DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S3-13-15
Baltimore, MD 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

**Center for Medicaid and State Operations (CMSO)**

Brenda M. Harvey, Commissioner
State of Maine
Department of Health and Human Services
221 State Street
11 State House Station
Augusta, ME 04333-0011

APR 16 2010

RE: Maine 09-012

Dear Ms. Harvey:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-012. Specifically, it revises the methodology used to inflate the direct care and routine cost components. In addition, the peer group upper limit for the direct care and routine costs has been lowered to 89.185% of the median base year cost per day. Also, it adds a new provision, principle 173, which allows remote island facilities to be reimbursed at actual cost.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-012 is approved effective July 1, 2009. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid and State Operations (CMSO)

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 09 – 012

2. STATE: MAINE

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE(S)
7/1/09

5. TYPE OF PLAN MATERIAL *(CHECK ONE)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY '10 $ 26,743.77
b. FFY '11 $ 25,023.36

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-D- SECTION 1, PAGES 19-24, AND 45-53

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATTACHMENT 4.19- D, PAGES 19-24 AND 45-53

SUBJECT OF AMENDMENT: NURSING FACILITY REIMBURSEMENT

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
COMMISSIONER, DEPT. OF HUMAN SERVICES

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
BRENDA HARVEY

14. TITLE:
Commissioner, Maine Department of Health and Human Services

15. DATE SUBMITTED: 9/30/09

16. RETURN TO:

ANTHONY MARPLE

Director, MaineCare Services
#11 State House Station

442 CIVIC CENTER DRIVE
Augusta, ME 04333-0011

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED: 4-16-10

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL – 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMSO

23. REMARKS

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Supersedes
Tn. No.: 05-003

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(1) Within 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 30 days of receipt of the decision made as a result of the informal review.

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

(4) To the extent the Department upholds the original determination of the Office of MaineCare Services, review of the results of the administrative hearing is available in conformity with the Administrative Procedures Act, 5 M.R.S.A. §11001 et seq.

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

41.31 Direct Care Cost. The base year costs for direct care shall be the actual audited direct care costs incurred by the facility in the fiscal year ending in calendar year 2005 except for facilities whose MaineCare rates are based on proforma cost reports in accordance with Sections 80.6 and 80.7. All base year costs are subject to upper limits defined in Section 80.3.3.5.

43 ROUTINE COST COMPONENT- All allowable costs not specified for inclusion in another cost category pursuant to these rules shall be included in the Routine cost component subject to the limitations set forth in these Principles. The base year costs for the routine cost component shall be the audited costs incurred by the facility in the fiscal year ending in calendar year 2005, except for facilities whose MaineCare rates are based on proforma cost reports in accordance with Sections 80.6 and 80.7. All base year costs are subject to upper limits defined in Section 80.5.4.

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

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

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

43.4 Allowable costs for the Routine component of the rate shall include but not be limited to costs reported in the following functional cost centers on the facility's cost report.

(a) fiscal services, (not to include accounting fees)
(b) administrative services and professional fees not to exceed the administrative and management ceiling,
(c) plant operation and maintenance including utilities,
(d) laundry and linen,
(e) housekeeping,
(f) medical records,
(g) subscriptions related to resident care,
(h) employee education, as defined in Section 43.42.9, except wages related to initial and on-going nurse aide training as required by OBRA,
(i) dietary,
(j) motor vehicle operating expenses,
(k) clerical,
(l) transportation, (excluding depreciation),
(m) office supplies/telephone,
(n) conventions and meetings within the state of Maine,
(o) EDP bookkeeping/payroll,
(p) fringe benefits, to include:
(1) payroll taxes,
(2) qualified retirement plan contributions,
(3) group health, dental, and life insurance, and
(4) cafeteria plans.
(q) payroll taxes,
(r) one association dues, the portion of which is not related to lobbying
(s) food, vitamins and food supplements,
(t) director of nursing, and fringe benefits,
(u) social services, and fringe benefits,
(v) pharmacy consultant, dietary consultant, and medical director.

See the explanations in Section 43.42.1 - 43.45 for a more complete description of allowable costs in each cost center.

43.42.1 Allowable Administration and Management Expenses.

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

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

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

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

43.42.2 Ceiling. The administration and policy-planning ceiling that is in effect as of July 1, 1995 is listed below. The ceiling shall be increased quarterly to reflect the rate of inflation from July 1, 1995, to the appropriate quarter.
*up to 30 beds: $37,772 plus $637 for each licensed bed in excess of 10;
*31 to 50 beds: $54,240 plus $545 for each licensed bed in excess of 30;
*51 to 100 beds: $67,432 plus $364 for each licensed be in excess of 50; and
*over 100 beds: $90,757 plus $273 for each licensed bed in excess of 100.

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

43.42.3 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:

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

43.42.3.2 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



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43.42.3.3 This ceiling is not to include any Director of Nursing, Dietary Supervisor, or other department head, whose prime duties are not of an administrative nature but who may be responsible for hiring or purchasing for their Department.

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

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

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

43.42.6 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.

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

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

43.42.8 Laundry services including personal clothing for MaineCare residents.

43.42.9 Cost of Educational Activities

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

43.42.9.2 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.

43.42.9.3 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.

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

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

43.43 Motor Vehicle Allowance. Cost of operation of one 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 automobiles use for business purposes is required. Prior approval from the Division of Audit is required if additional vehicles are needed by the nursing facility.

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

43.45 Consultant Services. The following types of consultative services will be considered as part of the allowable routine costs and be built into the base year routine cost component subject to the limitations outlined in subsections 43.45.1 – 43.45.3.

43.45.1 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.

43.45.2 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.

43.45.3 Medical Directors

The base year cost of a Medical Director, who is responsible for implementation of resident care in the facility, is an allowable

cost. The base year allowable cost will be established and limited to $10,000.

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

43.6 Grants, Gifts, and Income from Endowments

43.61 Principle. Unrestricted grants, gifts and income from endowments should not be deducted from operating costs in computing reimbursable costs. However, unrestricted 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.

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

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

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

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

43.7 Purchase Discounts and Allowances and Refunds of Expenses.

payment will be allocated based on the percentage of Medicaid incremental cost increase for each qualifying facility. The Medicaid incremental cost increase is calculated by subtracting the facilities rate effective October 1, 2008 (base year 1998) inflated to January 1, 2009 adjusted for the January 1, 2009 CMI from the rebased rate effective January 1, 2009 (base year 2005). The resulting difference is multiplied by the facilities estimated annual Medicaid days. Each facilities relative share of the Medicaid increased cost is multiplied by the pool amount of $6,829,632 to determine the facility share of the supplemental payment. The Medicaid incremental cost increase will be reconciled using actual days of service from January 1, 2009 through June 30, 2009 in place of estimated annual Medicaid days. Any over or under payments will be reflected on the audit of the providers fiscal year which includes June 30, 2009 days of service.

The base year direct and routine cost component costs will be trended forward using the guidelines as described in Section 91. (See Section 80.3 for a complete description of the rate setting process for the direct care component and inflation guidelines from the base year through June 30, 2008.) The prospective rate shall consist of three components: the direct care cost component as defined in Section 41, the routine cost component as defined in Section 43, and the fixed cost component as defined in Section 44.

## 80.2 FIXED COST COMPONENT

The fixed cost component shall be determined from the most recent audited or, if more recent information is approved by the Department, it shall be based on that more recent information using allowable costs as identified in Section 44. As described in Section 44, fixed costs will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to fixed costs shall be based upon a theoretical level of occupancy of ninety percent (90%). The adjustment to the fixed cost shall be based upon a theoretical level of occupancy of ninety percent (90%). For all new providers coming into the program, the 90% occupancy adjustment will not apply for the first 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 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 85% occupancy rate adjustment will be applied to fixed costs for facilities' fiscal years beginning on or after 7/1/97, 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 85% occupancy adjustment will not apply for the ~~fist~~first 30 days of operation. It will, however, apply to the remaining months of their initial operating period.

## 80.3 DIRECT CARE COST COMPONENT

### 80.3.1 Case Mix Reimbursement System

80.3.1.1 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 Section 41.2.;

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

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

80.3.2 Case Mix Resident Classification Groups and Weights

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

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

| RESIDENT CLASSIFICATION GROUP | | CASE MIX WEIGHT |
|---|---|---|
| **REHABILITATION** | | |
| REHAB ULTRA HI/ADL | 16-18 | 1.986 |
| REHAB ULTRA HI/ADL | 9-15 | 1.426 |
| REHAB ULTRA HI/ADL | 4 - 8 | 1.165 |
| REHAB VERY HI/ADL | 16-18 | 1.756 |
| REHAB VERY HI/ADL | 9-15 | 1.562 |
| REHAB VERY HI/ADL | 4 - 8 | 1.217 |
| REHAB HI/ADL | 13-18 | 1.897 |
| REHAB HI/ADL | 8-12 | 1.559 |
| REHAB HI/ADL | 4 - 7 | 1.260 |
| REHAB MED/ADL | 15-18 | 2.051 |
| REHAB MED/ADL | 8 -14 | 1.635 |
| REHAB MED/ADL | 4 - 7 | 1.411 |
| REHAB LOW/ADL | 14 -18 | 1.829 |
| REHAB LOW/ADL | 4-13 | 1.256 |
| **EXTENSIVE** | | |
| EXTENSIVE 3/ADL | 7-18/Head Injury – ADL 15 - 18 | 2.484 |
| EXTENSIVE 2/ADL | 7-18/Head Injury – ADL 10 - 14 | 2.057 |
| EXTENSIVE 1/ADL | 7-18/Head Injury – ADL 7 - 9 | 1.910 |
| **SPECIAL CARE** | | |
| SPECIAL CARE/ADL | 17-18 | 1.841 |
| SPECIAL CARE/ADL | 15-16 | 1.709 |
| SPECIAL CARE/ADL | 4-14 | 1.511 |

| | | |
|---|---|---|
| CLINICALLY COMPLEX | | |
| CLIN. COMP W/DEP/ADL | 17-18D | 1.826 |
| CLIN. COMP/ADL | 17-18 | 1.663 |
| CLIN. COMP W/DEP/ADL | 12-16D | 1.503 |
| CLIN. COMP/ADL | 12-16 | 1.389 |
| CLIN. COMP W/DEP/ADL | 4-11D | 1.331 |
| CLIN. COMP/ADL | 4-11 | 1.149 |
| IMPAIRED COGNITION | | |
| COG. IMPAIR W/RN REHAB/ADL | 6-10 | 1.199 |
| COG. IMPAIR/ADL | 6-10 | 1.152 |
| COG. IMPAIR W/RN REHAB/ADL | 4-5 | 0.945 |
| COG. IMPAIR/ADL | 4-5 | 0.888 |
| BEHAVIOR PROBLEMS | | |
| BEHAVE PROB W/RN REHAB/ADL | 6-10 | 1.180 |
| BEHAVE PROB/ADL | 6-10 | 1.123 |
| BEHAVE PROB W/RN REHAB/ADL | 4-5 | 0.905 |
| BEHAVE PROB/ADL | 4-5 | 0.759 |
| PHYSICAL FUNCTIONS | | |
| PHYSICAL W/RN REHAB/ADL | 16-18 | 1.454 |
| PHYSICAL/ADL | 16-18 | 1.421 |
| PHYSICAL W/RN REHAB/ADL | 11-15 | 1.323 |
| PHYSICAL/ADL | 11-15 | 1.281 |
| PHYSICAL W/RN REHAB/ADL | 9-10 | 1.219 |
| PHYSICAL/ADL | 9-10 | 1.088 |
| PHYSICAL W/RN REHAB/ADL | 6-8 | 0.833 |
| PHYSICAL/ADL | 6-8 | 0.854 |
| PHYSICAL W/RN REHAB/ADL | 4-5 | 0.776 |
| PHYSICAL ADL | 4-5 | 0.749 |
| UNCLASSIFIED | | 0.749 |

80.3.3 Base Year Direct Care Cost Component

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

80.3.3.2 Case Mix Index

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

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

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

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

(d) Direct Care Regional Index
Each region's cost index shall be determined as follows:

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

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

iii) The regional cost indices are as follows:
Region I - 1.10
Region II - 1.06
Region III - 1.02
Region IV - 1.00

80.3.3.3 Base year case mix and regionally adjusted MaineCare cost per day.

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

(a) The facility's direct care cost per day, as specified in Section 80.3.3.1, is divided by the facility's base year case mix index and regional cost index to yield the case mix adjusted cost per day.

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

The direct care cost component will be inflated from the end of the facility's base year to July 1, 2008 ~~usingthe~~using the CMS Nursing Home Without

Capital Market Basket Index, Table 6.7, published in the HIS Global Insight HealthCare Cost Review, 1st Quarter Edition Index, 2009.

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

80.3.3.5 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 89.185%.

80.3.3.6 Each facility's case mix adjusted direct care rate shall be the lesser of the limit in Section 80.3.3.5. or the facility's base year case mix and regionally adjusted cost per day multiplied by the regional cost index.

80.3.4 Quarterly Calculation of the Direct Care Component

The Office of MaineCare Services shall compute the direct resident care cost component for each facility on a quarterly basis.

80.3.4.1 Calculation of the quarterly case mix index.

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

For each facility the number of MaineCare residents in each case mix classification group shall be determined from the most recent MDS on all MaineCare residents in the facility as of the 15th day of the prior quarter (e.g. For a October 1 rate, the facility's case mix index would be computed using the most recent assessments of MaineCare residents with an assessment date of June 15.)

For each facility, MaineCare Services will multiply the number of MaineCare residents in each case mix classification group including those in the unclassified group by the case mix weight for the relevant classification group. The sum of these products divided by the total number of MaineCare residents equals the facility's quarterly case mix index. The roster provided to the nursing facility for confirmation of residents in the nursing facility is relied upon by the Department in determining the residents in the nursing facility. It is the nursing facilities responsibility to check the roster and make corrections within one week of the availability of the roster and submit such corrections to the Department or its designee. MDS Corrections for assessments used in the calculation of a facility's quarterly case mix index will not be considered in the calculation of the index when received in the MDS CORE system after the calculation of the rate by the Office of MaineCare Services.

For purposes of this section, resident assessments that are incomplete due to the death, discharge, or hospital admission of the resident during the time frame in which the assessment must be completed will not be included in the unclassified group or used to compute the case mix index. (Note: For MaineCare residents,

the facility would be paid the facility rate for the number of days the resident is at the facility.)

80.3.4.2 Direct care rate per day

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

80.3.4.3 Direct Care Add-On

The direct care rate shall be increased by 25% of the excess of the base year direct care cost inflated to July 1, 2008 over the direct care rate, as determined in 80.3.4(2) using the case mix index for the quarter beginning April 1, 2008 as the applicable case mix index for this calculation and limited to a maximum of $15 per day.

80.3.4.4 Hold Harmless Provision

The direct care rate as determined in 80.3.4(2) and 80.3.4 (3) may be further increased if the rate for quarter beginning July 1, 2009 is less than the direct care rate issued for July 1, 2008. If the July 1, 2009 rate is lower, the rate shall be increased ~~bythe~~byte smaller of the following two differentials:

1. The differential between the July 1, 2009 and July 1, 2008 direct care rates, as adjusted by the wage index and the case mix index for the quarter beginning July 1, 2008; or

2. The differential between the July 1, 2009 direct care rate and the allowable base year direct care cost per day inflated to July 1, 2008 as adjusted by the wage index and the case mix index for the quarter beginning July 1, 2008.

80.3.4.5 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 as of 12/1/03.

80.3.5 Direct Care Cost Settlement.

For dates of service beginning on or after July 1, facilities that incur allowable direct care costs during their fiscal year that are less than their 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 prospective rate for direct care, will receive no more than the amount allowed by the prospective rate.

80.5 ROUTINE COST COMPONENT

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

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

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

80.5.3 The routine cost component is inflated from the end of the facility's base year to July 1, 2008 using the CMS Nursing Home Without Capital Market Basket Index, Table 6.7, published in the IHS Global Insight Healthcare Cost Review, 1st Quarter Index, 2009. For each peer group (hospital based facilities, non-hospital based facilities with less than or equal to 60 beds, and non-hospital based facilities with greater than 60 beds), the Office of MaineCare Services shall array all nursing facilities' base year costs per day inflated to July 1, 2008 from high to low and identify the median.

80.5.4 For each peer group, the upper limit on the base year cost per day shall be the median multiplied by 89.185%.

80.5.5 Each facility's Base Year Routine Care cost per diem rate shall be the lesser of the limit set in Subsection 80.5.4 or the facility's base year per diem allowable routine care costs inflated to July 1, 2008.

80.5.6 Routine Hold Harmless Provision:

The routine rate may be further increased if the rate for the quarter beginning July 1, 2009 is less than the rate issued July 1, 2008. If the July 1, 2009 rate is ~~low~~lower, then the rate shall be increased by the smaller of the following two differentials:

1. The differential between the July 1, 2009 and July 1, 2008 routine rates; or

2. The differential between the July 1, 2009 routine rate and the allowable base year routine costs per day inflated to the July 1, 2008.

80.5.7 Routine Cost Settlement. Facilities that incur allowable routine costs less than their prospective rate for routine costs may retain any savings as long as it is used to cover direct care costs. Facilities that incur allowable routine costs during their fiscal year in excess of the routine cost component of the prospective rate will receive no more than the amount allowed by the prospective rate.

80.6 RATES FOR FACILITIES RECENTLY SOLD, RENOVATED OR NEW FACILITIES

80.6.1 A nursing home project that proposes renovation, replacement or other actions that will increase MaineCare costs and for which an application is filed after March 1, 1993 may be approved only if appropriations have been made by the Legislature expressly for the purpose of meeting those costs. The basis for establishing the facility's rate through the certificate of need review is the lesser of

the rate supported by the costs submitted by the applicant or the statewide base year median for the direct and routine cost components inflated to the current period. The fixed costs determined through the Certificate of Need review process must be approved by the Office of MaineCare Services (also see Section 44.25.2).

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

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

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

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

80.6.5 For the first, second, and third rate setting period, the base year case mix index that will be used for the prospective rate calculation will be 1.000. Similarly, the quarterly case mix index will be set at 1.000. For the fourth rate setting period, the base year index will be calculated based on all the nursing facility's MaineCare resident's average case mix indexes excluding the not classified group as of the 15th of the fourth month after the fiscal year begin date of the pro forma cost report. For example, if a facility's fiscal year beginning was January 1, 2001, the base year index would be calculated using all MaineCare residents with classifiable assessments as of April 15, 2001. The quarterly rate setting index would then be set as specified in Section 80.3.4.

## 80.7 NURSING HOME CONVERSIONS

80.71 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:

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

80.71.2 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.

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

80.71.4 The case mix index will be determined as stated in Sections 41.2, 80.3.1, 80.3.2, 80.3.3.2, and 80.3.4.1.

80.71.5 The upper limits for the direct and routine care cost components will be inflated forward to the end of the fiscal year of the proforma cost report submitted as required in Section 80.71.1.

80.71.6 The reimbursement rates set, as stated in Sections 80.71.1 and 80.71.5, 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.

80.71.7 At the conclusion of the three years, the reimbursement rate will be rebased to the fiscal year stated in Sections 41.3.1, 42.1, and 43 or the most recent audited full fiscal year occurring after the conversion of nursing facility beds to residential care beds, whichever is the most current.

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

## 81 INTERIM AND SUBSEQUENT RATES

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

81.2 Effective July 1, 2002, 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 for the subsequent quarterly calculation of the direct care component.

## 82 FINAL PROSPECTIVE RATE.

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

82.1 A cost report is settled if there is no request for reconsideration of the Division of