon the advice of the Office of the Attorney General, the changes in reimbursement methodology will be effective August 2, 2018; this effective date comports with the federal law requirement. Pending approval of the proposed changes to the Section 67 State Plan Amendment that were submitted to the Centers for Medicare and Medicaid Services, the reimbursement methodology changes will be implemented with an August 2, 2018 effective date.

The Department initially implemented these rule changes on December 4, 2018 through emergency rulemaking under 5 M.R.S. §8054(1); those changes are effective for 90 days. Through the emergency rulemaking, an August 2, 2018 retroactive effective date was necessary to implement these changes as soon as possible. The retroactive application comports with 22 M.R.S. § 42(8), which authorizes the Department to adopt rules with a retroactive application (where there is no adverse impact on providers or members) for a period not to exceed eight (8) calendar quarters. The Department initiates this proposed routine technical rulemaking seeking public comment and thereafter, to permanently adopt these rule changes.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare website at http://www.maine.gov/dhhs/oms/rules/index.shtml or for a fee, interested parties may request a paper copy of rules by calling (207) 624-4050 or Maine Relay number 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rulemaking Proposal, which can be found at http://www.maine.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rulemaking process. Please address all comments to the agency contact person identified in the Notice of Agency Rulemaking Proposal.
Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, MaineCare Services, Division of Policy

CHAPTER NUMBER AND TITLE: 10-144 C.M.R., ch. 101, MaineCare Benefits Manual (MBM), Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities

PROPOSED RULE NUMBER:

CONCISE SUMMARY: These proposed rule changes to Chapter III, Section 67, Principles of Reimbursement for Nursing Facility services are made, in part, in order to comply with Public Law 2017, ch. 460, An Act Making Certain Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government (“the Act”), Section B-1 and B-3.

This proposed rulemaking makes a number of changes to the reimbursement methodology for Nursing Facilities pursuant to “the Act”. These changes include a change in the Occupancy Adjustment to allow for reduced occupancy percentages, an increase in the utilization payments, and the addition of a special supplemental allowance to account for wage increases. The Legislature further required that, for state fiscal year beginning July 1, 2018, the base year for each facility is its fiscal year that ended in calendar year 2016; for state fiscal years beginning on or after July 1, 2019, subsequent rebasing must be based on the most recent cost report filings available. Further, for the state fiscal year beginning July 1, 2018, the rates for each rebasing year must include an inflation adjustment for a cost-of-living percentage change in nursing facility reimbursement each year in accordance with the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index – medical care services index from the prior December for professional services, nursing home, and adult day care services. Finally, the Department added an aggregate hold harmless provision to reflect that the revised method of rebasing a nursing facility’s base year may not result in a rate of reimbursement for direct and routine costs that is lower than the rate in effect June 30, 2018.

Additional changes include:

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retroactive application (where there is no adverse impact on providers or members) for a period not to exceed eight (8) calendar quarters. The Department initiates this proposed routine technical rulemaking seeking public comment and thereafter, to permanently adopt these rule changes.


**STATUTORY AUTHORITY:** 22 M.R.S. §§ 42(8), 3173; 22 M.R.S. § 1708(3); P.L. 2017, ch. 460, Sec. B-1 and B-3; P.L. 2013, ch. 594, Sec. 3

**PUBLIC HEARING:**

**Date:** January 2, 2019  
**Time:** 10:00 a.m.  
**Location:** Cross Office Building  
Room 300  
111 Sewall Street  
Augusta, ME 04330

The Department requests that any interested party requiring special arrangements to attend the hearing contact the agency person listed below before December 27, 2018.

**DEADLINE FOR COMMENTS:** Comments must be received by 11:59 p.m. on January 12, 2019.

**AGENCY CONTACT PERSON:** Heidi Bechard, Comprehensive Health Planner II  
**AGENCY NAME:** Office of MaineCare Services  
**ADDRESS:** 242 State Street  
11 State House Station  
Augusta, Maine 04333-0011  
heidi.bechard@maine.gov  
**TELEPHONE:** 207-624-4074 FAX: (207) 287-1864  
TTY: 711 (Deaf or Hard of Hearing)

**IMPACT ON MUNICIPALITIES OR COUNTIES (if any):** The Department anticipates that this rulemaking will not have any impact on municipalities or counties.

**CONTACT PERSON FOR SMALL BUSINESS INFORMATION (if different):** N/A
PRINCIPLES OF REIMBURSEMENT FOR NURSING FACILITIES

RECENT HISTORY:

Amended effective December 4, 2018 - EMERGENCY
Amended effective January 18, 2017
Amended effective February 13, 2016
Amended effective November 17, 2015 - EMERGENCY
Amended effective September 15, 2015
Amended effective November 13, 2014
Amended effective August 15, 2014 – EMERGENCY
Amended effective May 29, 2014
Amended effective November 14, 2007
Amended effective September 2, 2002 (filing 2002-330) and September 29, 2002 (filing 2002-362)
Emergency Language effective January 1, 2003 (filing 2002-514)
Amended effective April 1, 2003 (filing 2003-84)
Amended effective April 1, 2003 - EMERGENCY - expires June 29, 2003 (filing 2003-94)
Amended effective June 30, 2003 (filing 2003-201)
Amended effective January 1, 2004 (filing 2003-477)
Amended effective September 1, 2004 (filing 2004-365)
Amended effective October 12, 2005 (filing 2005-404)
Amended effective November 14, 2007 (filing 2007-459)
Amended effective December 16, 2008 – EMERGENCY – expires March 15, 2009 (filing 2008-584)
Amended effective March 15, 2009 (filing 2009-100)
Amended effective June 11, 2009 – EMERGENCY – expires September 2, 2009(filing)- REPEALED
Amended effective July 1, 2009 – EMERGENCY- expires September 29, 2009 (filing 2009-288)
Amended effective September 28, 2009 (2009-210)
Amended effective April 25, 2010 (2010-142)
Amended effective July 1, 2010 – EMERGENCY- expires September 29, 2010 (filing 2010-271)
Amended effective September 29, 2010 (filing 2010-443)
Amended effective March 3, 2012 (filing 2012-55)
Amended effective May 29, 2014 (filing 2014-101)
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INTRODUCTION

1 GENERAL PROVISIONS

1.1 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 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.

1.2 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).

1.3 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 nursing facility’s base year cost report is reviewed, used, to review the facility’s costs against these rules, to determine and identify which costs are allowable under this rule, 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.

* The Department is seeking, and anticipates receiving, approval from CMS for this Section. Pending approval, the change will be effective August 2, 2018.

1.4 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
1.4 DEFINITIONS (cont.)

Certification requirements for nursing care facilities that are in effect at the time the cost is incurred.

**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. The base year will be the fiscal year of each nursing facility ending in calendar year 2011, and change every two years to the preceding three (3) year’s audited cost report if available. If the audited cost report is not available, the Department will use the as-filed cost report. For the state fiscal year beginning July 1, 2018, the base year for each facility is its fiscal year that ended in the calendar year 2016. For state fiscal years beginning on or after July 1, 2019, subsequent rebasing must be based on the most recently filed cost report available by April 1st of the rebasing year.

For the state fiscal year beginning July 1, 2018, the rates set for each rebasing year shall include an inflation adjustment for a cost-of-living percentage change in nursing facility reimbursement each year in accordance with the United States Department of Labor Statistics Consumer Price Index – medical care services index from the prior December for professional services, nursing home, and adult day care services.

**Base Year Costs** shall be the costs as shown on the cost report for the base year, as audited by the Department. If the audit has not been completed, then as-filed costs may be used in lieu of the audited costs.

**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.
1.4 DEFINITIONS (cont.)

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.

Consumer Price Index (CPI) is the CPI published by the U.S. Department of Labor.

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.

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 Care Base Rate is the facility specific direct care cost per day as determined from the base year.

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.
1.4 DEFINITIONS (cont.)

**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;

(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.

**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.
1.4 DEFINITIONS (cont.)

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 lessee after the expiration of the lease.

MaineCare Utilization means, for nursing facilities, a fraction (expressed as a percentage), the numerator of which is the nursing facility’s number of MaineCare days attributable to MaineCare patients whose claims were reimbursed for those days, and the denominator of which is the total number of the nursing facility’s days of care for that period.

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 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:
1.4 DEFINITIONS (cont.)

(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.

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 Principle 91 of these Principles.

Total Resident Census is the total number of residents residing in a nursing facility during the facility’s fiscal year.
2 REQUIREMENTS FOR PARTICIPATION IN MAINECARE PROGRAM

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

2.1.1 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

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

2.2 MaineCare payments shall not be made to any facility that fails to meet all the requirements of Principle 2.1.

3 RESPONSIBILITIES OF OWNERS OR OPERATORS

3.1 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.

4 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:

4.1 Comply with the provisions of Principles 3 and 4 setting forth the requirements for participation in the MaineCare Program.

4.2 Submit master file documents and cost reports in accordance with the provisions of Principles 13.1 and 13.2 of these Principles.

4.3 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.

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

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

4.6 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 Principle 37 of these Principles.
ACCOUNTING REQUIREMENTS

5.1 ACCOUNTING PRINCIPLES

5.1.1 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.

5.1.2 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.

5.1.3 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.

PROCUREMENT STANDARDS

6.1 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.

6.2 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 Principle 9.2 in these Principles. See cost to related organizations Principle 9.8.

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:

7.1 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.
COST ALLOCATION PLANS AND CHANGES IN ACCOUNTING METHODS (cont.)

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

7.3 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

7.3.1 the nature of the change;
7.3.2 the reason for the change;
7.3.3 the effect of the change on the per diem rate of payment; and
7.3.4 the likely effect of the change on future rates of payment.

7.4 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.

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

7.6 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.

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

7.8 It is the duty of the provider to notify the Division 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.

7.9 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.

7.10 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.
SECTION 67  PRINCIPLES OF REIMBURSEMENT FOR NURSING FACILITIES  Established 3-13-79

EMERGENCY RULE: 12/4/18

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

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

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

7.10.2 Other Nursing Costs. Nursing salaries cost allocations.

7.10.3 Plant operation and maintenance. Square feet serviced.

7.10.4 Housekeeping. Square feet serviced.

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

7.10.6 Dietary. Number of meals served.

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

8  ALLOWABILITY OF COST

8.1 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.

9  COST RELATED TO RESIDENT CARE

9.1 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.

9.2 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.

9.3 Costs must not be of the type conceived for the purpose of circumventing the regulations. Such costs will be disallowed under Principle 11.

9.4 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.
9 COST RELATED TO RESIDENT CARE (cont.)

9.5 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.

9.6 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.

9.7 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.

9.8 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 Principle 6 of these Principles.

10 UPPER PAYMENT LIMITS

10.1 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.

10.2 If the Division of Audit projects that MaineCare payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division of Audit shall limit some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit as set forth in Principle 10.3.

10.3 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
10 \textbf{UPPER PAYMENT LIMITS} (cont.)

requested within thirty (30) days of the effective date of these regulations, and thereafter, at the time the interim rates are set.

10.4 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.

11 \textbf{SUBSTANCE OVER FORM}

11.1 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.

12 \textbf{RECORD KEEPING AND RETENTION OF RECORDS}

12.1 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.

12.2 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.

12.3 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 Division 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 Division of Audit shall retain all records that are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

12.4 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
RECORD KEEPING AND RETENTION OF RECORDS (cont.)

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 Principle 37 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.

FINANCIAL REPORTING

13.1 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:

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

13.1.2 Chart of accounts and procedures manual, including procurement standards established pursuant to Principle 6;

13.1.3 Plant layout;

13.1.4 Terms of capital stock and bond issues;

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

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

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

13.1.8 Related party information on affiliations, and contractual arrangements;

13.1.9 Tax returns of the nursing facility; and

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

If any of the items listed in Principle 13.1.1 – 13.1.10 are not submitted in a timely fashion the Department may impose the deficiency per diem rate described in Principle 37 of these Principles.
13 FINANCIAL REPORTING (cont.)

13.2 UNIFORM COST REPORTS

13.2.1 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, Division 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.

13.2.2 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.

13.2.3 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 Division 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 Division 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 Principle 37.

13.2.4 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.

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

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

13.2.6.1 Financial statements,

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

13.2.6.3 Reconciliation of the financial statements to the cost report,

13.2.6.4 Any other financial information requested by the Department.

13.2.6.5 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.
13.3 ADEQUACY AND TIMELINESS OF FILING

13.3.1 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%).

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

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

13.4 REVIEW OF COST REPORTS BY THE DIVISION OF AUDIT

13.4.1 Uniform Desk Review

13.4.1.1 The Division of Audit shall perform a uniform desk review on each cost report submitted.

13.4.1.2 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 Division of Audit will schedule an on-site audit or will prepare a settlement based on the findings determined by the uniform desk review.

13.4.1.3 Uniform desk reviews shall be completed within one calendar year 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.

13.4.1.4 Unless the Division 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.

13.4.2 On-site Audit

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

13.4.2.2 The Division 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
13.4 REVIEW OF COST REPORTS BY THE DIVISION OF AUDIT (cont.)

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.

13.4.2.3 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 Division of Audit’s requirements.

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

13.5 SETTLEMENT OF COST REPORTS

13.5.1 Cost report determinations and decisions, otherwise final, may be reopened and corrected
when the specific requirements set out below are met. The Division 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.

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

13.5.2.1 At the request of either the Department, or a provider within the applicable
time period set out in paragraph 13.5.4; and,

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

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

13.5.4 A determination or decision may only be re-opened within three (3) years from the date
of notice containing the Division 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.

13.5.5 The Division 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 Division of Audit shall
not accept an amended cost report to avail the provider of an option it did not
originally elect.
14 REIMBURSEMENT METHOD

14.1 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.

14.2 Nursing facilities costs will be rebased by the Department every two years beginning July 1, 2014.

15 COST COMPONENTS

15.1 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:

15.1.1 Direct Care Costs,
15.1.2 Routine Costs, and
15.1.3 Fixed Costs.

Principles 16-18 describe the cost centers in each of these categories, the limitations and allowable costs placed on each of these cost centers.

16 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.

16.1 Direct care costs include salary, wages, and benefits for:

16.1.1 registered nurses salaries/wages (excluding Director of Nursing),
16.1.2 licensed practical nurses salaries/wages,
16.1.3 nurse aides salaries/wages,
16.1.4 patient activities personnel salaries/wages,
16.1.5 ward clerks’ salaries/wages,
16.1.6 contractual labor costs,
16.1.7 fringe benefits for the positions in Principles 16.1.1 through 16.1.5 include:

(1) payroll taxes,
16 DIRECT CARE COST COMPONENT (cont.)

(2) qualified retirement plan contributions,

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

(4) cafeteria plans.

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services for this Section. Pending approval, the following will be effective retroactive to July 1, 2015.

16.1.8 Cost of Educational Activities

(1) **Principle.** An appropriate part of the net cost of educational activities is an allowable cost. Appropriate 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 not be included as an allowable cost based on findings.

(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.

16.1.9 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.
16  DIRECT CARE COST COMPONENT (cont.)

16.2  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.

16.2.1  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.

16.2.2  Electronic Submission of the MDS Information

(1)  Encoding Data: A facility must encode the data on every assessment as listed in Sec 16.2.1 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 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
16 DIRECT CARE COST COMPONENT (cont.)

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.

16.2.3 Quality review of the MDS process

16.2.3.1 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 Principle 16.2 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 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
assessments 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.

16.2.3.2 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.

16.2.3.3 Assessment Review Process

(1) Assessment reviews shall be conducted by staff or designated agents of the Department.
16 DIRECT CARE COST COMPONENT (cont.)

(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.

16.2.3.4 Sanctions

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 16.2.3.3.), 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%).
16 **DIRECT COST COMPONENT** (cont.)

(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.

16.2.3.5 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 37 of these Principles of Reimbursement. Completed MDS corrections and assessments, as defined in Principle 16.2, shall be submitted to the Department or its designee according to CMS guidelines.

16.2.3.6 **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.
16 DIRECT CARE COST COMPONENT (cont.)

(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 Procedure Act, 5 M.R.S.A. §11001 et seq.

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

16.3.1 Direct Care Cost. The base year costs for direct care shall be the base year cost as defined in Principle 1.4 for those costs listed in Principle 16.1, except for facilities whose MaineCare rates are based on pro forma cost reports in accordance with Principles 22.5 and 22.6. The direct care cost component is determined by adjusting direct care costs pursuant to Principle 22.3.3.

16.3.2 Continuing Education for Direct Care Staff. Effective July 1, 2015, if CMS approves, continuing education for direct care staff is included as a direct care component rather than a routine cost component.

17 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 base year costs for the routine cost component shall be the base year routine costs defined in Principle 1.4 for these costs listed in Principle 17, except for facilities whose MaineCare rates are based on pro forma cost reports in accordance with Principles 22.5 and 22.6. The routine cost component is determined by adjusting routine costs pursuant to Principles 22.4.

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

17.2 Inventory Items. 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.

17.3 Allowable Costs. 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.

17.4 Allowable costs for the routine component of the rate.

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

(a) fiscal services
(b) administrative services and professional fees, including administrative functions,
17 ROUTINE COST COMPONENT (cont.)

(c) plant operation and maintenance including utilities,
(d) laundry and linen,
(e) housekeeping,
(f) medical records,
(g) subscriptions related to resident care,
(h) dietary,
(i) motor vehicle operating expenses,
(j) clerical,
(k) transportation, (excluding depreciation),
(l) office supplies/telephone,
(m) conventions and meetings within the state of Maine,
(n) EDP bookkeeping/payroll,
(o) fringe benefits, to include:
(1) payroll taxes,
(2) qualified retirement plan contributions,
(3) group health, dental, and life insurance, and
(4) cafeteria plans.
(p) payroll taxes,
(q) one (1) association dues, the portion of which is not related to lobbying,
(r) food, vitamins and food supplements,
(s) director of nursing, and fringe benefits,
(t) social services, and fringe benefits,
(u) pharmacy consultant and dietary consultant, and medical director.

For a more complete description of allowable costs in each cost center, see the explanations in Principles 17.4.1 - 17.4.2.11.

17.4.2 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:

17.4.2.1 Central Office operational costs for business managers, controllers, reimbursement managers, office managers, personnel directors and purchasing agents are to be according to an allocation of those costs on the basis of all licensed beds operated by the parent company.

17.4.2.2 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.
17 ROUTINE COST COMPONENT (cont.)

17.4.2.3 **Compliance.** Compliance with all other regulations specific to administrative functions in Nursing Facilities that are included in State Licensing Regulations and all other State and Federal regulations.

17.4.2.4 **Dividends and Bonuses.** Bonuses, dividends, or accruals for the express purpose of giving additional funds to the administrator or owners of the facility will not be recognized as allowable costs by the Department.

17.4.2.5 **Management fees.** Management fees charged by a parent company or by an unrelated organization or individual are not allowable costs.

17.4.2.6 **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.

17.4.2.7 **Central Office Operational Costs.** Central office bookkeeping costs and related clerical functions 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.

17.4.2.8 **Laundry services** including personal clothing for MaineCare residents.

17.4.2.9 **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.

17.4.2.10 **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 Division of Audit is required if additional vehicles are needed by the nursing facility.

17.4.2.11 **Dues.** 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.

17.4.2.12 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 Principle 17.4.2.12(1) – 17.4.2.12(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 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.

17.5 Principle. Research Costs are not includable as allowable costs.

17.6 Grants, Gifts, and Income from Endowments

17.6.1 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.
ROUTINE COST COMPONENT (cont.)

1. Unrestricted grants, gifts, income from endowment. Unrestricted grants, gifts, 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.

17.6.2 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.

17.6.3 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.

17.7 Purchase Discounts and Allowances and Refunds of Expenses

17.7.1 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.

17.7.2 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.

17.7.3 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.

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

17.8 **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.

17.9 **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.

17.10 **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.

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

18 **FIXED COSTS COMPONENT**

18.1 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:

18.1.1 depreciation on buildings, fixed and movable equipment and motor vehicles.
18 FIXED COSTS COMPONENT (cont.)

18.1.2 depreciation on land improvements and amortization of leasehold improvements,

18.1.3 real estate and personal property taxes,

18.1.4 real estate insurance, including liability and fire insurance,

18.1.5 interest on long term debt,

18.1.6 rental expenses,

18.1.7 amortization of finance costs,

18.1.8 amortization of start-up costs and organizational costs,

18.1.9 motor vehicle insurance,

18.1.10 facility's liability insurance, including malpractice costs and Workers compensation,

18.1.11 administrator in training,

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

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

18.1.14 nursing facility health care provider tax.

18.1.15 payment for High MaineCare Utilization as defined by in Principle 18.12

18.1.16 payment for supplemental wage allowance, as defined in Principle 18.13*. 

For a more complete description of allowable costs in each of these cost centers, see the explanations in Principle 18.2.

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

18.2.1 Depreciation. Allowance For Depreciation Based on Asset Costs.

The depreciation must be:

18.2.1 Identified and recorded in the provider's accounting records.

18.2.2 Based on historical cost and prorated over the estimated useful life of the asset using the straight-line method.
18.2.3 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

18.2.3.1 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.

18.2.3.2 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 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.

18.2.3.3 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
18  **FIXED COSTS COMPONENT** (cont.)

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 to 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:

1.  Insulation (fiberglass, cellulose, etc.).
2.  Energy Efficient Windows or Doors for the outside of the facility, including insulating shades and shutters.
3.  Caulking or Weather stripping for windows or doors for the outside of the facility.
4.  Fans specially designed for circulation of heat inside the building.
5.  Wood and Coal burning furnaces or boilers (not fireplaces).
6.  Furnace Replacement burners that reduce the amount of fuel used.
7.  Enetrol or other devices connected to furnaces to control heat usage.
8.  A Device or Capital Expenditures for modifying an existing furnace that reduces the consumption of fuel.
9.  Solar active systems for water and space heating.
10.  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.
11.  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.
18 FIXED COSTS COMPONENT (cont.)

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

18.2.3.4 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.

(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.

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

18.2.3.6 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.

18.2.3.7 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.

18.2.3.8 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:

(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. If CMS approves, effective November 1, 2014, for For sales of nursing facilities that occur on or after July 1, 2014, the calculation of the credits for building and fixed equipment will be from the date the owner began operating the facility with the original license.
18 FIXED COSTS COMPONENT (cont.)

(b) If CMS approves, effective November 1, 2014, for sales of nursing facilities that occur on or after July 1, 2014, moveable equipment will accumulate credits as follows: for the first four years the asset is placed into service, all but ten percent (10%) per year will be recaptured and from the fifth (5th) and sixth (6th) year, all but thirty percent (30%) per year will be recaptured, not to exceed one hundred percent (100%). The calculation of credits for moveable equipment will be from the date the asset is placed into service by the provider.

(c) 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.

(d) 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.

(e) 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.

18.2.3.9 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.

18.3 Purchase, Rental, Donation and Lease of Capital Assets

18.3.1 Purchase of facilities from related individuals and/or organization where a facility, through purchase, converts from a proprietary to a nonprofit status and
18 FIXED COSTS COMPONENT (cont.)

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:

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

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

1. a child
2. a grandchild
3. a brother or sister
4. a spouse of a child, grandchild, or brother or sister, or
5. an entity controlled by a child, grandchild, brother, sister or spouse of
child, grandchild or combination brother or sister thereof; or

18.3.1.1 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 Principle 18.2.3.8 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.

18.3.1.2 One-time exception to Principle 18.3.1.1. At the election of
the seller, Principle 18.3.1 will not apply to a sale made to a
buyer defined in Principle 18.3.1.1 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 Principle
18.3.1 or 18.3.1.1, 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
Principle 18.3.1.2(c)

(e) if the seller makes a valid election to be exempted from
the application of 18.3.1.1 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.

18.3.1.3 The one (1) exception to Principle 18.3.1.1 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.

18.3.1.4 Limitation in the application of Principle 18.3.1.3

18.3.1.4.1 Principle 18.3.1.2 shall not apply to any sale or exchange by the seller if an election by the seller under Principle 18.3.1.2 with respect to any other sale or exchange has taken place.

18.3.1.4.2 Principle 18.3.1.2 shall not apply to any sale or exchange by the seller unless the seller:

18.3.1.4.2.1 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

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

18.3.1.4.2.3 agrees to file an agreement with the Department of Health and Human Services to notify the Department that any acquisition as defined by the Principle 18.3.1.4.2.2 has occurred.

18.3.1.4.2.4 If Principle 18.3.1.4.2 is satisfied, Principle 18.3.1.1 and Principle 18.3.11 will also be satisfied.

18.3.1.4.2.5 If the seller acquires any interest defined by Principle 18.3.1.4.2.2 then pursuant to the agreement
18.3.2 **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.

18.3.3 **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.

18.4 **Leases and Operations of Limited Partnerships**

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

18.4.1.1 A copy of the signed lease agreement is required.

18.4.1.2 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 Principle 12.
18  **FIXED COSTS COMPONENT** (cont.)

18.4.1.3  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.

18.4.1.4  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 Principle 12.

18.4.1.5  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.

18.4.1.6  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 recaptured in accordance with Principle 18.2.3.8. This change will become effective when and if CMS approves this new language in the state plan.

18.4.2  **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.

18.4.3  **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: Principles 18.4.3.1 or 18.4.3.2.

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

18.4.3.2  The actual lease payments made by the lessee to the lessor.
18 FIXED COSTS COMPONENT (cont.)

18.4.3.3 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 fifteen percent (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.

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.

18.4.3.4 If the cost as defined in Principle 18.4.3.2 are less than the costs as defined in Principle 18.4.3.1, then the difference can be deferred to a subsequent fiscal period. If in a later fiscal period, costs as defined in Principle 18.4.3.2 exceed costs as defined in Principle 18.4.3.1, 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.

18.4.3.5 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.
18.4.3.6 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, Principles 18.4.3.6(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 18.4.3.1 or 18.4.3.2 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:

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

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

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

4. 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.

18.4.4 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.
18 FIXED COSTS COMPONENT (cont.)

* The Department is seeking, and anticipates receiving, approval from CMS for this Section. Pending approval, this change will be effective August 2, 2018.

18.5 Interest Expense

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

18.5.2 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 Principle 18.5.4.6, interest does not include interest and penalties charged for failure to pay accounts when due.

18.5.3 Necessary. In order to be considered “necessary”, *To be allowable interest expense, interest must be:

18.5.3.1 Incur on a loan made to satisfy a financial need of the provider for capital purposes, such as acquisition of facilities and equipment, and capital improvements, incurred on a loan.

18.5.3.2 Loans which result in excess funds or investments would be considered unnecessary; and

18.5.3.3 Proper. Proper requires that interest:

18.5.3.3.1 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.

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

18.5.2 Swap Investments. Swap investments, also known as swap loans or swaps are defined as an interest rate swap agreement between two counterparties in which one stream of future interest payments is exchanged for another based on a specific principal amount. The Department will not pay for swap investments.
18.5.3.4 Refinancing. Any refinancing of property mortgages or loans on fixed assets must be prior approved in writing by the Department’s Division of Licensing and Certification, prior to the closing of the loan. If written prior approval is not obtained any additional interest costs or finance charges will not be allowed. The Department will pay the lowest of the following:

1. The actual interest paid, or

2. The amount of interest the provider would have paid in the current fiscal year, under the terms of the original loan. Original loan means the last Department approved loan.

(A) If the original loan had a variable rate, the last variable rate will be the rate that is utilized throughout the term of the refinanced loan. If the original loan had a fixed rate, that will be the rate utilized throughout the term of the refinanced loan.

(B) Interest payments are allowable only for the period of a time not to exceed the remaining useful life of the items, pursuant to 18.2.3.4 herein, to be purchased.

(C) Closing costs for a refinanced loan are not allowed.

The Department may condition refinancing approvals.

18.5.4 Borrower-lender relationship

18.5.4.1 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 Division of Licensing and Certification shall make the determination for written prior approvals. 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.
18 FIXED COSTS COMPONENT (cont.)

18.5.4.2 **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.

18.5.4.3 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 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.

18.5.4.4 **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.

18.5.4.5 **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.

18.5.4.6 **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:

18.5.4.6.1 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;

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

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

18.5.4.6.4 Approval in writing has been given by the Department
18.5.4.7 **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.

18.5.5 **Adjustments.** 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.

18.6 **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 Principle 18.1.4). 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.

18.6.1 **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 the time of audit.
18.6.2 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.

18.6.3 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.)

18.7 **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.

18.8 **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
18 FIXED COSTS COMPONENT (cont.)

applicable Certificate of Need. This acquisition cost will not include any fees (e.g.: accounting, legal) associated with the acquisition.

* The Department is seeking, and anticipates receiving, approval from CMS for this Section. Pending approval, the change will be effective August 2, 2018.

18.9 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-seven percent (97%) for the state fiscal years ending June 30, 2019, June 30, 2020, and June 30, 2021. The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of ninety-seven percent (97%). For all new providers coming into the program, the seventy-nine percent (79%) 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. For state fiscal years ending June 30, 2022 and thereafter, the reduction in allowable costs applies only for an annual level of occupancy less than eighty percent (80%).

*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%) for state fiscal years ending June 30, 2019, June 30, 2020, and June 30, 2021. The adjustment to the 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. For state fiscal years ending June 30, 2022 and thereafter, the reduction in allowable costs applies only for an annual level of occupancy less than eighty percent (80%).

This occupancy adjustment does not apply to High MaineCare Utilization or the Nursing Facility Health Care Provider Tax.

18.10 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 thereof, 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 startup 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
18 FIXED COST COMPONENT (cont.)

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 charged to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the Department, these costs need not be capitalized, but will be charged to operations in the periods incurred. For program reimbursement purposes, costs of the provider's facility and building equipment should be depreciated over the lives of these assets starting with the month the first resident is admitted for treatment, subject to the provider's method of determining depreciation in the year of acquisition or construction. Where portions of the provider's facility are prepared for resident care services after the initial start-up period, these asset costs applicable to each portion should be depreciated over the remaining lives of the applicable assets. If the portion of the facility is a resident care area, depreciation should start with the month the first resident is admitted for treatment. If the portion of the facility is a non-revenue-producing resident care area or unallowable area, depreciation should begin when the area is opened for its intended purpose. Costs of major movable equipment, however, should be depreciated over the useful life or each item starting with the month the item is placed into operation. Where a provider prepares all portions of its facility for resident care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratable over a period of sixty (60) consecutive months beginning with the month in which the first resident is admitted for treatment. 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.

18.11 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.

18.12 Payment for High MaineCare Utilization. Nursing Facilities that have MaineCare utilization greater than seventy percent (70%) of their annual total days of care will receive a payment of $.40 per reimbursed MaineCare day for each one (1) percent over seventy percent (70%), subject to the limitations set forth below.

Prospective Per Diem Rate

The payment for High MaineCare Utilization shall be calculated as total annual MaineCare days divided by total days of care in the facility’s prior year fiscal year cost report (MaineCare days/total days of care * $.40 * per each percent over seventy percent (70%) and will be cost settled at audit. Days waiting placement (DWP) are excluded from
18  FIXED COST COMPONENT (cont.)

this calculation. The payment for High MaineCare Utilization is included as part of the per
diem rate.

*The Department is seeking, and anticipates receiving, approval from CMS for this Section. Pending
approval, the change will be effective August 2, 2018.

*Beginning July 1, 2019, the high MaineCare utilization payment, for any nursing facility
whose MaineCare residents constitute more than eighty percent (80%) of the nursing
facility’s total number of residents and whose base year direct and routine aggregate costs
per day are less than the median aggregate direct and routine allowable costs for the
facility’s peer group, increases to .60 cents per resident day, is not subject to cost
settlement and must be retained by the facility in its entirety.

The high MaineCare utilization payment is calculated as described above.

The high MaineCare utilization for nursing facilities above seventy percent (70%), but
below eighty percent (80%) shall remain paid as described in the first paragraph above.

Audit Cost Settlement

At the time of audit, the allowable Payment for High MaineCare Utilization shall be
calculated. Days waiting placement (DWP) are excluded from this calculation.

Nursing Facilities that have MaineCare utilization greater than seventy percent (70%) of
their annual total days of care, and that have MaineCare allowable costs for the routine
and direct care components, in excess of MaineCare reimbursement for the routine and
direct care components (excess MaineCare allowable costs) will receive a Payment for
High MaineCare Utilization, for no more than the excess MaineCare allowable costs. Any
over or under payments will be included as part of the audit settlement.

For the first cost settlement after July 1, 2014, if a Nursing Facility has a fiscal year that
begins prior to July 1, 2014, the calculation of the Payment for High MaineCare
Utilization will use only days of care after July 1, 2014, and rather than using the facility’s
total annual MaineCare days and total annual days of care, the Department will calculate
the total number of days of care beginning on July 1, 2014. Intensive Rehabilitation NF
Services for individuals with Acquired Brain Injury are not eligible for the High
MaineCare Utilization payment.

* The Department is seeking, and anticipates receiving, approval from CMS for this Section. Pending
approval, the change will be effective August 2, 2018.

*18.13 Supplemental Wage Allowance. For the state fiscal year ending June 30, 2019, a
supplemental wage allowance shall be made to provide for increases in wages and wage-
related benefits in both the direct care cost component and routine care cost component as
follows. The allocated amount, equal to ten percent (10%), of all allowable wages and
associated benefits and taxes, does not include contract labor, as reported on each facility’s
as-filed cost report for its fiscal year ending in calendar year 2016 and shall be added
18 **FIXED COST COMPONENT** (cont.)

to the cost per resident day in calculating each facility’s prospective rate, notwithstanding any otherwise applicable caps or limits on reimbursement. This supplemental wage allowance shall be allowed and paid at final audit to the full extent that it does not cause reimbursement to exceed the facility’s allowable costs in that fiscal year.

The Supplemental Wage Allowance will be paid at 78.12% of the calculated per diem rate.

Providers must ensure that the increase in reimbursement rates effective August 2, 2018 is applied in full to wages and benefits for employees who provide direct services. Providers must document compliance with this requirement in their financial records and provide such documentation to the Department upon request.

*18.14 Aggregate Hold Harmless*. Effective August 2, 2018, the rate of reimbursement for nursing facilities for direct care and routine costs that result from amending the law or the rules to reflect the revised method of rebasing the nursing facility’s base year pursuant to P.L. 2017, ch. 460, Sec. B-1, may not result in any nursing facility receiving a rate of reimbursement that is lower than the rate in effect on June 30, 2018.

19 **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.

20 **SPECIAL SERVICE ALLOWANCE**

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

20.1.1 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.

20.1.2 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.
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.

ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE

22.1 Principle. For services provided on or after July 1, 2014, 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 base year, as determined from the as filed audited cost report (or as filed cost report if audited cost report is not available) 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 Principles 22.3 and 22.4, respectively. Thereafter, inflation will be based on Principle 31. The prospective rate shall consist of three (3) components: the direct care cost component as defined in Principle 16, the routine cost component as defined in Principle 17, and the fixed cost component as defined in Principle 18.

* The Department is seeking, and anticipates receiving, Approval from CMS for this Section. Pending approval, the change will be effective August 2, 2018.

22.2 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 Principle 18. As described in Principle 18, fixed costs will be adjusted for providers whose annual level of occupancy is less than ninety-seven percent (97%). The adjustment to fixed costs shall be based upon a theoretical level of occupancy of ninety-seven percent (97%). For all new providers coming into the program, the ninety-seven percent (97%) 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.

22.3 Direct Care Cost Component

22.3.1 Case Mix Reimbursement System
22.3.1.1 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 Principle 16.2;

(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 Principle 22.3.2;

(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.

22.3.2 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 cannot 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

<table>
<thead>
<tr>
<th>Resident Classification Group</th>
<th>Case Mix Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>REHAB ULTRA HI/ADL</td>
<td>16 - 18 1.986</td>
</tr>
<tr>
<td>REHAB ULTRA HI/ADL</td>
<td>9 - 15 1.426</td>
</tr>
<tr>
<td>REHAB ULTRA HI/ADL</td>
<td>4 - 8 1.165</td>
</tr>
<tr>
<td>REHAB VERY HI/ADL</td>
<td>16 - 18 1.756</td>
</tr>
<tr>
<td>REHAB VERY HI/ADL</td>
<td>9 - 15 1.562</td>
</tr>
<tr>
<td>REHAB VERY HI/ADL</td>
<td>4 - 8 1.217</td>
</tr>
<tr>
<td>REHAB HI/ADL</td>
<td>13 - 18 1.897</td>
</tr>
<tr>
<td>REHAB HI/ADL</td>
<td>8 - 12 1.559</td>
</tr>
<tr>
<td>REHAB HI/ADL</td>
<td>4 - 7 1.260</td>
</tr>
<tr>
<td>REHAB MED/ADL</td>
<td>15 - 18 2.051</td>
</tr>
<tr>
<td>REHAB MED/ADL</td>
<td>8 - 14 1.635</td>
</tr>
<tr>
<td>REHAB MED/ADL</td>
<td>4 - 7 1.411</td>
</tr>
<tr>
<td>REHAB LOW/ADL</td>
<td>14 - 18 1.829</td>
</tr>
<tr>
<td>REHAB LOW/ADL</td>
<td>4 - 13 1.256</td>
</tr>
</tbody>
</table>

#### EXTENSIVE

<table>
<thead>
<tr>
<th>Resident Classification Group</th>
<th>Case Mix Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXTENSIVE 3/ADL</td>
<td>7-18/Head Injury – ADL 15 - 18 2.484</td>
</tr>
<tr>
<td>EXTENSIVE 2/ADL</td>
<td>7-18/Head Injury – ADL 10 - 14 2.057</td>
</tr>
<tr>
<td>EXTENSIVE 1/ADL</td>
<td>7-18/Head Injury – ADL 7 - 9 1.910</td>
</tr>
</tbody>
</table>
22 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE (cont.)

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

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

22.3.3 Base Year Direct Care Cost Component

22.3.3.1 Source of Base Year Cost Data. The source for the direct care cost
component is the audited cost report (as filed cost report if an audit has not been completed) for the nursing facility’s base year except for facilities whose MaineCare rates are determined in accordance with Principles 22.5 and 22.6, as described in Principle 16.

The total audited–inflated allowable base year 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.

22.3.3.2 Case Mix Index

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

i) First, calculate the nursing facility’s 2011-2016 average direct care case mix adjusted rate by dividing each facility’s gross direct care payments received for their 2011-2016 base year by their 2011-2016 base year MaineCare direct care resident days.

ii) Second, calculate the nursing facility’s 2011 case mix index by dividing the facility’s 2011 average direct care case mix adjusted rate calculated above, by the facility’s 2005 base year direct care rate.

(a) 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 December 31, 2013-2017.

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

iii) The direct care regional indices are as follows:

Region I – 1.0908
Region II – 1.0402
Region III – 1.00
Region IV – 1.0011

22.3.3.3 Base year case mix and regionally adjusted MaineCare cost per day
22  ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE (cont.)

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 Principle 22.3.3(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.

22.3.3.4 Array of the base year case mix and regionally adjusted cost per day


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 December 31, 2013-2017 from high to low and identify the median.

b. 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 one hundred ten percent (110%).

22.3.3.5 Each facility's case mix adjusted direct care rate shall be the lesser of the limit in Principle 22.3.3.4. or the facility's base year case mix and regionally adjusted cost per day multiplied by the regional cost index.

22.3.4 Calculation of the Direct Care Component

The Office of MaineCare Services shall compute the direct resident care cost component for each facility as follows:

22.3.4.1 Direct Care rate per day

The total direct care rate per day, as determined by 22.3.3, shall be calculated by multiplying the total inflated direct care rate by the applicable case mix index for the RUG group on the resident’s active assessment (OBRA assessment).
22.3.4.2 Direct Care Add-on

The direct care rate shall be increased by twenty-five percent (25%) of the excess of the base year direct care cost inflated to December 31, 2013-2017 over the direct care rate, as determined in 22.3.4.1 using the facility-specific average case mix index for the base year 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 only at the time of rebasing and is included as a direct care add-on to the direct care rate.

22.3.4.3 Hold Harmless Provision

The direct care rate as determined in 22.3.4.1 and 22.3.4.2 for each nursing facility’s first fiscal year to which amendments to these rules, effective July 1, 2014, apply, is less than the direct care rate in effect on April 1, 2014, the rate shall be increased by the differential between these two rates.

22.3.4.4 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.

22.3.4.5 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, except to the extent that the facility qualifies for High MaineCare Utilization.

22.4 Routine Cost Component

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

22.4.1 Using each facilities base year cost report, the provider's base year total allowable routine costs shall be determined in accordance with Principle 17.
22.4.2 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.

22.4.3 The routine cost component is inflated from the end of the facility’s base year to December 31, 2013-2017 using the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index for Medical Care Services – Nursing Homes and Adult Day Care services. 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 December 31, 2013-2017 from high to low and identify the median.

22.4.4 For each peer group, the upper limit on the base year cost per day shall be the median multiplied by one hundred ten percent (110%).

22.4.5 Each facility's Base Year Routine Care cost per diem rate shall be the lesser of the limit set in Principle 22.4.4 or the facility's base year per diem allowable routine care costs inflated to December 31, 2013-2017.

22.4.6 Routine Hold Harmless Provision

If the routine rate for the first fiscal year to which the July 1, 2014 amendments to these rules apply, is less than the routine care rate in effect on April 1, 2014, the rate shall be increased by the differential between the these two rates.

22.4.76 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, except to the extent that the facility qualifies for High MaineCare Utilization.

22.5 Rates for Facilities Recently Sold, Renovated or New Facilities

22.5.1 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 Principle 18.2.3.4(2)).
22.5.1.1 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.

22.5.2 Nursing facilities 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.

22.5.3 The reimbursement rates set, as stated in Principles 22.5.1 and 22.5.2, will remain in effect for the period of three (3) years from the date that they are set under these Principles.

22.5.4 At the conclusion of the three (3) years, the reimbursement rate will be rebased to the fiscal year stated in Principles 16.3.1 and 17 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.

22.6 Nursing Home Conversions

22.6.1 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.

22.6.1.1 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 Aging and Disability Services and to the Division of Reimbursement and Financial Services of the Office of MaineCare Services.

22.6.1.2 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.

22.6.1.3 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
SECTION 67  PRINCIPLES OF REIMBURSEMENT FOR NURSING FACILITIES  Established 3-13-79

EMERGENCY RULE: 12/4/18

22  ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE (cont.)

at the time of the conversion or at the ninety-five percent (95%) occupancy level, whichever is greater.

22.6.1.4  The case mix index will be determined as stated in Principles 16.2, 22.3.1, 22.3.2, and 22.3.3.2.

22.6.1.5  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 Principle 22.6.1.1.

22.6.1.6  The reimbursement rates set, as stated in Principles 22.6.1.1 and 22.6.1.5, 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.

22.6.1.7  At the conclusion of the three (3) years, the reimbursement rate will be rebased to the fiscal year stated in Principles 16.3.1 and 17 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.

22.6.1.8  Principle 22.6 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.

23  INTERIM, SUBSEQUENT, AND PROSPECTIVE RATES

*The Department is seeking, and anticipates receiving, approval from CMS for this Section. Pending approval, the change will be effective August 2, 2018.

23.1  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 Principle 22.3.4.

23.2  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.

23.3  Prospective Rate. The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services for this provision. Pending approval, the following will be effective retroactive to August 2, 2016 2018*: the prospective rate,
23. INTERIM, SUBSEQUENT, AND PROSPECTIVE RATES (cont.)

excluding fixed costs, shall be calculated to be 100 percent (100%) of all of the calculated Direct Care Cost Components and all of the Routine Cost Components.

23.4. Funding Adjustment. The Department will:

a. Take each individual nursing facility’s July 1, 2014 rebased Direct Care Rate and rebased Routine Care Rate, after those rates have been adjusted to the prospective rate described in Principle 23.3, and add the two rates together (“Sum of July 1, 2014, adjusted and rebased Direct Care and Routine Care rates”).

b. The Department will compare the Sum of July 1, 2014, adjusted and rebased Direct Care and Routine Care rates to each individual nursing facility’s Sum of April 1, 2014 Direct Care and Routine Care rates.

c. If the Sum of July 1, 2014, adjusted and rebased Direct Care and Routine care rates is less than the Sum of its April 1, 2014, Direct Care and Routine Care rates, the Department will make the following adjustment:

i. The Department will take the difference between the two sums, and add that difference to the rebased and adjusted July 1, 2014 routine rate.

d. This Funding adjustment will be done each year, by comparing the difference between the April 1, 2014 Sum of Direct Care and Routine Care rates, and the Sum of Direct Care and Routine Care rates for the applicable year.

* The Department is seeking, and anticipates receiving, approval from CMS for this Section. Pending approval, the change will be effective August 2, 2018.

24. FINAL PROSPECTIVE RATE

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services for this provision. Pending approval, the following will be retroactive to July 1, 2016 August 2, 2018*: Upon final audit of all nursing facility’s base year cost reports, the Department will determine a final prospective rate, which cannot be greater than 100 percent (100%) of all of the calculated direct Care Cost Components and all of the Routine Cost Components.

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

25. FINAL AUDIT OF FIRST AND SUBSEQUENT PROSPECTIVE YEARS

25.1. Principle. All facilities will be required to submit a cost report in accordance with Principle 13.2 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
25 **FINAL AUDIT OF FIRST AND SUBSEQUENT PROSPECTIVE YEARS** (cont.)

may consist of a full scope examination by Department personnel and which will be conducted on an annual basis.

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

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

25.2.2 Determine the occupancy levels of the nursing facility,

25.2.3 Determine reimbursable direct care costs incurred by the facility during the reporting period per Principle 22.3.4.54.

25.2.4 Determine the actual allowable routine costs incurred by the facility during the cost reporting period per Principle 22.4.6.

25.2.5 Determine if the payment criteria as described in 18.12 has been met.

25.2.6 Calculate a final rate.

25.2.7 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.

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 Division 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.

26 **SETTLEMENT OF FIXED EXPENSES**

26.1 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.
26 SETTLEMENT OF FIXED EXPENSES (cont.)

26.2 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.

27 ESTABLISHMENT OF PEER GROUP

27.1 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 Principle 1.4 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.

28 CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS

Upon determination of the final rate as outlined in Principle 25 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
28 CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS (cont.)

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 Principle 36.

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.

29 BEDBANKING OF NURSING FACILITY BEDS

29.1 Any bed-banking request must be submitted to the Department for review by the Office of Elder Services and the Office of MaineCare Services. Nursing facilities are permitted to bank nursing facility beds, according to the guidelines contained in Title 22, Chapter 103A, Section 333, providing the space left vacant in the facility is not used for the creation of private rooms. In addition to those guidelines, a floor plan must be submitted to the Office of Aging and Disability 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:

29.1.1 the use of the space is not reimbursable under the criteria contained in these Principles,

29.1.2 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,

29.1.3 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).

29.2 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
29  BEDBANKING OF NURSING FACILITIES (cont.)

the bed days used in the calculation of the rate after the bed banking 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:

29.2.1  Routine Cost Component

(1)  Administrative and Management Ceiling
(2)  Housekeeping Supplies
(3)  Laundry Supplies
(4)  Dietary Supplies
(5)  Patient Activity Supplies
(6)  Food Costs

29.3  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:

29.3.1  RNs
29.3.2  LPNs
29.3.3  CNAs, CNAs-M
29.3.4  Contract Nursing
29.3.5  Payroll Benefits and taxes for 29.3.1 through 29.3.3
29.3.6  Medical Supplies/Medicine and Drugs

(e.g. Using the example in Principle 29.2 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.)

30  DECERTIFICATION/DELCENSING OF NURSING FACILITY BEDS

30.1  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
30  DECERTIFICATION/DELICENSEING OF NURSING FACILITY BEDS (cont.)

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:

30.1.1 the use of the space is not reimbursable under the criteria contained in these Principles,

30.1.2 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,

30.1.3 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).

30.2 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 Principle 29.2 to also applicable to this Principle. 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:

30.2.1 Routine Cost Component

  30.2.1.1 Administrative and Management Ceiling.
  30.2.1.2 Housekeeping Supplies
  30.2.1.3 Laundry Supplies
  30.2.1.4 Dietary Supplies
  30.2.1.5 Patient Activity Supplies
  30.2.1.6 Food Costs

30.3 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:

30.3.1 RNs
30.3.2 LPNs
30.3.3 CNAs, CNAs-M
30.3.4 Contract Nursing
30.3.5 Payroll Benefits and taxes for 90.31 through 90.34.
30.3.6 Medical Supplies/Medicine and Drugs
30 DECERTIFICATION/DELICENSEING OF NURSING FACILITY BEDS (cont.)

(e.g. Using the example in Principle 29.2 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.)

30.4 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.

31 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.

31.1 The COLA will be two percent (2%) effective October 1, 2011. For each subsequent year, there will be an inflation adjustment based on the Consumer Price Index (CPI), as described in Principle 22.3.3.4 and 22.4.3. For those applicable fiscal periods where a COLA will be made, and the Department has sent forth the above notice, the following will apply:

31.1.1 Total wages, as set forth in Principle 9.5, and benefits, as set forth in Principle 1.4, for “front line employees,” as defined in the Definitions subsection of this Principle, be divided by total worked hours to determine the average wage and benefit rate per hour for front line employees for the applicable fiscal period in which a COLA has been made.

31.1.2 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.

31.1.3 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.

31.1.4 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.
31 INFLATION ADJUSTMENT – Cost of Living Adjustment (COLA) (cont.)

31.1.5 The following applies for the COLA effective October 1, 2011: Nursing Facilities must demonstrate, to the satisfaction of the Department, a two percent (2%) increase in the average wage and benefit rate per hour for front line employees for their first fiscal years ending after July 1, 2013, from the average wage and benefit rate per hour for front line employees that was in effect for their fiscal years ending 2008. If the nursing facilities cannot demonstrate that two percent (2%) increase to the satisfaction of the Department, then the Department will recoup, at time of audit, the difference between what the average wage and benefit rate per hour for front line employees for the first fiscal years ending after July 1, 2013, should have been if it had been increased by two percent (2%) from what it was.

32 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

33 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.

34 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

If the Department concludes that an extraordinary circumstance existed, an adjustment will be made by the Department in the form of a supplemental allowance.
34 **EXTRAORDINARY CIRCUMSTANCE ALLOWANCE** (cont.)

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.

35 **ADJUSTMENTS**

35.1 **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.

35.2 **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.

35.3 **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.

36 **APPEAL PROCEDURES-START UP COSTS-DEFICIENCY RATE - RATE LIMITATION**

36.1 **Appeal Procedures**

36.1.1 A facility may administratively appeal any of the following types of Division 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.

36.1.2 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 Division 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...
APPEAL PROCEDURES-START UP COSTS-DEFICIENCY RATE – RATE LIMITATION (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 Division 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.

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:

37.1 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;

37.2 Food service does not meet the Federal Certification and State Licensing requirements;

37.3 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;

37.4 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;

37.5 Failure to submit a cost report, financial statements, and other schedules as requested by the Division 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.

Failures to correct MDS, as requested in writing, and submit within the specified time outlined in Principle 16.2.1 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.

38 INTENSIVE REHABILITATION NF SERVICES FOR INDIVIDUALS WITH ACQUIRED BRAIN INJURY (ABI)

It has been determined that the reasonable cost of comprehensive rehabilitative services of acquired 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 ABI services. The Department will require that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with the ABI 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-ABI 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 ABI rehabilitative services, for individuals classified as eligible for ABI 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.

38.1 Principle. A nursing facility which has a recognized ABI 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.

38.2 Cost. The Department's payments made for allowable ABI services provided will be based on the actual cost of services provided. The allowable per diem cost for ABI services will include a direct care price, a routine service component, a rehabilitative ancillary service component, and a fixed cost component.

38.2.1 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 Principle 31, 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 Acquired 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.

38.2.2 The Routine Cost component rate will be increased annually by the rate of inflation, as defined in Principle 31, 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 Acquired
38 INTENSIVE REHABILITATION NF SERVICES FOR INDIVIDUALS WITH ACQUIRED BRAIN INJURY (ABI) (cont.)

Brain Injury services in accordance with the allocations defined in Principle 7.10 of these Principles.

38.2.3 Rehabilitative ancillary services included in the care of an individual with brain injured residing in a recognized ABI 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 Principle 31, at the beginning of a facility’s fiscal year. 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 Principle 7.10 of these Principles.

38.2.4 Fixed Costs. Fixed Costs are an allowable cost as defined in Principle 18 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 Acquired Brain Injury services in accordance will the allocations defined in Principle 7.10 of these Principles.

38.3 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  
- Psychiatric Evaluation and Consultation Services  
- Neuropsychology Evaluation and Consultation Services  
- Psychology Evaluation and Consultation Services

38.4 Cost Reporting. Costs will be reported on forms provided by the Department that will segregate NF-ABI routine costs and ABI ancillary costs from standard NF costs.

For the purpose of calculating a separate NF-ABI rate, whether interim or final, a facility that has been granted a special NF-ABI 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.

39 COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS

Community-based specialty nursing facility units providing medical-psychiatric services under contract with the Department to former residents of the Riverview Psychiatric Center (formerly Augusta Mental Health Institute) and the Dorothea Dix Psychiatric Center (formerly Bangor Mental Health Institute (BMHI)) as well as other individuals with qualifying mental disorders who have
COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS (cont.)

been deemed eligible by the Department or its Authorized Entity to receive these services. The Department shall designate specialty nursing facility units that provide medical-psychiatric special services under contract with the Department to former residents of the Riverview Psychiatric Center and the Dorothea Dix Psychiatric Center (BMHI). 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 disorder 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 as approved by the Office of Aging and Disability Services.

Such designated specialty units shall be subject to the provision of these rules, except for the rate limitations contained in Principles 22-27.

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.

39.1 Principle. A nursing facility that is recognized as a specialty unit under this Principle 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.

39.2 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 Principle 31. 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.

39.3 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 these Principles pertaining to the allowability, recording, and reporting of costs shall apply.
40 PUBLICLY OWNED NURSING FACILITIES

40.1 For publicly owned nursing facilities, as defined in Principle 1.4, 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.

41 REMOTE ISLAND NURSING FACILITIES

41.1 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 ninety five (95%) or greater.

41.2 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.

41.3 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 Principle 31. 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.

41.4 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 Principles 22-27, all other sections of these principles pertaining to the allowability, recording, and reporting of costs shall apply.

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Service for Principle 42 (Ventilator Care Services). Pending approval, Covered Services will be provided as follows:
VENTILATOR CARE SERVICES

In order for a nursing facility to receive additional reimbursement for ventilator care, a nursing facility must meet all of the following criteria:

1. The nursing facility must supply their own ventilators; and
2. The nursing facility must employ or contract with a pulmonologist or other health care professional trained in respiratory therapy; and
3. The nursing facility must have the required additional staffing to meet the needs of ventilator dependent members.

**Principle.** A nursing facility with qualifying ventilator care services under this section will be reimbursed for the additional care associated with members receiving ventilator care through a prior authorization from the Department using CPT code 94004. Prior authorization for these services will state what is included in the custom reimbursement rate.

**Rate setting.** Qualified providers must receive a prior authorization from the Department to bill for Ventilator Services.

**Audit.** The additional ventilator care add-on will be considered an ancillary service. All costs including general & administrative costs associated with the provision of ventilator care services will be considered ancillary costs and will not be cost settled. Any capital costs that are incurred as a result of the development of a vent unit or due to the admission of a vent patient will also be considered ancillary costs that are not reimbursable during cost settlement.
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 is 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 Division 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.