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State/Territory Name: ME

State Plan Amendment (SPA) #: 18-0023

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

March 27, 2019

Jeanne Lambrew, Acting Commissioner
Department of Health and Human Services
221 State Street
11 State House Station
Augusta, ME 04333-0011

RE: Maine 18-0023

Dear Commissioner Lambrew:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 18-0023. Effective August 2, 2018, this amendment proposes mandated legislative changes to the reimbursement methodology for nursing facility services. Specifically, it changes the base year used to set payment rates to calendar year 2016; provides for a special wage allowance that is 65.01 percent of the calculated per diem rate; revises the current occupancy penalty percentage levels; and provides for an increase of 60 cents per diem for specified facilities based on high Medicaid utilization.

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. We are pleased to inform you that Medicaid State plan amendment 18-0023 is approved effective August 2, 2018. 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]

Kristin Fan
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER	2. STATE
18-0023	Maine

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

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

3. PROPOSED EFFECTIVE DATE
August 2, 2018

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
42 CFR 447.201; P.L. 2017, ch. 460

7. FEDERAL BUDGET IMPACT
a. FFY 2018 increase: $ 2,970,536
b. FFY 2019 increase: $11,915,386

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, Pages ii, 2, 28, 39, 44-46, 46(a), 48, 50-54, 56, 67

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
Attachment 4.19-D, Pages ii, 2, 28, 39, 44-46, 48, 50-54, 56, 67

10. SUBJECT OF AMENDMENT Rate increases resulting from Maine P.L. 2017, ch. 460

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

Stefanie Nadeau, Director,
MaineCare Services

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Stefanie Nadeau

14. TITLE
Director, MaineCare Services

15. DATE SUBMITTED
September 28, 2018

16. RETURN TO

Stefanie Nadeau
Director, MaineCare Services
#11 State House Station
242 State Street
Augusta, Maine 04333-0011

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED MAR 27 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
AUG 02 2018

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Kristin Fan

22. TITLE
Director, FMG

Pen and ink changes in section 3 per state request on February 6, 2019.

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AICPA is the American Institute of Certified Public Accountants.

Allowable Costs are costs that MaineCare will reimburse under these Principles of Reimbursement and that are below the caps (upper limits).

Ancillary Services are Medical items or services identifiable to a specific resident furnished at the direction of a physician and for which charges are customarily made in addition to the per diem charge.

Base Year is a fiscal period for which the allowable costs are the basis for the case mix prospective rate. For the state fiscal year beginning July 1, 2018, the base year for each facility is its fiscal year that ended in the calendar year 2016. For state fiscal years beginning on or after July 1, 2019, subsequent rebasing must be based on the most recently filed cost report available by April 1st of the re-basing year.

Base Year Cost shall be the costs as shown on the cost report for based year as audited by the Department.

Capital Asset is defined as services, equipment, supplies or purchases which have a value of $500 or greater.

Case Mix Weight is a relative evaluation of the nursing resources used in the care of a given class of residents.

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

Centers for Medicare and Medicaid Services (CMS) is the agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

Common Ownership exists when an individual possesses significant ownership or equity in the provider and the institution or organization serving the provider.

Compensation means total benefit provided for the administration and policy-planning services rendered to the provider. It includes:

(a) Fees, salaries, wages, payroll taxes, fringe benefits, contributions to deferred compensation plan, and other increments paid to or for the benefit of, those providing the administration and policy-planning services;

(b) The cost of services provided by the provider to, or for the benefit of, those providing the administration and policy planning services, including, but not limited to food, lodging, and the use of the provider's vehicles.

Nursing Facility Services Detailed Description of Reimbursement

18.1.15. Payment for High MaineCare Utilization as defined in Section 18.12

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

See the explanations in Sections 18.11 for a more complete description of allowable costs in each of these cost centers.

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

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

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

18.2.3. The total historical cost of a building constructed or purchased becomes the basis for the straight-line depreciation method. Component depreciation is not allowed except on those items listed below with their minimum useful lives:

Electric Components	20 years
Plumbing and Heating Components	25 years
Central Air Conditioning Unit	15 years
Elevator	20 years
Escalator	20 years
Central Vacuum Cleaning System	15 years
Generator	20 years

18.2.3.1. Any provider using the component depreciation method that has been audited and accepted for cost reporting purposes prior to April 1, 1980, will be allowed to continue using this depreciation mechanism.

18.2.3.2. Where an asset that has been used or depreciated under the program is donated to a provider, or where a provider acquires such assets through testate or intestate distribution, (e.g., a widow inherits a nursing facility upon the death of her husband and becomes a newly certified provider;) the basis of depreciation for the asset is the lesser of the fair market value, or the net book value of the asset in the hands of the owner last participating in the program. The basis of depreciation shall be determined as of the date of donation or the date of death, whichever is applicable.

18.2.3.3. Special Reimbursement Provisions for Energy Efficient Improvements

18.4.3.1. Be incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments would be considered unnecessary; and

18.4.3.2. Be reduced by investment income except where such income is from gifts, whether restricted or unrestricted, ruld which are held separate and not commingled with other funds. Income from funded depreciation is not used to reduce interest expense.

18.4.3.3. Proper. Proper requires that interest:

18.4.3.3.1. Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

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

18.4.3.4. Refinancing. Any refinancing of property mortgages or loans on fixed assets must be prior approved by the Department. If prior approval is not obtained any additional interest costs or finance charges will not be allowed.

18.4.4. Borrower-lender relationship

18.4.4.1. To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement with higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arm's-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowed. Where the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, where interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans shall be treated as invested funds in the computation of the provider's equity capital.

unallowable cost at time of audit. Failure to become an administrator within one year following completion of the examination to become a licensed administrator will result in the Department of Health and Human Services recovering 100% of the amount allowed of the administrator in training. If the administrator in training discontinues the training program for any reason or fails to take the required examination to become a licensed administrator, 100% of the amount allowed will be recovered by the Department.

18.7. Acquisition Costs. Fifty percent of the acquisition cost of the rights to a nursing facility license shall be approved as a fixed cost in those situations where the purchaser acquires the entire existing nursing facility license of a provider and delicenses all or a significant portion (at least 50%) of the beds associated with that license. This amount will be amortized over a ten (10) year period, beginning with the subsequent fiscal year after completion of the acquisition. This acquisition cost will not include any fees (eg: accounting, legal) associated with the acquisition.

18.8. Occupancy Adjustment.

Facilities with Greater Than 60 Beds. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than seventy percent (70%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of seventy percent (70%). For all new providers coming into the program, the seventy percent (70)% occupancy adjustment will not apply for the first 90 days of operation. It will, however, apply to the remaining months of their initial operating period. The occupancy rate adjustment will be applied to fixed costs and shall be cost settled at the time of audit.fiscal years ending June 30, 2022 and thereafter, the reduction in allowable costs applies only for an annual level of occupancy less than eighty-five percent (85%).

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

Facilities With 60 or Fewer Beds. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than seventypercent (70%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of seventy percent (70%).. For all new providers of sixty (60) or fewer beds coming into the program, the seventy (70%) occupancy adjustment will not apply for the first 90 days of operation. It will, however, apply to the remaining months of their initial operating period. The occupancy rate adjustment will be applied to fixed costs and shall be cost settled at the time of audit. For state fiscal years ending June 30, 2022 and thereafter, the reduction in allowable costs applies only for an annual level of occupancy less than eighty percent (80%).

18.9. Start Up Costs Applicability

Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first resident is admitted for treatment, or where the start-up costs apply only to nonrevenue-producing resident care functions or unallowable functions, to the time the areas are used for their intended purposes. Start-up costs are charged to operations. If a provider intends to

prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility will be accumulated in a single deferred charge account and will be amortized when the first resident is admitted for treatment. If a provider intends to prepare portions of its facility on a piecemeal basis (e.g., preparation of a floor or wing of a provider's facility is delayed), start-up costs would be capitalized and amortized separately for the portion(s) of the provider1s facility prepared during different time periods. Moreover, if a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas.

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the Department need not be capitalized, but rather will be charges to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the Department, these costs need not be capitalized, but will be charged to operations in the periods incurred.

For program reimbursement purposes, costs of the provider's facility and building equipment should be depreciated over the lives of these assets starting with the month the first resident is admitted for treatment, subject to the provider's method of determining depreciation in the year of acquisition or construction. Where portions of the provider's facility are prepared for resident care services after the initial start-up period, these asset costs applicable to each portion should be depreciated over the remaining lives of the applicable assets. If the portion of the facility is a resident care area, depreciation should start with the month the first resident is admitted for treatment. If the portion of the facility is a nonrevenue-producing resident care area or unallowable area, depreciation should begin when the area is opened for its intended purpose. Costs of major movable equipment, however, should be depreciated over the useful life or each item starting with the month the item is placed into operation.

Where a provider prepares all portions of its facility for resident care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratable over a period of 60 consecutive months beginning with the month in which the first resident is admitted for treatment.

Where a provider prorates portions of its facility for resident care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for resident care services during different periods of time.

18.10. Return on Net Assets for Non-Profit Providers -A reasonable return on net assets invested and used in the provision of resident care is allowable as an element of the reasonable cost of covered services furnished to the beneficiaries by nonprofit providers. The amount on an annual basis is equal to one quarter (1/4) of the amount allowed for proprietary providers as stated in Section 18.6.1 of these Principles of Reimbursement.

18.10.1. The calculation of the return on net assets will be made in accordance with Sections 18.6.3 - 18.6.7.13 of these Principles of Reimbursement.

Nursing Facility Services Detailed Description of Reimbursement

18.11. Payment for High MaineCare Utilization

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

Diem Rate

The payment for High MaineCare Utilization shall be calculated as total annual MaineCare days divided by total days of care in the facility's prior year fiscal year cost report (MaineCare days/total days of care * $.40 * per each percent over seventy percent (70%) and will be cost settled at audit. Days waiting placement (DWP) are excluded from this calculation. The payment for High MaineCare Utilization is included as part of the per diem rate.

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

Audit Cost Settlement

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

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

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

18.12 **Special Wage Allowance.** Special Wage Allowance for the fiscal year 2018-2019. For the state fiscal year ending June 30, 2019, a special supplemental allowance shall be made to provide for increases in wages and wage-related benefits in both the direct care cost component and routine care cost component as follows. The allocated amount, equal to ten percent (10%), of all allowable wages and associated benefits and taxes, this does not include contract labor, as reported on each facility's as-filed cost report for its fiscal year ending in calendar year 2016 shall be added to the cost per resident day in calculating each facility's prospective rate, notwithstanding any otherwise applicable caps or limits on reimbursement. This supplemental allowance shall be allowed and paid at final audit to the full extent that it does not cause reimbursement to exceed the facility's allowable costs in that fiscal year.

The Supplemental Wage Allowance will be paid at 65.01% of the calculated per diem rate.

18.14 **Aggregate Hold Harmless**. The rate of reimbursement for nursing facilities for direct care and routine costs that result from amending the law or the rules to reflect the revised method of rebasing the nursing facility's base year pursuant to this Section may not result in any nursing facility in a rate of reimbursement that is lower than the rate in effect on June 30, 2018.

19. WAIVER

The failure of the Department to insist, in any one or more instances, upon the performance of any of the terms or conditions of these Principles, or to exercise any right under these principles, or to disapprove of any practice, accounting procedure, or item of account in any audit, shall not be construed as a waiver of future performance of the right. The obligation of the Provider with respect to future performance shall continue, and the Department shall not be stopped from requiring such future performance.

20. SPECIAL SERVICE ALLOWANCE

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

information using allowable costs as identified in Section 18. As described in Section 44, fixed costs will be adjusted for providers whose annual level of occupancy is less than seventy percent (70%). The adjustment to fixed costs shall be based upon a theoretical level of occupancy of seventy percent (70%). The adjustment to the fixed cost shall be based upon a theoretical level of occupancy of seventy percent (70%). 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 seventy percent (70%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of seventy percent (70%). The 70% 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 70% occupancy adjustment will not apply for the first 30 days of operation. It will, however, apply to the remaining months of their initial operating period.

22.3. DIRECT CARE COST COMPONENT

22.3.1. Case Mix Reimbursement System

22.3.1.1. The direct care cost component utilizes a case mix reimbursement system. Case mix reimbursement takes into account the fact that some residents are more costly to care for than others. Thus the system requires:

(a) the assessment of residents on the Department's approved form
- MDS as specified in Section 18.2.;

(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 22.3.2.;

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

22.3.2. Case Mix Resident Classification Groups and Weights

There are a total of forty-five (45) case mix resident classification groups including one resident classification group used when residents cannot 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:

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/AOL	6-8	0.833
PHYSICAL/ADL	6-8	0.854
PHYSICAL W/RN REHAB/ADL	4-5	0.776
PHYSICAL ADL	4-5	0.749

UNCLASSIFIED 0.749

22.3.3. Base Year Direct Care Cost Component

22.3.3.1. Source of Base Year Cost Data. The source for the direct care cost component is the cost report for the nursing facility's base, except for facilities whose MaineCare rates are determined in accordance with Sections 22.5 and 22.6, as described in Principle 16. The total inflated allowable base year direct care costs are divided by the total actual days. Recalculation of the upper limits shall not occur until subsequent rebasing of all components occurs.

22.3.3.2. Case Mix Index. The Office of MaineCare Services shall compute the facility's specific case mix index for the base year as follows:

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

22.3.3.3. Direct Care Regional Index
Each region's cost index shall be determined as follows:

i) The average case mix adjusted cost per day shall be calculated for each region from base year adjusted costs per day inflated to December 31, 2013.

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 direct care regional indices are as follows:

Region I – 1.08
Region II – 1.02
Region III – 1.00
Region IV – 1.11

22.3.3.4. 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 22.3.3.1, is divided by the facility's base year case mix index and regional cost index to yield the case mix adjusted cost per day.

22.3.3.5. 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 December 31, 2017 using the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index, Historical Consumer Price Index for Urban Wage Earners and Clerical Workers – Nursing Home and Adult Day service.

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

22.3.3.6. Limits on the base year case mix and regionally adjusted cost per day.

Within each peer group, the upper limit on the base year case mix and regionally adjusted cost per day shall be the median multiplied by One hundred ten percent (110%).

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

22.3.4. Calculation of the Direct Care Component.

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

22.3.4.1. Direct care rate per day

The direct care rate per day, as determined by 22.3.3 shall be calculated by multiplying the total inflated direct care rate by the applicable case mix index for the RUG (RUG III Version 5.12.) group on the residents active assessment (OBRA assessment).

22.3.4.2. 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 December 31, 2017 over the direct care rate, as determined in 22.3.4.1 using the case mix index for the base year as the applicable case mix index for this calculation and limited to a maximum of
$15 per day. Effective 8/1/10 This direct care add-on is calculated only at the time of rebasing and is included as a direct care add-on to the direct care rate.

22.3.4.3. 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.

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

22.4. ROUTINE COST COMPONENT

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

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

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

22.4.3. The routine cost component is inflated from the end of the facility's base year to December 31, 2017 using the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index for Medical Care Services -Nursing Homes and Adult Day Care services. For each peer group (hospital based facilities, non-hospital based facilities with less than or equal to 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 December 31, 2017 from high to low and identify the median.

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

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

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

22.5. RATES FOR FACILITIES RECENTLY SOLD, RENOVATED OR NEW FACILITIES

22.5.1. A nursing home project that proposes renovation, replacement or other actions that will increase MaineCare costs and for which an application is filed after March 1, 1993 may be approved only if appropriations have been made by the Legislature expressly for the purpose of meeting those costs. The basis for establishing the facility's rate through the certificate of need review is the lesser of the rate supported by the costs submitted by the applicant or the statewide base year median for the direct and routine cost components inflated to the current period. The fixed costs 22.5.2.

determined through the Certificate of Need review process must be approved by the Office of MaineCare Services (also see Section 44.2.5(2)).

22.5.1.1. 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.

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

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

22.5.5. At the conclusion of the three years, the reimbursement rate will be rebased to the fiscal year in section 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 new facility, the completion of the new renovation, or the sale of the facility, which ever is the most current.

22.5.6. 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 22.5.5.

22.6. NURSING HOME CONVERSIONS

22.6.1 In reference to Public Law 1981, c. 705, Pt. V, § 304, the following guidelines have been established in relation to how nursing facilities that convert nursing facility beds to residential care beds will be reimbursed:

22.6.1.1 A pro forma step down cost report for the year in which the bed conversion will take place or the first full fiscal year in which the facility will operate with both nursing facility and residential care facility levels of care will be

24. FINAL PROSPECTIVE RATE.

Upon final audit of all nursing facility's base year cost repolts, the Department will determine a final prospective rate, which cannot be greater than 100 percent of all of the calculated direct Care Cost Component and all of the Routine Cost Components.

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

25. FINAL AUDIT OF FIRST AND SUBSEQUENT PROSPECTIVE YEARS.

25.1. Principle. All facilities will be required to submit a cost report in accordance with Section 13.2 at the end of their fiscal year on cost report forms approved by the Department. The Department will conduct a final audit of each facility's cost repolt, which may consist of a fu.11 scope exami nation by Department personnel and which will be conducted on an annual basis.

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

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

25.2.2. Determine the occupancy levels of the nursing facility,

25.2.3. Determine reimbursable direct care costs i ncurred by the facility during the repolting period per Section 22.3.5

special NF-BI rate for a distinct part shall allocate its costs to the distinct part as if the distinct part were licensed as a separate level of care.

All other principles pertaining to that allowability, recording and reporting of costs shall apply.

39. COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS

Community-based specialty nursing facility units providing medical-psychiatric services with the Department of Health and Human Services to former residents of the Augusta Mental Health Institute (AMHI) and the Bangor Mental Health Institute (BMHI) as well as other individuals who are in need of and deemed eligible by the Department to receive these services.

The Department shall designate specialty nursing facility units that provide special services with the Department of Health and Human Services to former residents of the Augusta Mental Health Institute (AMHI) and the Bangor Mental Health Institute. It has been determined that the reasonable cost of services for these residents, who have multiple medical needs that make them eligible for nursing facility level of care and have a primary diagnosis of mental illness that requires the ongoing supervision of trained professionals, is an allowable cost. This requires the nursing facility unit to possess characteristics, both in terms of staffing and physical design, for providing services to these residents as approved by the Office of Aging and Disability Services.

Such designated specialty units shall be subject to the provision of these rules, except for the rate limitations contained in Sections 22-87.

The Department will require that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with these facilities from the Office of MaineCare Services. In the event a facility believes that the needs of the residents it serves have increased or decreased, the facility must request prior approval from the Office of MaineCare Services authorizing such a change to its staffing pattern.

39.1. Principle. A nursing facility that is recognized as a specialty unit under this section will be reimbursed for services provided to residents covered under the Title XIX program based upon the actual cost of services provided. The Department will establish the rate and determine that the cost is reasonable and adequate to be an efficiently and economically operated facility in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

39.2. Cost. The Department's payments made for allowable services provided will be based on the actual allowable cost of services provided to such residents. Effective 8/1/10 the allowable per diem cost for the services will be increased annually by the rate of inflation at the beginning of each facility's fiscal year based on Section 91. This per diem rate is subject to audit and will be adjusted to the actual allowable costs of providing services to such residents in these units at year end.

39.3. Cost Reporting. Costs will be reported in a manner that will segregate the costs of such residents in the specialty unit from the costs of other residents in the unit and the standard nursing facility's costs as apply under these Principles.