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DATE: March 8, 2016

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Emergency Major Substantive Rule: 10-144, C.M.R. ch. 101, MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institution (PNMI) Services

This letter gives notice of an Emergency Major Substantive rulemaking for 10-144, C.M.R. ch. 101, MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institution Services.

This emergency major substantive rulemaking complies with Resolves 2015, ch. 45, *To Require the Department of Health and Human Services to Provide Supplemental Reimbursement to Residential Care Facilities in Remote Island Locations*, which requires the Department to amend its rules in 10-144 C.M.R. ch. 101, MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institution Services. Further the rule must provide eligible residential care facilities with supplemental payment of fifteen (15) percent in addition to the MaineCare rate. This increase will apply only to Appendix C PNMIs located on an island not connected to the mainland by a bridge.

In addition, this rulemaking increases the Appendix C and F PNMIs' assisted living reimbursement rate by four (4) percent. This rulemaking complies with Public Law 2015, Chapter 267, Parts A, Section A-32, and UU, which became law on June 30, 2015 and was enacted with an emergency preamble.

The Department shall seek approval from the federal Centers for Medicare and Medicaid Services (CMS) for a State Plan Amendment for these changes. Pursuant to 22 M.R.S.A. §42(8), if CMS approves, the increased rates to eligible remote island facilities will be effective retroactive to October 1, 2015. Appendix C and F PNMIs' assisted living reimbursement rate of four (4) percent will be effective retroactive to July 1, 2015. The Department published notices of changes in reimbursement methodology, pursuant to 42 C.F.R. §447.205, on August 7, 2015 relative to the four (4) percent increase and on September 30, 2015 relative to the supplemental payment increase of fifteen (15) to remote island facilities.

This emergency major substantive rule will remain in effect for up to one year or earlier if the Legislature approves the provisionally adopted major substantive rule.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare Services 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. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

A concise summary of the Emergency Major Substantive rule is provided in the Notice of Agency Rule-making Adoption, which can be found at <http://www.maine.gov/sos/cec/rules/notices.html>.

This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Adoption.

Notice of Agency Emergency Major Substantive Rule-making

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144, C.M.R. ch. 101, MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institution Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: This emergency major substantive rule seeks to provide a supplemental payment of fifteen (15) percent, in addition to the facility's MaineCare rate, to residential care facilities in remote island locations. Eligible facilities are Appendix C Private Non-Medical Institutions (PNMI) located on an island not connected to the mainland by a bridge.

In addition, this rule seeks to increase Appendix C and F PNMIs' assisted living reimbursement rate by four (4) percent.

The Department shall seek approval from the federal Centers for Medicare and Medicaid Services (CMS) for a State Plan Amendment for these changes. If CMS approves, the fifteen (15) percent supplemental payments to remote island facilities will be effective retroactive to October 1, 2015. Appendix C and F PNMIs' assisted living reimbursement rate increase of four (4) percent will be effective retroactive to July 1, 2015.

This emergency major substantive rule will remain in effect for up to one year or earlier if the Legislature approves the provisionally adopted major substantive rule.

HTTP://WWW.MAINE.GOV/DHHS/OMS/RULES/INDEX.SHTML for rules and related rulemaking documents.

EFFECTIVE DATE: July 1, 2015 & October 1, 2015

AGENCY CONTACT PERSON: Heidi Bechard, Comprehensive Health Planner

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SECTION 97

PRIVATE NON-MEDICAL INSTITUTION SERVICES

Established 6/11/90
Emergency Rule: 3/8/16

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GENERAL PROVISIONS

1000 **PURPOSE**

The purpose of these regulations is to define which items of expense will be taken into account and which will be excluded in the calculation of reasonable costs for Private Non-Medical Institutions. These Principles of Reimbursement for Private Non-Medical Institutions identify which costs are reimbursed under Chapter II, Section 97 - Private Non-Medical Institution (herein after, PNMI) Services of the MaineCare Benefits Manual. The Department will consider allowable costs identified by these Principles for reimbursement of services in a residential child care facility, substance abuse treatment facility, and community residences for persons with mental illness (for those facilities covered under Appendices B, D, and E) on the first day of the provider's fiscal year beginning on or after July 1, 2001. The Department will consider allowable costs identified by these Principles of Reimbursement for Private Non-Medical Institution medical and remedial facility services (under Appendices C and F) rendered on or after July 1, 2001. Prior to July 1, 2001, PNMI services rendered in a medical and remedial facility and non-case mixed medical and remedial facility shall follow the applicable appendix in effect prior to July 1, 2001, and the Principles of Reimbursement for Residential Care Facilities- Room and Board Costs.

1100 **SCOPE/AUTHORITY**

These Principles define scope and authority within the specific Appendix applicable to that type of Private Non-Medical Institution. These Principles define Department and member/resident in Section 10000 of this policy. These Principles define facility in each specific Appendix.

1300 **ADULT FAMILY CARE HOMES**

1300.1 The Department does not use these PNMI Principles in the determination of the reimbursable amount paid to Adult Family Care Homes.

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1400 REQUIREMENTS FOR MAINECARE REIMBURSEMENT

1400.1 In order to be reimbursed, all PNMI's identified as residential child care, substance abuse treatment, community residences for persons with mental illness, and Appendix F scattered site PNMI's for people for mental retardation must be licensed as applicable, in accordance with the Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug treatment Services, or Rules for the Licensure of Residential Child Care Facilities/Rights of Recipients of Mental Health Services Who are Children in Need of Treatment. In order to be reimbursed, medical and remedial service PNMI's and non-case mixed must be licensed by the Division of Licensing and Certification in the Department of Health and Human Services (See 10-149 C.M.R., Ch. 113), with the exception of Appendix F scattered site PNMI's for persons with mental retardation, which may be licensed as either a residential care facility or as a mental health provider in accordance with the Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug treatment services.

1400.2 All PNMI's must obtain licensure and a signed Provider/Supplier Enrollment Agreement with the Department of Health and Human Services, Office of MaineCare Services (OMS). Providers must submit a copy of the license accompanying the Provider/Supplier Enrollment Agreement to the Department.

1400.3 Types of PNMI's considered for MaineCare reimbursement, subject to the availability of funds, include:

1400.31 Facilities providing Private Non-Medical Institution services to members with significant mental or physical disability requiring structured, individualized habilitative or rehabilitative in-home programming as outlined in the provider agreement with the PNMI.

1400.32 Facilities with licensed Private Non-Medical Institution beds at scattered locations serving a minimum of four eligible members, as long as the service provided consistently fits within the definition of the applicable appendix stated below.

- Appendix B Substance Abuse Treatment Facilities
- Appendix D Child Care Facilities
- Appendix F Non-Case Mixed Medical and Remedial PNMI's

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1400 REQUIREMENTS FOR PARTICIPATION IN MAINECARE (cont.)

- 1400.4 Except for Child Care Facilities covered under Appendix D, the Department will reimburse PNMI's for services provided to eligible members based on an interim rate that the Department establishes and determines as reasonable and adequate to meet the costs that are 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. Appendix D standard rates are not interim and are not subject to cost settlement guidelines detailed in this Chapter.
- 1400.5 The Department requires cost reimbursed facilities to submit annual cost reports as stated in Section 3300.
- 1400.6 The Department will respond in writing to written requests for interpretation of these Principles. Providers should direct written requests to the Director, Office of MaineCare Services.
- 1400.7 The Department reserves the right to take legal action against, and/or terminate the provider agreement if a facility fails to comply with these Principles, or submits, or causes to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

1500 RESPONSIBILITIES OF OWNERS OR OPERATORS

The owners or operators of a Private Non-Medical Institution must prudently manage and operate a PNMI of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Commissioner, nor a duly authorized representative may in any way relieve the owner or operator of a PNMI from full responsibility for compliance with the requirements and standards of the Department or Federal requirements and standards.

1600 DUTIES OF THE OWNER OR OPERATOR

In order to qualify for MaineCare reimbursement the owner or operator of a PNMI, or a duly authorized representative must:

- 1600.1 Comply with the provisions of Chapter I; and Chapters II, III, and the applicable Appendix of Section 97 of the MaineCare Benefits Manual.
- 1600.2 Submit master file documents and cost reports in accordance with the provisions of Sections 3100 and 3300 of these Principles. Child Care providers under Appendix D must also submit these documents and cost reports, which the Department utilizes in setting appropriate reimbursement rates.

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1600 **DUTIES OF THE OWNER OR OPERATOR** (cont.)

- 1600.3 Maintain adequate financial and statistical records and make them available for inspection by an authorized representative of the Department, State, or the Federal government upon request.
- 1600.4 Assure that annual records are prepared in conformance with Generally Accepted Accounting Principles (GAAP), except where otherwise required.
- 1600.5 Assure that the construction of buildings and the maintenance and operation of premises and residential services comply with all applicable health and safety standards.
- 1600.6 Submit such data, statistics, schedules or other information that the Department requires in order to carry out its functions. Failure to supply the required documentation may result in the Department imposing the deficiency per diem rate described in Section 7000 of these Principles.

1700 **COVERED SERVICES**

See applicable section of Chapter II, Section 97, Private Non-Medical Institution Services.

1900 **TERMINATION UNDER TITLE XIX**

Termination of participation in Title XIX will result in the provider being terminated simultaneously from financial participation under PNMI cost reimbursement. Alternatively, termination of participation in cost reimbursement will result in the provider being terminated simultaneously from participation in Title XIX. Conditions that may result in termination of participation in MaineCare are listed in Chapter I of the MaineCare Benefits Manual. These conditions may result in termination of the provider contract to provide PNMI services:

- 1900.1 The Federal Government fails to provide agreed upon funds; or
- 1900.2 The State share of funds is unavailable; or
- 1900.3 The life, health, or safety of persons served is endangered, in the opinion of the Department; or
- 1900.4 The provider fails to submit fiscal or program reports on the prescribed dates; or
- 1900.5 Either the Department or the provider receives a written notice from the other for any reason stating that termination will occur in no later than 30 days; or

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1900 **TERMINATION UNDER TITLE XIX** (cont.)

- 1900.6 The provider fails to meet the applicable licensing regulations after a reasonable time for correction, or if the provider fails to deliver services in accordance with the plan of care; or
- 1900.7 The license to operate is revoked by Department or court action, or if the facility's owner or its administrator is convicted of any crime related to operation of the facility; or
- 1900.8 The same services can be provided at a lower rate on a fee-for-service basis or if the per diem rate is greater than the rates that third party payers are paying for comparable services under comparable circumstances.

2000 **ACCOUNTING REQUIREMENTS**

- 2000.1 All financial and statistical reports must be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless specific variations are required by these principles.
- 2000.2 The provider must establish and maintain a financial management system that assures adequate internal control and accuracy of financial data, the safeguarding of assets and operational efficiency.
- 2000.3 The provider must report on an accrual basis, unless it is a State or municipal institution that operates on a cash basis, unless the Department and the Department providing the State share of MaineCare reimbursement approves exceptional circumstances. The provider whose records are not maintained on an accrual basis must develop accrual data for reports on the basis of an analysis of the available documentation. The provider must retain all such documentation for audit purposes.
- 2000.4 It is the duty of the provider to notify the Division of Audit within 5 days of any change in its customary charges to the general public. The provider may submit a rate schedule to the Department to satisfy this requirement if the schedule allows the Department the ability to determine with certainty the charge structure of the Private Non-Medical Institution.

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2300 COST RELATED TO RESIDENT CARE (Excluding Appendix D Facilities)

2300.1 In order to be allowable, compensation must be reasonable and for services that are necessary and related to PNMI services. The services must actually be performed and incurred by the PNMI or its contractors. Providers must report all compensation to all appropriate state and federal tax authorities to the extent required by law for income tax, social security, and unemployment insurance purposes.

Providers may not claim reimbursement for personal expenses unrelated to member care. Bonuses that are part of a written policy of the provider and which require some measurable and attainable employee job performance expectations are allowable. Bonuses based solely on the availability of any anticipated savings are not allowable.

2300.2 Costs incurred for PNMI 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.

2400 ALLOWABILITY OF COST

2400.1 Allowable costs shall include salaries and wages for direct service staff.

See applicable Appendix for each type of PNMI for the list of approved direct service staff:

- Appendix B Substance Abuse Treatment Facilities
- Appendix C Medical and Remedial Service Facilities
- Appendix D Child Care Facilities
- Appendix E Community Residences for Persons with Mental Illness
- Appendix F Non-Case Mixed Medical and Remedial Facilities

2400.2 Allowable costs shall also include the following taxes and benefits applicable to direct service staff as defined in the applicable Appendix:

- Payroll taxes/unemployment payroll taxes
- Health insurance
- Dental insurance
- Employer term life/disability insurance
- Qualified retirement contributions
- Worker's Compensation insurance

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2400 **ALLOWABILITY OF COST** (cont.)

2400.3 The Department will approve the direct care staffing.

2400.31 The Department will determine the reasonableness of costs based on the budget submitted prior to the beginning of the provider's fiscal year, subject to final approval by the Office of MaineCare Services. The total amount approved in the budget will serve as a cap for reimbursement.

2400.32 A Rate Letter will inform the provider of the approved total cost cap and per diem rate based on a review of the submitted budget per Section 2400, Chapter III, General Provisions. For case mix facilities covered under Appendix C, the rate letter informs the agency of the Industry Price and Average Case Mix Index.

2400.4 Allowable costs may also include contract fees, which are fees paid in lieu of salary, paid for use of foreign exchange fellows, such as those participating in the ILEX international professional exchange program for social workers, in lieu of direct service staff as defined in the applicable appendix. Contract fees must be prior-approved by the Department, and must meet all staff qualifications. The Department will reimburse the provider for the contract fee, based on a calculation of hours worked by the foreign exchange fellow, at the salary, wages and taxes and benefits that would be allowable under these regulations for a comparable direct service staff working those hours. The Department will only reimburse up to the allowed contract fee amount, and will not reimburse any wages and benefits to the foreign exchange fellow other than reimbursing the allowable contract fee amount.

2410 State-Mandated Service Tax: Effective July 1, 2004, allowable costs shall include a State-mandated service tax. The State-mandated service tax is a 5% tax on the value of PNMI services, as defined in 36 M.R.S.A. §2552(1)(G).

2450 Program Allowance: See the applicable Appendix for the allowable program allowance.

The maximum reimbursement amount allowed, including the program allowance, will not be greater than the total costs of the program.

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2400 **ALLOWABILITY OF COST** (cont.)

2470 Certifying Other Qualified Staff (With exception for Appendix C and F facilities) Training and experience requirements of other qualified staff may vary by definition. However, in all cases, other qualified staff including exchange fellows must be certified or approved by a specified State agency, or its designee, as meeting these requirements. (The specified State agency, or its designee, would be the agency approving the staff for the facility.) These certifications/approvals must be on file. The approval must be in writing and dated at the time the approval is made. This approval process must not be delegated to a provider. The PNMI provider may certify to the approving agency that employees have or will have the requisite training. However, the approving agency must provide the written approvals for the provider to maintain on file. MaineCare payments made for individuals who have not been approved provisionally or fully certified by the State agency, or its designee, are subject to recoupment.

2480 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.

2500 **NON-ALLOWABLE COSTS**

An unallowable cost includes all costs not included in Section 2400.

2600 **SUBSTANCE OVER FORM**

The cost effect of transactions that have the effect of circumventing these rules may be adjusted by the Department on the principle that the substance of the transaction shall prevail over the form.

2700 **RECORD KEEPING AND RETENTION OF RECORDS**

2700.1 Providers must make all financial and member records available to representatives of the State of Maine, Department of Health and Human Services or the U.S. Department of Health and Human Services, or the Maine Attorney General's Office, as required by Section 2700.3.

The Department will give providers a three-day notice when requesting fiscal records.

2700.2 Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the cost report.

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2700 **RECORD KEEPING AND RETENTION OF RECORDS** (cont.)

- 2700.3 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, Federal and State income tax information, asset acquisition, lease, sale, or any other action, franchise or management arrangement, 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 will 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.
- 2700.4 The provider must maintain all such records for at least 5 years from the date of settlement of the final audit. The Division of Audit must keep all cost reports, supporting documentation submitted by the provider, correspondence, work papers and other analysis supporting audits for a period of three years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division of Audit must 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.
- 2700.5 When the Department determines that a provider is not maintaining records as outlined above for the determination of reasonable cost in the PNMI, the Department, upon determination of just cause, may impose the deficiency rate as described in Section 7000 of these Principles.

2900 **BILLING PROCEDURES**

- 2900.1 Substance abuse treatment facilities, child care facilities, and community residences for persons with mental illness will bill the Department of Health and Human Services and be reimbursed at the agreed rate in accordance with MaineCare billing instructions for the UB-92 Claim Form.
- 2900.2 Medical and remedial service facilities will bill the Department of Health and Human Services and be reimbursed at the agreed rate in accordance with MaineCare billing instructions for the UB-92 Claim Form.
- 2900.3 Claims cannot include dates of service that overlap the provider's fiscal years.

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3000 **REIMBURSEMENT METHOD**

3000.1 The Department will reimburse facilities for services provided to members based on a rate that the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs incurred by an efficiently and economically operated facility. The provider must provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

3000.11 Except for Appendix D facilities, the Department will limit reimbursement to the approved amount in Section 2400. Appendix D facilities receive a standard rate not subject to Section 2400 adjustments for allowability of cost.

3000.2 Rate Setting Procedures

See applicable Appendix for type of Private Non-Medical Institution:

- Appendix B Substance Abuse Treatment Facilities
- Appendix C Medical and Remedial Service Facilities Participating in Case Mix
- Appendix D Child Care Facilities
- Appendix E Community Residences for Persons with Mental Illness
- Appendix F Non-Case Mixed Medical and Remedial Facilities

3000.3 Rate Adjustments For Facilities Under Appendix B, E, and F

Facilities covered under Appendix B, E, and F may request rate adjustments as necessary. The relevant Appendix details the process for such requests. The Department will not grant retroactive rate adjustments unless they are approved by the OMS and the Department under exceptional circumstances as determined by these two agencies.

3000.4 For out-of-state PNMI services provided by out-of-state providers, the Division of Financial Services will determine whether the rate paid to these providers will be either 1) based on the methodology set forth in this section, or 2) be the Medicaid rate of the state in which the PNMI services are provided.

The following is subject to CMS approval

3000.5 A PNMI that qualifies as a remote island facility under this section will receive a 15 percent supplemental payment in addition to their MaineCare rate.

Subject to
CMS approval
effective
10/1/15

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3100 **FINANCIAL REPORTING**

3100.1 Master File

When requested by the Department the provider must submit the following documents to the Office of MaineCare Services or its designee. Providers must update documents to reflect any changes. The Department will use the following documents to establish a master file for each facility in MaineCare:

- 3100.11 Copies of the articles of incorporation and bylaws, of partnership agreements of any provider or any entity related to the provider;
- 3100.12 Chart of accounts and procedures manual, including procurement standards;
- 3100.13 Plant layout;
- 3100.14 Terms of capital stock and bond issues;
- 3100.15 Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing, and bonus agreements;
- 3100.16 Schedules for amortization of long-term debt and depreciation of plant assets;
- 3100.17 Summary of accounting principles, cost allocation plans, and step-down statistics used by the provider;
- 3100.18 Related party information on affiliations, and contractual arrangements;
- 3100.19 Tax returns of the Private Non-Medical Institution; and
- 3100.20 Any other documentation requested by the Department for purposes of establishing a rate.

If any of the items listed in Subsections 3100.11 through 3100.20 are not submitted in a timely fashion, the Department may impose the deficiency per diem rate described in Section 7000 of these Principles.

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3300 UNIFORM COST REPORTS

3300.1 The Department requires all PNMI's to submit cost reports. Cost reports, as prescribed herein, must be mailed to the State of Maine, Department of Health and Human Services, Division of Audit, and to the Division of Financial Services, Office of MaineCare Services, 11 State House Station, Augusta, ME, 04333-0011. Those out-of-state providers who are using another state's Medicaid rate or have two or fewer MaineCare residents must obtain prior authorization from the OMS Division of Financial Services, # 11 State House Station, Augusta, Maine 04333-0011 to be exempted from filing a cost report. The facility's financial statements will be the basis for completing the cost report. The cost reports must be based on the fiscal year of the facility. If the provider determines from its as filed cost report that it owes money to the Department, a check equal to 50% of the amount owed to the Department must accompany the cost report. If the Department does not receive a check with the cost report, the Department may elect to offset, pursuant to State and federal law, the current payments to the facility until the entire amount is collected from the provider.

3300.2 Forms/Electronic Media. The Department will supply annual cost report forms/electronic media for use by PNMI's in the State of Maine.

3300.3 Each PNMI in Maine must submit a completed annual cost report within five months of the end of each fiscal year on forms/media prescribed by the Division of Audit. If available, the PNMI will submit a copy of the cost report on a computer disk or electronically.

The inclusive dates of the reporting year are the 12-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. Failure to submit an acceptable cost report in the time prescribed above may result in the Department imposing the deficiency per diem rate described in Section 7000.

3300.4 Certification by operator. Each provider must examine the cost report and supporting schedules prepared for submission to the Department and must certify that the report is a true, correct, and complete statement prepared from the books and records of the provider. The owner or administrator of the PNMI must certify the cost report. If someone other than the owner or administrator prepares the return, the preparer must also sign the report.

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3300 **UNIFORM COST REPORTS** (cont.)

3300.5 The provider must submit the Cost Report with required supporting documentation to the Division of Audit. Supporting documentation requirements are defined by the Division of Audit. Supporting documentation includes, at a minimum, financial statements and reconciliation of the financial statements to the cost report. All cost reports must bear original signatures.

Providers must also submit a copy of the cost report without supporting documentation to the Division of Financial Services at the Office of MaineCare Services.

3300.6 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.

3300.7 The Division of Audit may reject any cost report filing that does not comply with these regulations. In such case, the report will be deemed not filed, until refiled and in compliance. A rejected cost report will subject the provider to the deficiency per diem as stated in Section 7000.

3300.8 Extension for filing of the cost report with the required supporting documentation beyond the prescribed deadline will only be granted under the regulations stated in the Medicare Provider Reimbursement Manual (HIM-15).

3300.9 When a provider fails to file an acceptable cost report by the required date, the Department will send the provider a notice by certified mail, return receipt requested, advising the provider that all payments will be suspended 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 will be at the deficiency rate as stated in Section 7000.

3400 **SETTLEMENT OF COST REPORTS**

3400.1 Uniform Desk Review

See applicable PNMI Appendix for uniform desk review procedures.

3400.2 Calculation of the Final Settlement

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3400 **SETTLEMENT OF COST REPORTS** (cont.)

See Applicable Appendix for calculation of the final settlement. Calculation of the final settlement is subject to reimbursement methods, limits, and reductions set forth in this Section. Appendix D facilities are not subject to cost settlement.

3500 **ADJUSTMENTS TO AUDIT SETTLEMENTS** (Except for Appendix D)

3500.1 Finalized cost report determinations and decisions may be reopened and corrected when the Division of Audit finds new and material evidence submitted by the provider or discovered by the Department or evidence of a clear and obvious material error.

3500.2 Reopening means an affirmative action taken by the Division of Audit to re-examine the correctness of a determination or decision that is otherwise final. Such action may only be taken:

3500.21 At the request of either the Department or a provider, within the applicable time period set out in paragraph 3500.4; and,

3500.22 When the reopening may have a material effect (more than one percent) on the provider's MaineCare rate payments.

A correction is a revision (adjustment) in the Division of Audit's determination, otherwise final, that is made after a proper re-opening. The Division may make a correction, or require the provider to file an amended cost report.

3500.4 A re-opening of an audit may occur within three 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. No time limit will apply in the event of fraud or misrepresentation.

3500.41 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.

3500.42 No final audit will be reopened, or any hearing allowed concerning matters contained in any final audit if three years following the date of the final audit settlement have passed. This limitation does not apply in the event of fraud or misrepresentation.

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3600 **SETTLEMENTS OF OVERPAYMENTS OR UNDERPAYMENTS** (Except for Appendix D)

3600.1 Underpayments: If, at the time the audit is completed, the Department determines that it has underpaid a facility; the Department will pay the amount due and forward the result to the facility within thirty working days.

3600.2 Overpayments:

3600.21 If the Department has overpaid a provider, it will recover overpayments by offset, recoupment, or other methods allowed by law.

3600.22 The department may withhold payment on pending or future claims in an amount equal to the overpayment, pursuant to State and federal law. The amount may be withheld all at once or over a period of time established by the Department. Amounts are to be repaid within 90 days of the date the audit is finalized unless otherwise negotiated by the Department.

3600.23 If there are insufficient claims sent to the Department against which the Department can offset the amount of an overpayment, the Department will direct the provider to remit the payment in full. If repayment is not made, the Department may exercise any or all appropriate action against the provider and exercise all other civil remedies in order to recover the overpayments.

4000 **PUBLIC HEARING**

The State of Maine will provide for public hearings as described MBM, Chapter I.

5000 **WAIVER**

The failure of the Department to insist, in any one 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, will 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.

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6000 **POST AUDIT APPEAL PROCEDURES** (Except for Appendix D)

- 6000.1 These provisions apply only to appeals after audit adjustment. See MBM, Chapter I for all other appeals procedures. A provider may administratively appeal an audit adjustment made by the Division of Audit.
- 6000.2 An administrative appeal will proceed in the following manner:
- 6000.21 Within sixty (60) 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.
- 6000.22 The Director or his/her designee will 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 sixty (60) days of receipt of the decision made as a result of the informal review.
- 6000.23 To the extent the Department rules in favor of the provider, the audit report will be revised.
- 6000.24 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 Procedures Act, 5 M.R.S.A. §11001 *et seq.*

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7000 DEFICIENCY PER DIEM RATE (Except for Appendix D)

In addition to the deficiency rate, civil and/or monetary sanctions may be applied by the State agency responsible for licensing the facility when a facility is found not to have provided the quality of service or level of care required. The Department will reimburse at 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:

- 7000.1 Staffing over a period of two weeks or more does not meet the Federal Certification and State Licensing requirements;
- 7000.2 Food service does not meet the Federal Certification and State Licensing requirements;
- 7000.3 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 30 days from written notification that such deficiencies exist;
- 7000.4 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;
- 7000.5 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, suspension, withholding of, or recoupment of MaineCare reimbursement. The deficiency per diem rate for these items will go into effect immediately upon receipt of written notification from the Department.
- 7000.6 Failure to complete acceptable assessments, as defined in Appendix C.

A reduction in rate because of deficiencies will remain in effect until the deficiencies have been corrected, as defined in the applicable Appendix, or 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 will 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.

8000 START UP COSTS APPLICABILITY

Prior to admitting residents, certain costs are incurred, which are referred to as start-up costs. No start-up costs can be allowed for the PNMI component.

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10000 GENERAL DEFINITIONS

“Accrual Basis 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.

“Allowable Costs” are those operating costs remaining after the adjustments required by the Principles have been applied to the provider’s total operating costs reported in the annual cost reports.

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

“Census/Days of Care”: For purposes of counting the number of patient days, the day of the patient’s admission will be counted, but the day of discharge will not be counted.

“Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)” is the Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and federal Medicaid programs.

“Common Ownership” exists if an individual or individuals possess significant (10%) ownership or equity in the provider and the institution or organization serving the provider.

“Control” exists if 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” are the processes of segregating costs by cost centers and allocating indirect cost to determine the cost of services provided.

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

“Generally Accepted Accounting Principles (GAAP)” are 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.

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

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10000 **GENERAL DEFINITIONS** (cont.)

“Division of Audit” used throughout these Principles refers to the Department of Health and Human Services, Division of Audit.

“MaineCare Eligible Days” are the actual days of service for which payment was made by the Office of MaineCare Services through the claims process.

“Necessary and Proper Costs” are costs for services and items that are essential to provide appropriate resident care and resident 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.

“Occupancy Level” as referenced in this policy consists of the total licensed beds of a PNMI times the number of days available in the fiscal period (e.g.: A PNMI licensed for 10 beds and open for a full 12 month period, with the fiscal period covering the full 12 months, would have its occupancy level stated at 3650. Ten beds multiplied by 365 days in the year equals 3650 days.)

“Owners” include any individual or organization with 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” includes total allowable costs divided by days of care.

“Reasonable Costs” are those incurred by a provider which are reasonable and necessary in providing adequate care to eligible residents and which are within the requirements and limitations of this policy. The reasonableness and necessity of any costs will be determined by reference to, or in comparison with, the cost of providing comparable services.

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

“Remote Island Facility” for the purposes of this section, means a facility located on an island not connected to the mainland by a bridge.

“Resident” as used throughout this policy refers to the person residing in the facility and is receiving services in the PNMI. The term is also synonymous with “member.”

“Rider A” is used to denote the State’s share of funds used to draw down the federal Medicaid funds by a specific agency/facility. The form states the amount of State money total (of State and Federal) that the agency/facility can receive in that fiscal year.

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10000 GENERAL DEFINITIONS (cont.)

“State Licensing and Federal Certification” as used throughout these principles are the applicable “Regulations Governing the Licensing and Functioning of Level I Private Non-Medical Institutions,” “Regulations Governing the Licensing and Functioning of Level II Private Non-Medical Institutions,” “Regulations Governing the Licensing and Functioning of Level III Private Non-Medical Institutions,” or “Regulations Governing the Licensing and Functioning of Level IV Private Non-Medical Institutions”, “Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services,” “Regulations for Licensing and Certifying of Alcohol and Drug Treatment Services,” or “Rules for the Licensure of Residential Child Care Facilities/Rights of

Recipients of Mental Health Services Who are Children in Need of Treatment;” and the Federal Certification requirements for Private Non-Medical Institutions that are in effect at the time the cost is incurred.

“Leave (bedhold) days” are when the resident is not in the facility and no treatment is provided. Leave days are not a covered service.

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PROC. CODE	DESCRIPTION	MAXIMUM ALLOWANCE
* See Below		
SUBSTANCE ABUSE TREATMENT FACILITIES		
H0010	Detoxification (Non Hospital based)	\$210.96 per diem
H2034	Halfway House Services	\$102.91 per diem
H2036	Extended Care	\$113.38 per diem
H2036 HF	Residential Rehabilitation Type 1	\$217.71 per diem
H2034 HF	Residential Rehabilitation Type II	\$116.07 per diem
H2036 HA	Adolescent Residential Rehabilitation	\$182.04 per diem
T1020 HF	Personal Care - Substance Abuse (Substance Abuse Shelter Services)	\$55.17 per diem

* Room and Board costs are not reimbursed in the rates for PNMI Substance Abuse Treatment Services

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RESIDENTIAL CHILD CARE FACILITY		
	Child Care Facility PNMI Services	Per Diem
H0019-HE	Child Mental Health Level I*	\$327.60 per diem
H0019-CG	Child Mental Health Level II*	\$431.29 per diem
H0019-SE	Mental Retardation and Pervasive Developmental Disorder Level I*	\$392.73 per diem
H0019-U9	Mental Retardation and Pervasive Developmental Disorder Level II*	\$580.07 per diem
H0019-HA	Crisis Residential	\$534.80 per diem
H0019-HU	Treatment Foster Care	\$102.53 per diem
H0019-HY	Treatment Foster Care- Multidimensional (Juvenile Justice)	\$149.03 per diem
S9485	* Temporary High Intensity Service for Children in ITRT Setting. This service is only available for Mental Health Level I and II and Mental Retardation Level I and II.	By Report per diem

COMMUNITY RESIDENCES FOR PEOPLE WITH MENTAL ILLNESS		
* (H0019)	Rehabilitation Services	By Report
* (T1020-HE)	Personal Care Services-Residences For People With Mental Illness	By Report

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RESIDENTIAL CARE FACILITIES		
* (T1020)	Medical and Remedial Personal Care Services	By Report
* (T1020)	Medical And Remedial Services	By Report
COMMUNITY RESIDENCES FOR PEOPLE WITH MENTAL RETARDATION		
RMR* (T1020)	Personal Care Services-Residences For People With Mental Retardation	By Report
MRP* (H0019)	PNMI Services	By Report

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1000 INTRODUCTION

1010 **Purpose.** The purpose of these regulations is to define the payment mechanism for Title XIX funds in medical and remedial services facilities under Chapter II, Section 97 - Private Non-Medical Institution Services of the MaineCare Benefits Manual. The Department pays a case mix adjusted industry-specific price for direct care services provided in medical and remedial services facilities, plus a program allowance and a personal care services component.

1020 **Authority.** The authority of the Maine Department of Health and Human Services to accept and administer funds that may be available from private, local, State, or Federal sources for the provision of services set forth in these Principles of Reimbursement is established in Title 22 of the Maine Revised Statutes Annotated (MRSA), §3, §10, §42, §3273, §7906-A and 7910. The regulations are issued pursuant to authority granted to the Department of Health and Human Services by Title 22 MRSA §42(1).

1030 **Principle.** In order to receive payment for services according to this Appendix, a provider must be licensed as a residential care facility and have a provider contract specifying the conditions of participation in Title XIX as a Private Non-Medical Institution as described in Section 97, Chapter II of the MaineCare Benefits Manual. Determination of members' eligibility for PNMI services is made according to Chapter II, Section 97 of the MaineCare Benefits Manual. Residents 18-64 years of age and living in Institutions for Mental Disease are not eligible for services under this Appendix. However, the cost of covered services to residents of Institutions for Mental Diseases who are 65 years of age and over can be claimed under this appendix provided they meet all other requirements for eligibility.

Payment will be made for any eligible member only if the provider obtains the signature of a physician prescribing covered services prior to the first date of service. The PNMI must maintain this information as part of the member's record at the facility.

The Department will not make payment under this Appendix for residents who are family members of the owner or provider staff providing medical and remedial services.

1040 **Scope.** Residential Care Facilities that provide custodial (e.g. supervision, medication administration, and room and board) services to six or fewer residents and do not provide individualized in-home programming to persons with severe physical or functional disability are not eligible for payment under Appendix C. The Department reimburses these providers on a flat rate basis.

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2000 **DEFINITIONS**

- 2010 **Member** as used throughout this Appendix refers to an individual who is MaineCare eligible.
- 2020 **Room and Board** costs means those costs that are not medical and remedial services costs and are not covered services under Appendix C.
- 2030 **Resident Assessment Instrument (RAI)** is the assessment tool approved by the Department for use by the provider to obtain an accurate, standardized, reproducible assessment of each resident's functional capacity. It consists of the Minimum Data Set-Residential Care Assessment instrument (hereinafter MDS-RCA), the training manual for the MDS-RCA Tool, and any updates provided by the Department.
- 2040 **Remote Island Facility** for the purposes of this section, means a facility located on an island not connected to the mainland by a bridge.

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2400 **ALLOWABILITY OF COST**

2400.1 **Case Mix Adjusted Price**

The case mix adjusted price includes services provided by the direct care services staff listed below. Allowable costs include salaries, wages, benefits, and consultant fees for direct care staff and services listed below:

- Clinical consultant services
- Interpreter services
- Licensed practical nurse services
- Licensed social workers or other social worker services
- Personal care services staff
- Practical nurses
- Registered nurse consultant services, and
- Other qualified medical and remedial staff.

2400.2 **Program Allowance**

A program allowance of thirty five (35) percent, expressed as a percentage of the allowable costs, as defined in Chapter III, Section 97, Sections 2400.1 and 2400.2 will be allowed in lieu of indirect and/or PNMI related cost.

2400.3 **Personal Care Services Not Included in the Case Mix Adjusted Price**

Effective July 1, 2002, personal care services not included in the case mix adjusted price include salaries, wages, and benefits (as described in Chapter III, Section 2400.2) for direct care staff listed below:

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2400 **ALLOWABILITY OF COST** (cont.)

Laundry
Housekeeping, and
Dietary services

The personal care services component is determined by inflating the facility's 1998 audited costs for these services to June 30, 2003. This becomes the PNMI's facility specific cap. The actual allowable personal care services costs will be settled at audit up to this cap.

2400.4 **Allowable Costs Related to Contract Fees for Exchange Fellows**

Allowable costs will also include the contract fee paid for use of exchange fellows in lieu of direct service staff as defined in the applicable appendix. Contract fees must be prior-approved by the seeding Department. The contract fee paid cannot exceed the normal salary plus benefits and taxes for comparable direct service staff within the provider agency.

2400.5 **State Mandated Service Tax**

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

2400.6 **Remote Island Supplemental Payment**

Eligible facilities will be allowed to retain the "remote island facility" supplemental payment, representing a fifteen (15) percent rate increase, in addition to the total allowable rate for private non-medical institution direct care services and personal care services costs otherwise determined under these rules.

3000 **GENERAL DESCRIPTION OF THE PRICING METHODOLOGY**

3010 **Direct Care Services Included in the Case Mix-Adjusted Price**

The Department utilizes a case mix-adjusted pricing methodology with three peer groups for medical and remedial services provided in residential care facilities, unless the provider is exempted from participation in this Appendix. The Department calculates the price by:

- Grouping residential care facilities that had completed MDS-RCA assessments for MaineCare residents on 9/15/98, and that had audited costs for 1998 (hereinafter the base year), into four peer groups, as described in Section 6000;
- Aggregating total allowable direct care costs, applicable workers compensation costs, medical supplies (see Section 3020) and

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3000 **GENERAL DESCRIPTION OF THE PRICING METHODOLOGY** (cont.)

Department-approved medical and remedial services training costs in the base year to calculate each provider's adjusted direct care costs;

- Dividing the adjusted direct care costs by the actual occupancy to determine an adjusted direct care cost/day;
- Inflating the direct care cost from the base year through June 30, 2001 using the regional variations in labor costs by comparing the percentage increase in the weighted average of the actual salaries paid to direct care staff in the base year by medical and remedial PNMI's covered under this Appendix to the weighted average of the actual salaries paid to direct care staff in the subsequent year (based on that subsequent year's audited or as filed cost report);
- Dividing each facility's inflated adjusted direct care cost/day by the facility-specific MaineCare case mix index as of September 15, 1998, and aggregating to arrive at an average industry Direct Care Price (hereinafter DCP) for each of the four peer groups. MDS assessments that could not be classified on the September 15, 1998 roster were excluded from the calculation;
- Adding a Program Allowance (PA) determined by the Commissioner, as set forth in Chapter III, Section 97; and
- Calculating the MaineCare payment to each provider by multiplying the DCP by the facility-specific case mix index for MaineCare members, and adding the applicable program allowance.

3020 **Personal Care Services Component Not Included in the Case Mix-Adjusted Price**

Effective July 1, 2002, the Department will determine the rate for the personal care services component by the following method:

- Aggregating total audited allowable costs for housekeeping, laundry, and dietary wages, taxes, and benefits, including applicable Worker's Compensation costs, and benefits in the facility's base year;
- Dividing the costs by the actual occupancy to determine the personal care services component rate; and
- Inflating the personal care services component rate through June 30, 2003.

The actual allowable personal care services costs will be determined at the time of audit of the cost report required under Chapter III, Section 3300, and cost settled up to each PNMI's facility-specific personal services cap.

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3000 GENERAL DESCRIPTION OF THE PRICING METHODOLOGY (cont.)

For new facilities, the allowable personal care services costs will be determined initially based on a proforma cost report.

3030 Medical Supplies Included in the Price

Medical supplies contained in the direct care price include but are not limited to the following items: non-prescription analgesics, non-prescription antacids, applicators, bandages, blood pressure equipment, non-prescription calcium supplements, cotton, cough syrup and expectorants, dietary supplements, disinfectants, dressings, enema equipment, gauze bandages, sterile or non-sterile gloves, ice bags, non-prescription laxatives, lotions, ointments and creams, stethoscopes, non-prescription supplies, tapes, thermometers, and rectal medicated wipes.

4000 FACILITIES EXEMPT FROM THE CASE MIX PRICING METHOD

The following types of medical and remedial PNMI are exempt from case mix pricing method and will be reimbursed in accordance with Appendix F:

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

5000 CASE MIX ADJUSTED DCP

The basis for case mix adjustment is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them. The DCP is multiplied by the average case mix weight for all MaineCare residents in the facility as of the payment roster date. The PA is added to the case mix adjusted DCP and becomes the facility's MaineCare rate. The Direct Care Price will be inflated annually. Every six months the Department will adjust data for facility-specific acuity.

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6000 PEER GROUPS

The Department will classify facilities into one of four peer groups. The peer groups are divided as follows: freestanding facilities with 15 or fewer beds, facilities that are not freestanding with 15 or fewer beds or facilities with 16 to 24 beds, facilities with 25 or more beds, and Specialty Alzheimer's Units. Each peer group has its own DCP and PA calculated in accordance with Sections 3000 and 9000. The Department will notify facilities the amounts of the DCP and PA.

7000 RESIDENT ASSESSMENTS

7010 Purpose of Resident Assessments

The provider shall assess each resident, regardless of payment source utilizing an assessment tool on which provider staff will base a service plan designed to assist the resident to reach his/her highest practicable level of physical, mental, and psychosocial functioning. The MDS-RCA is the Department's approved resident assessment instrument

7020 Schedule of Resident Assessments

The provider must complete the MDS-RCA within 30 days of admission and at least every 180 days thereafter during a resident's stay. The provider will sequence the assessments from the date in Section S.2.B of the MDS-RCA, Assessment Completion Date. The provider will complete subsequent assessments within 180 days from the date in S.2.B. Providers must complete a significant change MDS-RCA assessment within 14 calendar days after determination is made of a significant change in resident status as defined in the Training Manual for the MDS-RCA Tool. Providers must complete a Resident Tracking Form within 7 days of the discharge, transfer, or death of a resident. Providers must maintain all resident assessments completed within the previous 12 months in the resident's active record.

7030 Accuracy of Assessments

7030.1 Each assessment must be conducted or coordinated by staff trained in completion of the MDS-RCA.

7030.2 Certification: Each individual who completes a portion of the assessment must sign and date the form to certify the accuracy of that portion of the assessment.

7030.3 Documentation: Documentation is required to support the time periods and information coded on the MDS-RCA.

7030.4 Penalty for Falsification: The provider may be sanctioned whenever an individual willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment. This may be in addition to any other penalties provided by statute, including but not limited to,

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7000 RESIDENT ASSESSMENTS (cont.)

22 MRSA §15. The Department’s R.N. assessors will review the accuracy of information reported on the MDS-RCA instruments. If the Department determines that there has been a knowing and willful certification of false statements, the Department may require (for a period specified by the Department) that the resident assessments under this Appendix be conducted and certified by individuals who are independent of the provider and who are approved by the Department.

- 7030.5 Review of Assessment Forms: The Department may review all forms, documentation and evidence used for completion of the MDS-RCA at any time. The Department will undertake quality review periodically to ensure that assessments are completed accurately, correctly, and on a timely basis.
- 7030.6 Facilities shall submit completed assessments to include Admissions, Semi-Annuals, Annuals, Significant Change, other required assessments and MDS Tracking Forms within 30 days of completion to the Department or the Department’s designated agent.
- 7030.7 Providers must submit all claims on electronic media to be specified by the Department. Failure to submit on electronic media on or after this date may result in the provider being paid the DCP adjusted by the default classification (not classified) weight of 0.731.
- 7030.8 Providers must use the MDS-RCA Correction Form in order to request modification or inactivation of erroneous data previously submitted as part of the MDS record (assessment or tracking forms). The MDS-RCA Correction Form is for corrections of two types:
- 1) Modification, which should be requested when a valid MDS-RCA record (assessment or tracking form) is in the State MDS-RCA database, but the information in the record contains errors; or
 - 2) Inactivation, which should be requested when an incorrect reason for assessment has been submitted under item “Reason for Assessment.” Providers must then resubmit the record with the correct reason for assessment. An inactivation should also be used when an invalid record has been accepted into the State MDS-RCA database. A record may considered invalid for the following reasons: 1) the event did not occur; 2) the record submitted identifies the wrong resident;
 - 3) the record submitted identifies the wrong reason for assessment; or
 - 4) it was an inadvertent submission of a non-required record.

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7040 QUALITY REVIEW OF THE MDS-RCA PROCESS

7040.1 Definitions

- 7040.1.1 MDS-RCA assessment review is conducted at residential care facilities (RCFs) by the Department, and consists of review of assessments, documentation and evidence used in completion of the assessments, in accordance with Section 7000, to ensure that assessments accurately reflect the resident’s clinical condition.
- 7040.1.2 Assessment review error rate is the percentage of unverified Case Mix Group Records in the drawn sample. Samples shall be drawn from Case Mix Group Records completed for residents who have MaineCare reimbursement. MDS-RCA Correction forms received in the central repository or included in the clinical record will be the basis for review when completed before the day of the review and included as part of the resident’s clinical record.
- 7040.1.3 Verified Case Mix Group Record is an MDS-RCA assessment form completed by the provider, which has been determined to accurately represent the resident’s clinical condition during the MDS-RCA assessment review process. Verification activities include reviewing resident assessment forms and supporting documentation, conducting interviews, and observing residents.
- 7040.1.4 Unverified Case Mix Group Record is one which, for payment purposes, the Department has determined does not accurately represent the resident’s condition and, therefore, results in an inaccurate classification of the resident into a case mix group that increases the case mix weight assigned to the resident. If the Department identifies any such record, it will require providers to follow appropriate clinical guidelines for completion and submission. Correction forms received prior to calculating the rate setting quarterly index will be used in the calculation of that index.
- 7040.1.5 Unverified MDS-RCA Record is one that, for clinical purposes, does not accurately reflect the resident’s condition.

7050 CRITERIA FOR ASSESSMENT REVIEW

- 7050.1 Providers may be selected for an MDS-RCA assessment review by the Department based upon but not limited to any of the following:
- (a) The findings of a licensing survey conducted by the Department indicate that the provider is not accurately assessing residents;

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7050 CRITERIA FOR ASSESSMENT REVIEW (cont)

- (b) An analysis of a provider's case mix profile of RCFs indicates changes in the frequency distribution of the residents in the major categories or a change in the facility average case mix score; or
- (c) Resident assessment performance of the provider, including but not limited to, on-going problems with assessment completion and timeliness, untimely submissions and high assessment error rates.

7050.2 Assessment Review Process

- 7050.2.1 Assessment reviews shall be conducted by staff or designated agents of the Department.
- 7050.2.2 Providers selected for assessment reviews must provide reviewers with reasonable access to residents, professional and direct care staff, the provider assessors, clinical records, and completed resident assessment instruments as well as other documentation regarding the residents' care needs and treatments.
- 7050.2.3 Samples shall be drawn from MDS-RCA assessments completed for residents who have MaineCare coverage.
- 7050.2.4 At the conclusion of the on-site portion of the review process, the reviewers shall hold an exit conference with provider representatives. Reviewers will share written findings for reviewed records. The reviewer may also request reassessment of residents where assessments are in error.

7060 SANCTIONS

- 7060.1 The Department will sanction providers for failure to complete assessments completely, accurately and on a timely basis.
- 7060.2 When a sanctionable event occurs, the Department shall base the sanctions on the total MaineCare payment received by the provider during the 4th through 6th months preceding the month in which the sanctionable event occurred. (For example, if the sanctionable event occurred in May, the sanction would be calculated by multiplying the sanction rate times the total MaineCare payments to the provider during the preceding November, December and January).
- 7060.3 The amount of the sanction will be based on an application of the percentages below multiplied by the MaineCare payments to the provider during the 4th through 6th months preceding the event. In no event will the payment to the provider be less than the price that would have been paid with an

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7060 **SANCTIONS** (cont.)

average case mix weight equal to 0.731. The sanctions shall be calculated as follows:

- a) 2% of MaineCare payments when the assessment review results in an error rate of 34% or greater, but is less than 37%
- b) 5% of MaineCare payments when the assessment review results in an error rate of 37% or greater, but is less than 41%.
- c) 7% of MaineCare payments when the assessment review results in an error rate of 41% or greater, but is less than 45%.
- d) 10% of MaineCare payments when the assessment review results in an error rate of 45% or greater.
- e) 10% of MaineCare payments if the provider fails to complete reassessments within 7 days of a written notice/request by the Department.

8000 **CASE MIX PAYMENT SYSTEM**

8010 **Industry-Specific DCP**

The Department multiplies the industry-specific DCP for each peer group by the facility's average MaineCare case mix so that this payment system can take into consideration that some residents are more costly to care for than others. Thus, the system requires:

- a) The assessment of residents on the Department's approved MDS-RCA form;
- b) The classification of residents into groups that are similar in resource utilization by use of the case mix resident classification groups defined in Section 9020 of this Appendix; and
- c) A weighting system that quantifies the relative cost of caring for different classes of residents by direct service staff to determine a resident's case mix index.

8020 **Case Mix Resident Classification Groups and Weights**

There are a total of 15 case mix resident classification groups, including one resident classification group used when residents cannot be classified into one of the 14 clinical classification groups.

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8020 RESIDENT CLASSIFICATION GROUP CASE MIX WEIGHT (cont.)

The Department assigns each case mix classification group a specific case mix weight, as follows:

RESIDENT CLASSIFICATION GROUP CASE MIX WEIGHT

Resident Group	Order	Short description	MaineCare Weight
IC1	1	IMPAIRED 15-28	2.25
IB1	2	IMPAIRED 12-14	1.568
IA1	3	IMPAIRED 0-11	1.144
CD1	4	COMPLEX 12+	1.944
CC1	5	COMPLEX 7-11	1.593
CB1	6	COMPLEX 2-6	1.205
CA1	7	COMPLEX 0-1	0.938
MC1	8	BEHAVIORAL HEALTH 16+	1.916
MB1	9	BEHAVIORAL HEALTH 5-15	1.377
MA1	10	BEHAVIORAL HEALTH 0-4	0.98
PD1	11	PHYSICAL 11+	1.418
PC1	12	PHYSICAL 8-10	1.019
PB1	13	PHYSICAL 4-7	1.004
PA1	14	PHYSICAL 0-3	0.731
BC1	15	NOT CLASSIFIED	0.731

8030 Rate Setting Case Mix

8030.1 The Department will calculate rates on January 1st and July 1st of each year, beginning on July 1, 2001.

8030.2 The Department will calculate each facility's rate setting case mix index using the number of MaineCare residents in each case mix classification group determined from the most recent MDS-RCA on all MaineCare residents in the facility as of the 15th of March for the July rate and the 15th of September for the January rate.

8030.3 The Department will compute the applicable rate setting case mix index by multiplying the number of residents in each case mix classification group, including those in the unclassified group, by the case mix weight for the relevant classification group. The sum of these products divided by the total number of MaineCare residents in the facility equals the rate setting case mix index.

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8000 CASE MIX PAYMENT SYSTEM (cont.)

- 8030.4 The Department will calculate the case mix rate by multiplying the rate setting case mix index by the DCP. The program allowance will be added to the case mix rate.
- 8030.5 The Department will send a roster of residents and source of payment as of March 15th and September 15th to facilities for verification prior to rate setting.
- 8030.6 The Department will utilize the roster in identifying MaineCare residents and their most recent assessment. It is the provider's responsibility to check the roster, make corrections and submit corrections to the Department or its designee within one week of receiving the roster.
- 8030.7 For purposes of this Appendix, the Department will not utilize assessments of residents for whom assessments are incomplete due to the death, discharge, or nursing facility or hospital admission of the resident during the time frame in which the assessment must be completed to compute payment.

8040 New Facilities

For new facilities opening after July 1, 2002, the Department will apply a case mix index of 1.000 to the price for new facilities for the first rate setting period. The Department will apply the actual case mix index to the first rate setting period after either a March 15th or September 15th roster is available, as applicable. The Department will not apply sanctions to new facilities until an actual case mix index is used in rate setting.

8050 Inflation Adjustment

Except when there is specific statutory direction, the Commissioner of the Department of Health and Human Services will determine if an inflation adjustment will be made, the amount of that adjustment, and any performance standards related to that adjustment.

8060 Hold Harmless Provisions

For the twelve (12) month period beginning on July 1, 2001, the direct care price and program allowance for each provider will be calculated as follows: Each provider's rate beginning on July 1, 2001 will be calculated by taking 50% of the interim rate that would otherwise be in effect on July 1, 2001, with inflation to the provider's year end, and 50% of the case mix-adjusted direct care price, to which the applicable program allowance will be added. These rates will not be cost settled.

On July 1, 2002, the Department will base payments on the case mix adjusted direct care price plus the applicable program allowance, plus the personal services component.

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9000 **CASE MIX PAYMENT SYSTEM** (cont.)

The Department will base rates for new facilities to be reimbursed under this Appendix after July 1, 2001 on the case mix adjusted direct care price and the applicable program allowance.

9000 **REGIONS**

The Department defines regions for calculation of inflation as:

Region I - Cumberland County, Knox County, Lincoln County, Sagadahoc County, and York County.

Region II - Androscoggin County, Franklin County, Kennebec County, Oxford County, and Somerset County.

Region III - Penobscot County, Piscataquis County, Waldo County, Hancock County, and Washington County.

Region IV - Aroostook County