# APPENDIX A

## Resolve of 1997, Chapter 81

APPROVED
JUN 12'97
BY GOVERNOR

CHAPTER
81
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-SEVEN

H.P. 486 - L.D. 657

**Resolve, to Establish the Commission to Examine Rate Setting and the Financing of Long-term Care Facilities**

**Emergency preamble. Whereas,** Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

**Whereas,** this resolve establishes the Commission to Examine Rate Setting and the Financing of Long-term Care Facilities; and

**Whereas,** this resolve is necessary as an emergency measure to afford adequate time for the issues to be appropriately addressed by the commission; and

**Whereas,** in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

**Sec. 1. Commission established. Resolved:** That the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities, referred to in this resolve as the "commission," is established; and be it further

**Sec. 2. Commission membership. Resolved:** That the commission consists of the following 15 members:

1. Two members of the Senate, appointed by the President of the Senate, one representing the majority party and one representing the minority party;

2. Two members of the House of Representatives, appointed by the Speaker of the House, one representing the majority party and one representing the minority party; and

3. Eleven other members appointed as follows:

A. The following members appointed by the Governor:

(1) The chair, who must have experience with rate setting;

(2) One representative of the Department of Human Services;

(3) One representative of the Long-term Care Steering Committee;

(4) One representative of the Maine Health and Higher Educational Facilities Authority; and

(5) One representative of a commercial lending institution; and

B. The following members appointed jointly by the President of the Senate and the Speaker of the House of Representatives:

(1) One representative of the long-term care ombudsma program;

(2) One representative of the Maine Health Care Association;

(3) One representative of the Maine Hospital Association;

(4) One representative of providers of long-term care services who is familiar with the principles of reimbursement;

(5) One representative of consumers of long-term care services who is familiar with the principles of reimbursement; and

(6) One representative of the American Association of Retired Persons; and be it further

**Sec. 3. Appointments; meetings. Resolved:** That all appointments must be made no later than 30 days following the effective date of this resolve. The Executive Director of the Legislative Council must be notified by all appointing authorities once the selections have been made. Within 15 days after appointment of all members, the Chair of the Legislative Council shall call and convene the first meeting of the commission; and be it further

**Sec. 4. Duties. Resolved:** That the commission shall examine the following issues concerning long-term care facilities:

1. The setting of rates for the different payers within the long-term care system, including monthly charges and charges for resident services and supplies, and ensuring affordability;

2. The levels of profit guaranteed by the rate of reimbursement, a comparison of rates among the different states and financial stability within the system;

3. The advisability of rate equalization between private and public payers, implementation of rate equalization and what the possible benefits and detriments might be for nursing facility residents;

4. The case mix payment system for private paying patients;

5. The possibility of regulating the long-term care industry in the manner of regulating public utilities; and

6. The relationship between staffing levels and quality of care and maintaining high-quality care; and be it further

**Sec. 5. Staff assistance. Resolved:** That the commission may request staffing assistance from the Legislative Council; and be it further

**Sec. 6. Compensation. Resolved:** That the members of the commission are not entitled to compensation or reimbursement of any type, except that members of the commission who are Legislators are entitled to receive per diem and reimbursement for travel and other necessary expenses related to their attendance at meetings of the commission; and be it further

**Sec. 7. Report. Resolved:** That the commission shall submit its report, together with any necessary implementing legislation, to the Second Regular Session of the 118th Legislature no later than December 15, 1997. If the commission requires an extension, it may apply to the Legislative Council, which may grant the extension; and be it further

**Sec. 8. Appropriation. Resolved:** That the following funds are appropriated from the General Fund to carry out the purposes of this resolve.

| | 1997-98 |
|---|---|
| **LEGISLATURE** | |
| **Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities** | |
| Personal Services | $1,100 |
| All Other | 1,500 |
| Provides funds for the per diem and expenses of legislative members and miscellaneous costs, including printing, of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities. | |
| **LEGISLATURE TOTAL** | $2,600 |

**Emergency clause.** In view of the emergency cited in the preamble, this resolve takes effect when approved.

# APPENDIX B

## Interim Report of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities

STATE OF MAINE
118TH MAINE LEGISLATURE

COMMISSION TO EXAMINE RATE SETTING AND THE
FINANCING OF LONG-TERM CARE FACILITIES

Joseph M. Kozak, Chair

November 13, 1997

Honorable Elizabeth H. Mitchell
Chair, Legislative Council
118th Maine Legislature

Dear Speaker Mitchell:

I am writing on behalf of the Commission to Examine Rate Setting and the Financing of Long-term Care Facilities to request an extension of our reporting deadline.

As you know, the resolve establishing this study commission was signed into law as an emergency on June 12th. Under the terms of the resolve, the first meeting was to be held before the end of July. The resolve establishes a reporting deadline of December 15th.

As the Legislature clearly understood, the scope and magnitude of this study are significant. The issues surrounding rate setting for long-term care facilities are many, interrelated and difficult. The time-line established for the commission by the resolve provided some five months to undertake the study.

However, as you are well aware, the appointments to this commission were only recently completed. As a result, we were first convened on November 3, forty-two days before our deadline to issue a report.

Members of the commission are unanimously of the opinion that the issues raised by the study are complex, difficult and cannot be treated quickly or in a cursory manner. The commission has received data showing that that the nursing facilities in the state currently carry on the order of a quarter billion dollars of debt, a sizable chunk of which is backed by the State's moral obligation. The commission feels it would be imprudent to produce any recommendations that could impact the repayment of this debt without first undertaking a thorough examination of the industry and the financial implications of any changes we might recommend. This will obviously require substantial time.

Commission members are of the opinion that the commission has insufficient time to undertake a credible study and to produce a report that will be of use to the Legislature. We also note that the issues raised by the study are sufficiently interrelated that it seems inappropriate and counter-productive for us to focus on some subset of the issues for

study; a report on such a subset of issues would likely amount to little more than a recitation of the interrelationship of those issues with other issues not examined.

We have been meeting weekly in an effort to begin the examination of the issues. We have been reviewing data and have developed a better sense of the scope of the study and the time we feel is needed to complete it. We have reviewed data on the financial condition of the industry (including long-term debt, financial ratios and comparisons with other states), staffing levels, the quality of care assessment system and the case mix reimbursement system. The data is voluminous and raises as many important questions as it answers.

In the process of examining the data we have noted a number of issues not specifically identified in the resolve that we feel need to be examined in the course of any serious study of the subject. The list is dynamic but presently includes these issues:

- What is the interface of the long-term care industry with the rest of the health care industry (how do decisions affecting one impact the other)?
- What are the effects of regulatory requirements on the industry (e.g., nurse time spent filling out forms)?
- How should and does the State's moral-obligation backing of industry debt affect state policy decisions with regard to the industry?
- How viable and stable is the industry today?
- What is the quality of current industry management and how can it be assessed?
- How do staffing levels relate to quality of care?
- What are the financial effects of the recent federal repeal of the so-called Boren Amendment?
- How will managed care impact the industry and how will it affect the State's control over the quality of care?

Based on our evaluation of the scope and magnitude of the study, the commission unanimously requests an extension until November 1998.

We are aware that the session begins in January. We are also aware that there are a number of issues associated with extending this study into the session, including the serious scheduling difficulties it will create for a number of members of the commission and the reduced availability of legislative staff.

We are asking for an extension to the next interim in order to avoid the difficulties associated with attempting to conduct the study during the session. This extension would allow us to set the work aside during the session and to recommence work in earnest after the session finished. Our report and recommendations would be available to the Legislature in the following session.

On behalf of the commission, I would like to thank the Council in advance for its consideration of this request. We look forward to the Council's decision and any further guidance it might care to provide to us in this matter.

Sincerely,

Joseph M. Kozak
Chair

cc: Members, Legislative Council
Sally Tubbesing
Commission members
Commission service list

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# 118th Maine Legislature

## Commission To Examine Rate Setting And The Financing Of Long-Term Care Facilities

Interim Report
December 15, 1997

Members:

Joseph M. Kozak, Chair
Senator Philip E. Harriman
Senator Rochelle Pingree
Representative Elaine Fuller
Representative Jean Ginn-Marvin
Francis Finnegan
Michael Goodwin
Harmon D. Harvey
Carolyn Kasabian
Michael McNeil
Judy McGuire
Hilton Power
Wayde Rankin
Betsy Sweet
Sally Wagley

Staff:

Jon Clark, Legislative Counsel
Jon Kachmar, Researcher
Office of Policy and Legal Analysis
13 State House Station
Augusta, ME 04333, Rm. 101/107/135
(207) 287-1670

# Interim Report of the Commission to Examine Rate Setting and the Financing of Long-term Care Facilities

The Commission to Examine Rate Setting and the Financing of Long-term Care Facilities Commission, established by Resolves of 1997, Chapter 81 (copy attached as Appendix A), was directed to examine a variety of issues related to the long-term care industry and to issue its report with necessary legislation by December 15, 1997.

On November 13, 1997, the commission submitted a letter to the Legislative Council requesting an extension of its deadline until November 1998 (letter attached as Appendix B). On November 20, pursuant to the authority granted under Resolves of 1997, Chapter 81, Section 7, the Council approved the requested extension.

The commission was called to its first meeting on November 3, 1997. It held three subsequent informational meetings on November 12, 19 and December 3 in which it received voluminous data concerning various aspects of the long-term care industry. The commission will hold an additional planning session on December 17 and expects to resume its study in April, 1998, following the Second Regular Session of the 118th Legislature.

## Findings and Recommendations

In order to complete its examination of the complex issues outlined in Resolves of 1997 Chapter 81, the commission finds it will require supplemental funding. The commission expects to need to hold ten to twelve meetings during the 1998 interim. It also finds that in order to obtain an adequate understanding of the complex issues surrounding rate setting for long-term are facilities, it will need to bring before it at least two expert consultants. The commission estimates that the cost of funding the expenses of the consultants, who will come from out of state, will be approximately $2,500 a person. In order to fund this expense, to continue to fund expenses and per diem for legislative members and to cover miscellaneous costs of copying and mailing materials, the commission recommends the commission receive supplemental funding of $10,000.

Pursuant to its authority under Resolves of 1997, Chapter 81, Section 7, attached to this report as Appendix C is draft legislation which implements the commission's recommendation for supplemental funding.

# APPENDIX C

## Report of four consumer members of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities, 1998

February 25, 1998

**TO:** Members, Joint Standing Committee on Health and Human Services

**FROM:** Harmon Harvey, Long Term Care Steering Committee
Hilton Power, American Association of Retired Persons
Betsy Sweet, Representing Consumers of Long Term Care Services
Sally Wagley, Long Term Care Ombudsman Program

**RE:** Preliminary Findings of Consumer Representatives on the "Commission to Examine Rate Setting and the Financing of Maine's Long Term Care Facilities"

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**Summary of Preliminary Findings**

*Note: The views expressed here are those of the authors and not those of the Rate Setting Commission as a whole.*

1. Principles of fairness require the State to equalize rates charged to Medicaid and to private payors.

2. Short of rate equalization, changes should be made to State law and regulations to provide greater protection to private pay residents.

3. Central to the issue of rate equalization and its impact on the Medicaid budget is the adequacy of current Medicaid reimbursement to nursing homes; more time and information are needed to make an informed judgment on this issue.

4. The evidence on the profitability in the nursing home industry is contradictory; more information and analysis is needed before reimbursement is increased.

5. To the extent that profits are low, the nursing homes bear some responsibility.

6. The Legislature should examine the appropriateness of continued public financing of nursing homes though low-interest loans from the Maine Health and Higher Education Facilities Authority.

7. There is room for improvement in the quality of care in Maine nursing homes; the reimbursement system should provide incentives for quality.

8. The State should consider approaches to reimbursement which encourage creativity, innovation and competition on the part of nursing homes: such as quality incentive programs, the use of vouchers, and a simpler reimbursement system.

9. There should be more openness and consumer involvement in State reimbursement of nursing homes.

## Introduction

Last fall, the four of us were appointed to this "Commission to Examine Rate Setting and the Financing of Maine's Long Term Care Facilities" as representatives of consumer interests. As you know, the Commission has been granted an extension until November 1998 to submit its report to the Legislature. The extension was requested due to the complexity of the issues involved and the long delay between adjournment of the Legislature and the completion of appointments to the Commission.

Several weeks ago, the Health and Human Services Committee requested that the Rate Setting Commission present a report to the Committee by March 1, 1998. We agree that the Committee and the Legislature should receive input from the Rate Setting Commission before the end of this session. To this end, we offer the following preliminary findings regarding the issues presented to the Commission. ***We emphasize that the views expressed here do not represent those of the Commission as a whole.***

Our examination of the issues presented in L.D. 657, "Resolve, to Establish the Commission to Examine Rate Setting and the Financing of Long Term Care Facilities," required us to balance a number of competing considerations: the quality of care in nursing facilities; the affordability of nursing home care, from the point of view of state taxpayers as well as private pay residents; the availability of funds for home and community based care; the impact of potential changes on the Medicaid budget; and the financial stability of a needed industry. Maine currently spends more than $273 million for long term care services, of which approximately 80 percent goes to nursing homes.

## Discussion of Preliminary Findings

### *1. Principles of fairness require the State to equalize rates charged to Medicaid and to private payors.*

One of the charges to the Rate Setting Commission was to examine the "affordability" of rates charged within the long-term care system. L.D. 657, Sec. 4, para.1. A focus of the public hearing on LD. 657 was the position of "private pay" residents in nursing homes, who occupy approximately 17 percent of Maine nursing home beds. (Letter from Michael McNeil to Health and Human Services Committee, 4/2/97.) These individuals are usually people of modest income do not qualify for Medicaid coverage of a nursing home stay because they have savings or countable assets in excess of either $2,000 for an individual or $3,000 for a couple. Most private pay residents eventually spend down all their assets in a matter of months or a few years at the most, to the point where they are impoverished and eligible for Medicaid.

From the perspective of these residents and their families, nursing home rates are not "affordable." This is borne out by calls to legislators, the Long Term Care Ombudsman Program and the Department of Human Services following the repeal of the gross receipts tax, when residents and their families were faced with rate increases rather than decreases in many nursing homes. (See "Final Report, Select Committee to Study Rate Increases in Nursing Homes, August 1996," Attachment B.)

Private pay residents have also complained about having to pay higher rates than those paid by Medicaid for the same services. At the time the Select Committee studied this issue, a review of nursing home rates by a consultant to the Maine Health Care Association showed that nursing homes charge private-pay residents as much as 39 percent more than they charge Medicaid residents. At the time the Select Committee held its hearings, private-pay rates were on average of 18.8 percent higher than Medicaid rates. (Final Report, Select Committee to Study Rate Increases in Nursing Homes, Attachment C, Table 1.) (The Rate Setting Commission did not receive more current data regarding differences in rates.) The disparity in rates may be a cause for cynicism for some residents and their families and may encourages people to attempt to shelter or transfer assets, thereby hastening their eligibility for Medicaid.

In response to suggestions that rates be equalized, the Maine Health Care Association has responded that the Medicaid rate is inadequate to cover the costs of providing quality care to residents; and that higher charges to private pay residents are necessary. Without this source of income, it is said, the quality of care will decline and facilities will close. (Michael McNeil letter, 4/2/97, p. 2.)

If Medicaid reimbursement is indeed inadequate, then fairness requires that the State stop shifting the cost to private pay residents and increase its payments for Medicaid residents. However, as detailed below, we consider the adequacy of Medicaid nursing home reimbursement to be an open question which needs far more scrutiny before an increase in Medicaid rates is approved. An extension of time and the ability to consult with disinterested experts on this topic would allow the Rate Setting Commission to give a more definitive answer to the Health and Human Services Committee. It would also allow the Commission to determine what cost, if any, there would be to the State if rate equalization were implemented.

***2. Short of rate equalization, changes should be made to State law and regulations to provide greater protection to private pay residents.***

Admission to a nursing home usually takes place in a crisis atmosphere, following an injury or illness or a hospitalization. Residents and families do not usually have the luxury of making a deliberate and reasoned choice of a nursing home. Those who do attempt to "comparison shop" for a facility providing quality care at a reasonable price may be confused by the facility's explanation of charges as well as by the agreement they

are required to sign on admission. They may not understand that, in addition to the per diem rate quoted by the facility, they may also face extra "a la carte" charges for items such as incontinence supplies, over-the-counter medication, and haircuts. These charges may come at a considerable mark-up from the retail price. Residents and their families, often confused about what is covered in the monthly rate and what is subject to an extra charge, may not challenge what seem like excessive charges. (Summary of 12/10/97 Rate Setting Commn mtg. by Jon Clark and Jon Kachmar, OPLA; Testimony of Brenda Gallant, Long Term Care Ombudsman Program, re L.D. 657, 4/1/97.)

Another difficulty faced by some private pay residents and their families comes in the form of a collection action by a facility against an unfortunate relative who signed on as a "responsible party" on an admissions contract. Some facilities do this even though federal regulations have forbidden the practice for many years. (Testimony of Brenda Gallant, 4/1/97.) Relatives who are pursued by facilities for payment often do not know their rights and may pay from their own pockets after a parent's life savings have been exhausted.

As the result of the passage of L.D. 991, "An Act to Address Issues Raised by the Select Committee to Study Rate Increases in Nursing Homes" last session, the Department of Human Services is currently developing a standardized contract which all facilities in the state will be required to use. This will make it easier for consumers and families to comparison shop. A list of residents' rights and a prohibition on pursuit of "responsible parties" for payment would also make residents' rights less vulnerable to overreaching by the facility.

We would like to see consumer protections for this group be taken a couple of steps further through regulatory changes which would accomplish the following:

- Require nursing homes to include within their per diem rate all those services and supplies which are covered under the Medicaid rate. This would allow consumers and their families to comprehend quickly and easily the package of services covered in the per diem rate and would enable them to make a quick comparison between the charges made by different facilities. This would also help consumers understand what "extras" they will be charged for once they spend down and become eligible for Medicaid.

- Require nursing homes to provide potential residents and families on admission with a list of "a la carte" charges. Also require at least 30 days notice to residents a la carte charges are increased. This would allow consumers and families to predict what the total charges will be and to develop a budget. We would like to see the Legislature direct that the Department adopt rules accomplishing these changes.

*3. Central to the issue of rate equalization and its impact on the Medicaid budget is the adequacy of current Medicaid reimbursement to nursing homes; more time and information are needed to make an informed judgment on this issue.*

Traditionally, consumer advocates have lobbied for increases in payments to health providers, on the theory that more money means greater access to care and better quality of care. In the field of long term care, however, the record shows that continual increases in the nursing home budget have meant fewer resources for home and community based care, which consumers strongly prefer. Moreover, there is little evidence that more reimbursement means better quality of care, without the right incentives.

National industry data indicate that Maine's level of reimbursement to its nursing homes is the sixth highest in the nation. (U.S. Administration on Aging, State Source Book, 1995. ) Nevertheless, the Maine Health Care Association, asserts that the Medicaid program does not pay the full cost of caring for Medicaid residents. The Department of Human Services' "Principles of Reimbursement" pay only for "allowable costs," and place limits on the extent to which it will reimburse those allowable costs. On this basis, the Association claims that it loses $16.7 per year in caring for Medicaid residents. (Michael McNeil letter, 4/2/97, p. 2.) A discussion at the Rate Setting Commission indicates that the Department of Human Services may at some point in the near future seek an appropriation of approximately $6 million from the general fund in order to increase reimbursement to nursing homes. (Summary of 11/19/97 Commn mtg. by Jon Clark, OPLA. )

The purpose of the Principles of Reimbursement is to provide reimbursement to facilities which is adequate to provide quality care while providing incentives to hold costs down. (State of Maine Dept. of Human Services, Principles of Reimbursement for Nursing Facilities, Sec. 10.) While the possibility exists that alleged losses may be due to overly restrictive principles, it is also possible that the industry itself is responsible for its own losses, because of poor business practices and a refusal to recognize a changing market in which both consumers and third party payors (such as Medicaid) are seeking out less restrictive forms of care.

Simply put, more information is needed in order to determine whether current levels of Medicaid reimbursement are adequate to allow nursing homes to provide quality care. On this point, Rep. Elaine Fuller, a member of the Rate Setting Commission, requested that the Health Care Association provide detail on these alleged underpayments. (Summary, 12/17/97 Mtg. of Rate Setting Comm, by Jon Clark and Jon Kachmar, OPLA.) More time is needed for the Rate Setting Commission to review this information once it is provided.

In some respects, the rules of Medicaid reimbursement favor nursing homes:

- The rules allow for-profit facilities to keep an 8 percent return on equity. (Principles of Reimbursement, Sec. 44.6.) While it may be true that many facilities have very low equity and get little from this rule, this is a business decision for which facilities must take responsibility.

- The rules allow facilities to get reimbursed for their fixed costs (buildings, fixtures, equipment, motor vehicles, and the like) through "straight-line depreciation," which allows facilities to take excess depreciation in the early years of ownership of a facility. (Principles of Reimbursement, Sec. 44.26.) One strategy (stated explicitly in at lease one certificate of need application) that a facility may use is to buy a facility, take the excess depreciation, and then sell the facility after ten years, when returns from depreciation start to decline.

- Facilities are shielded to some extent from losses from low occupancy by State rules which allow facilities to spread their fixed costs over the number of beds actually occupied, applying a penalty only when the occupancy declines to less than 90 percent (85 percent for smaller facilities). Principles of Reimbursement, Section 44.9. The average occupancy rate for facilities as of fall of 1997 was 89 percent. (Nursing Facility Occupancy Rates, Dec. 1994 - Nov. 97, submitted by DHS Bureau of Medical Services, 11/10/97.)

- The Certificate of Need laws applicable to nursing homes provide some protection to the existing providers by keeping out potential competitors. (See 22 M.R.S.A. Section 301 et seq.)

Information from other states is inconclusive with respect to the likely impact of rate equalization on the Medicaid budget. While North Dakota reported an increase in reimbursement due to rate equalization, Minnesota did not believe that the Medicaid budget increases could be attributed solely to rate equalization. Contacts in Minnesota noted that any increase in Medicaid payments would be offset by the fact that private pay residents would "spend down" more slowly, postponing the day when they would need Medicaid. (Memo to Commn from Jon Kachmar, OPLA, 12/2/97.)

### *4. The evidence on the profitability in the nursing home industry is contradictory; more information and analysis is needed before reimbursement is increased.*

One of the charges to the Rate Setting Commission in L.D. 657 was to examine "the levels of profit guaranteed by the rate of reimbursement. . . . and financial stability within the system." L.D. 657, Sec. 4, para. 2. These issues are crucial because the

nursing home industry in Maine, unlike other health care sectors such as hospitals, is dominated by for-profit providers, whose primary incentive in providing care is the rate of return. The level of profit potentially affects both the supply of care (i.e., the number of nursing homes who stay in business) and the quality of care (i.e., the resources that nursing homes have available to invest in qualified staff, food, physical plant, medical supplies, activities and the like).

With respect to profitability, the evidence is contradictory. Nursing home representatives provided the Rate Setting Commission with a plethora of evidence that the industry is in trouble: in 1994 profits were, on average 1.6 percent, compared with a national average of 3.5 percent; debt service coverage ratios were among the lowest (worst) in the country; and liquidity was the lowest (worst) in the country. (Maine Health Care Assn, Key Statistical and Financial Comparisons Abstract from 1996 Edition of "Guide to Nursing Home Industry,")

On the other hand, there are also signs that the nursing home business continues to be attractive to investors and that it does indeed generate revenue for owners and administrators, even if that revenue is not technically considered "profit." Those positive signals are:

- Salaries to administrators in 13 facilities were in the six figures in 1995. (See "Final Report, Select Committee to Study Rate Increases in Nursing Homes, August 1996," Attachment D, Nursing Facilities Administrative Costs, 1993-95.) (These salaries are considered a cost and do not show up as profit.)

- There has been brisk activity in the Bureau of Elder and Adult Services' Certificate of Need division, which reviews applications for purchase, construction or additions to nursing homes by companies both within and outside the state. Since 1998, there have been 17 applications for C.O.N., with capital costs totaling $58.5 million. (Information submitted by BEAS to Commission to Study Certificate of Need Laws, 1997.)

- A "Management Agreement" obtained from BEAS under the Freedom of Information Act shows payments of $48,000 per month by an out of state company to two owners of an in-state nursing home chain in exchange for the right to manage the facilities, control revenues and an option to buy.

We suspect that, while profits may appear low, some facilities may still be generating a good income for some individuals through high salaries, dividends and management fees. For this reason, a request has been made for information on the amount paid out by nursing homes for salaries, management fees and dividends, as well as how these items are reflected in the facilities' computation of profit and loss. (Summary of 11/19/97 Commission meeting, by Jon Clark, OPLA, p. 6.) Additional time is needed for the Rate Setting Commission to review this information once it has been obtained.

***5. To the extent that profits are low, the nursing homes bear some responsibility.***

We agree with the nursing home industry that one factor in the lower profits of Maine nursing homes is that Maine nursing homes are smaller and do not benefit from the economies of scale enjoyed by nursing homes in other states. We also agree that nursing home profits have been affected by the use of stricter medical criteria for Medicaid coverage of nursing homes care under the "MED 94/ 96" assessment tool, which has caused most facilities to have empty beds and therefore less revenue. We do not, however, think that State long term care policy should be driven by concerns for an industry's bottom line, but rather by the wise use of state funds for the care of elderly and disabled adults. It should be up to industry to adapt to a changing market and public policy.

To the extent that profits are low in some nursing homes, the providers themselves bear some responsibility. Industry practices which have contributed to low profits are:

- Many facilities have taken little interest in consumer demand for a less restrictive, more home-like environment. In spite of "MED 94," facilities were initially slow to convert beds to residential care and accordingly bear some responsibility for empty beds.

- Few providers have used their physical plant and staff to move into the home health industry, for which there is a strong need in rural parts of the state.

- Similarly, some providers have been slow to make their beds dually eligible for Medicare and Medicaid, even though they are required to by law.

- As stated above, some facilities have not chosen to build equity (as many Maine businesses do) but have taken full advantage of Maine reimbursement rules which allow them to extract excess depreciation, resulting in heavily leveraged businesses.

***6. The Legislature should examine the appropriateness of continued public financing of nursing homes though low-interest loans from the Maine Health and Higher Education Facilities Authority.***

Under Maine statute, nursing homes may apply to the Maine Health and Higher Education Facilities Authority (MHHEFA) for low-interest loans financed by public bonds. As of November 1, 1997, thirty-six nursing homes had outstanding loans

totaling $135,778,674. (Letter from Michael R. Goodwin, MHHEFA, to Rate Setting Commn, 11/17/97, with attachment.) According to the Maine Health Care Association, as of April 1997 there were 15 to 20 facilities that were unable to meet their required debt service coverage ratio. (Michael McNeil Letter, 4/2/97, p. 3.) According to Robert O. Lenna, Executive Director of MHHEFA, last April, five nursing homes were in arrears in the repayment of their loans, ranging from five to nine months. (Letter to Commn member Hilton Power, 4/30/97.)

Six of the MHHEFA loans, totaling $27,905,440, were made after the stricter medical eligibility criteria in the "MED 94" assessment tool was put into place, and after there were signs that the facilities were likely to experience low occupancy and therefore reduced revenue. (List attached to Michael Goodwin Letter to Rate Setting Commn.)

Last session, at the public hearings on the rate equalization bills, representatives of MHHEFA argued against adopting rate equalization on the ground that it would reduce nursing home profits and thereby impair the ability of the industry to re-pay its' loans to MHHEFA. (Testimony of Robert Dunn, MHHEFA, re L.D. 1219, "An Act to Prohibit Nursing Homes from Charging Private-Payor Patients More Than Medicaid Patients.") Similarly, the Maine Health Care Association interprets MHHEFA's enabling legislation, 22 M.R.S.A. Section 2072, as "preclud[ing] the Legislature from taking any action which could impair the ability of any bondholder under the MHHEFA program to meet their moral obligations under the bonds." (Michael McNeil Letter, 4/2/97, p. 3.)

It appears that we as a state are held hostage when we make loans of this type to nursing homes. By making these loans, we wed ourselves to perhaps outdated public policy which favors an industry's bottom line rather than good care for our citizens and sound fiscal policy. The State has gotten itself into a bind by making these loans to nursing facilities, particularly after public policy indicated a trend away from the use of nursing homes to home and community based care.

### *7. There is room for improvement in the quality of care in Maine nursing homes; the reimbursement system should provide incentives for quality.*

Maine is thought by many to have good nursing homes, compared with other states in which care may be truly abominable. (Summary of 11/19/97 Commission mtg. by Jon Clark, OPLA, p. 3.) This is attributed to higher rates of reimbursement, high licensing standards and perhaps to a culture which values the elderly.

Nevertheless, we think that "better than other states" is not good enough and that we, as consumers, should have higher standards for the care of the elderly and disabled. Gerontological research indicates that problems like incontinence, depression, immobility and skin breakdown are by no means inevitable in old age. Yet the data on "quality indicators" kept by the Department of Human Services' case mix project

indicate that as of July 1997, 64.2 percent of nursing home residents were incontinent, 19.6 percent suffered from depression, and 8.9 percent had pressure ulcers. ("Multistate Nursing Home Case Mix and Quality Demonstration Maine: Quality Indicators," charts submitted by Alison Moore, R.N., DHS Bureau of Medical Services, 11/10/97.) In recent years, two entire facilities have been shut down or taken over because of widespread deficiencies in the quality of care. (These facilities Greene Acres, in Greene, and Russell Park Manor, in Lewiston.) Substantial fines have been levied against at least four others.

The following changes in Maine's approach to nursing home care should be considered as ways to enhance the quality of care in Maine nursing homes:

- The use of quality indicators has provided us with a wealth of reliable data on the quality of care and outcomes for residents in Maine nursing homes. As a supplement to this, we recommend the development and use of "quality of life" indicators which are less oriented toward medical care but focus more on resident choice in such matters as bedtime, mealtime, diet and activities. Such indicators are currently being developed in connection with the Department of Human Services' new case mix project for residential care facilities. (Information from Alison Moore, R.N., DHS, Bureau of Medical Services.)

- Address staffing problems in nursing homes. According to the Long Term Care Ombudsman, widespread staffing problems in Maine nursing homes seriously compromise the quality of care. Last session a task force on minimum staffing was established under L.D. 1133, "Resolve, to Ensure Quality Care to Residents of Nursing Facilities through the Establishment of a Task Force on Minimum Staffing." The task force is about to issue a report indicating an increase in minimum staff-to-resident ratios. While higher ratios will held, regulation should go a step further by requiring facilities to maintain adequate staff coverage to meet the needs of the particular mix of residents, based on their acuity.

- Identify reasons for high staff turnover in Maine nursing homes (estimated by some within the industry to be as high as 100 percent) , and require facilities, as a condition of Medicaid reimbursement, to take corrective action.

- Look at opportunities in the reimbursement system to enable facilities to attract qualified staff. High employment rates in southern Maine are making it difficult for facilities to attract and retain certified nurses' assistants. The Legislature and the Department of Human Services should consider the use of "wage pass-throughs," under which money would be made available to facilities exclusively for the use of wages.

- Ensure that registered nurses who work in Maine nursing homes have training in gerontology. This might mean working with nursing schools in the state, as well as with nursing boards and organizations with respect to continuing education.

- Strengthen the Department's licensing and certification function, which is compromised. Ensure that deficiencies in nursing home care are penalized promptly and that fines are commensurate with the damage done. Recently, several facilities cited for deficiencies have been able to delay the payment of fines for as long as eight months.

- Ensure that administrators in facilities in which deficiencies are serious or widespread are held accountable by their licensing board.

***8. The State should consider approaches to reimbursement which encourage creativity, innovation and competition in the nursing home industry: such as quality incentive programs, the use of vouchers, and a simpler reimbursement system. .***

The extent and type of regulation of nursing homes in Maine may be stifling any inclination toward offering high quality care in a more home-like environment. There are a variety of alternatives to the way we now regulate and reimburse nursing homes. We have not studied any of them enough to recommend, at this point, that they be adopted, but we would like to see the Rate Setting Commission and eventually the Legislature consider the following possibilities:

- Eliminate Certificate of Need requirements for nursing homes, and allow new providers to enter the system, as long as they meet standards of competence and quality. This would encourage competition. (We acknowledge that the Commission to Study the Certificate of Need Laws has recommended a continuation of C.O.N. requirements applicable to nursing homes.)

- Consider letting the market work. Rather than reimburse facilities for empty beds by reimbursing them fully for their fixed costs, provide incentives for facilities to fill those beds. While this might mean fewer facilities in the state, those that would remain would be more financially stable and perhaps offer higher quality care. The state might then be able to offer quality nursing home care to our citizens within the current Medicaid budget, and continue to invest in home and community based care. The trade-off would be that consumers and families would not always be able to find a nursing facility close to home convenient for families to visit. We will encourage the Long Term Care Steering Committee to seek input from the public on these issues.

- Adopt a simpler Medicaid reimbursement system. . Rather than dog facilities every step of the way as to how they use Medicaid funds, we should consider allowing nursing homes more discretion as to how to spend the funds, while holding them to strict standards of quality. The current system, which provides reimbursement to facilities under four "cost components" (increased from two components in the late 1980's), offers facilities perverse incentives to divert direct care staff to activities which are of less direct benefit to residents, such as housekeeping and bookkeeping.

- Adopt a "quality incentive program" for facilities, under which facilities are rewarded for providing good outcomes for residents. The Department of Human Services currently has an initiative underway to adopt such an incentive program for residential care facilities, as part of its case mix project for those facilities. Quality would be measured by quality indicators, as well as quality of life indicators.

- Provide Medicaid recipients with vouchers which allow them to negotiate with facilities for a good care package at a reasonable price. Recipients could pocket any difference between the Medicaid rate and the monthly rate, to be used for goods and services which enhance the resident's health or quality of life. Such a voucher system would need to include a strong program of consumer education.

***9. There should be more openness and consumer involvement in State reimbursement of nursing facilities.***

L.D. 657 directed the Commission to consider "the possibility of regulating the long-term care system in the manner of regulating public utilities." Sec. 4, para. 5. We were unable to reach consensus with respect to the formation of a P.U.C. for long term care facilities. We did agree, however, that the public interest is just as strong with respect to long term care rate setting as it is with respect to rates for electric power, affecting access to and quality of nursing home care, as well as the availability of home and community based care. The promulgation of rules governing nursing home rates, as well as negotiations over how those rules apply to different providers, are generally a matter for providers and the Department of Human Services. Our hope is that a structure for formal consumer involvement can be developed.

# APPENDIX D

## List of members of the Commission

# COMMISSION TO EXAMINE RATE SETTING AND THE FINANCING OF LONG-TERM CARE FACILITIES

Chapter 81, Resolves of 1997

Membership

**Appointments by the Governor**

Joseph M. Kozak, **Chair**
P.O. Box 358
Manchester, Maine 04351
Tel: 621-4390

Harmon D. Harvey
7 Mayflower Lane
Hallowell, Maine 04347
Tel: 622-6896

Representing Long-term Care Steering Committee

Michael Goodwin
MEH
P.O. Box 2268
45 University Drive
Augusta, Maine 04330
Tel: 622-9386

Representing Maine Health & Higher Educational Facilities Authority

Michael McNeil
Berry, Dunn, McNeil & Parker
100 Middle Street
Portland, Maine 04112
Tel: 775-2387

Representing Commercial Lending Institutions

Francis Finnegan
Bureau of Medical Services
11 State House Station
Augusta, Maine 04333-0011
Tel: 287-2674

Representing Department of Human Services

**Appointments by the President**

Sen. Rochelle Pingree
92 Mills Street
North Haven, Maine 04853
Tel: 867-0966

Senate Member

Sen. Philip Harriman
P.O. Box 790
Yarmouth, Maine 04906
Tel: 846-0799

Senate Member

**Appointments by the Speaker**

Rep. Elaine Fuller — House Member
Pond Road
P.O. Box 187
Manchester, Maine 04351
Tel: 622-0293

Rep. Jean Ginn Marvin — House Member
Cranbrook Drive
Cape Elizabeth, Maine 04107
Tel: 799-6283

Deborah Williams — Consumers of Nursing Facility Service
121A Main Street
Topsham, Maine 04086
Tel: 775-5258

**Joint Appointments**

Sally Wagley — Representing Long-term Care Ombudsman Program
Levey & Wagley, P.A.
53 Main Street
P.O. Box 7
Winthrop, Maine 04364-0007
Tel: 377-6966

Ms. Judy McGuire — Representing Providers of Long-term Care Services
Administrator, Long Term Care and Residential Services
Cove's Edge, RR2, Box 4600
Damariscotta, Maine 04543
Tel: 563-4603

Ms. Carolyn Kasabian — Representing Maine Hospital Association
Vice President of Finance
St. Mary's Regional Medical Center
Lewiston, Maine 04243
Tel: 777-8100

Ms. Betsy Sweet — Representing Consumers of Long-term Care Services
P.O. Box 71
Hallowell, Maine 04347
Tel: 623-0718

Mr. Wayde Rankin — Representing Maine Health Care Association
North Country Associates
P.O. Box 1408
Lewiston, Maine 04240
Tel: 786-3554

Mr. Hilton Powers — Representing American Association of Retired Persons
AARP
5 Atwood Lane
Brunswick, Maine 04011
Tel: 725-8669

**Staff:** Jane Orbeton & Heather Henderson, Office of Policy and Legal Analysis

# APPENDIX E

## Resolve of 1997, Chapter 129

APPROVED

APR 16 '98

BY GOVERNOR

CHAPTER

129

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-EIGHT

H.P. 1534 - L.D. 2161

**Resolve, to Extend the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities**

**Emergency preamble. Whereas,** Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

**Whereas,** this resolve is necessary as an emergency measure to provide funding for the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities to continue its work immediately following the Second Regular Session of the 118th Legislature; and

**Whereas,** in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

**Sec. 1. Resolve 1997, c. 81, §2** is amended to read:

**Sec. 2. Commission membership. Resolved:** That, except as provided in section 2-A, the commission consists of the following 15 members:

1. Two members of the Senate, appointed by the President of the Senate, one representing the majority party and one representing the minority party;

2. Two members of the House of Representatives, appointed by the Speaker of the House, one representing the majority party and one representing the minority party; and

3. Eleven other members appointed as follows:

A. The following members appointed by the Governor:

(1) The chair, who must have experience with rate setting;

(2) One representative of the Department of Human Services;

(3) One representative of the Long-term Care Steering Committee;

(4) One representative of the Maine Health and Higher Educational Facilities Authority; and

(5) One representative of a commercial lending institution; and

B. The following members appointed jointly by the President of the Senate and the Speaker of the House of Representatives:

(1) One representative of the long-term care ombudsman program;

(2) One representative of the Maine Health Care Association;

(3) One representative of the Maine Hospital Association;

(4) One representative of providers of long-term care services who is familiar with the principles of reimbursement;

(5) One representative of consumers of long-term care services who is familiar with the principles of reimbursement; and

(6) One representative of the American Association of Retired Persons; and be it further

**Sec. 2. Resolve 1997, c. 81, §2-A** is enacted to read:

**Sec. 2-A. Additional member. Resolved:** That, after the effective date of this section, the Speaker of the House of Representatives shall appoint one additional member of the commission who represents consumers of nursing facility services; and be it further

**Sec. 3. Resolve 1997, c. 81, §§3, 4 and 7** are amended to read:

**Sec. 3. Appointments; meetings. Resolved:** That, except as provided in section 2-A, all appointments must be made no later than 30 days following the effective date of this resolve. The Executive Director of the Legislative Council must be notified by all appointing authorities once the selections have been made. Within 15 days after appointment of all members, the Chair of the Legislative Council shall call and convene the first meeting of the commission; and be it further

**Sec. 4. Duties. Resolved:** That the commission shall examine the following issues concerning long-term care facilities:

1. The setting of rates for the different payers ~~within the long-term care system~~ for nursing facility services, including monthly charges and charges for resident services and supplies, and ensuring affordability;

2. The levels of profit guaranteed by the rate of reimbursement, a comparison of rates among the different states and financial stability within the system;

3. The advisability of rate equalization between private and public payers, implementation of rate equalization and what the possible benefits and detriments might be for nursing facility residents;

4. The case mix payment system for private paying patients;

5. The possibility of regulating the ~~long-term care~~ nursing facility industry in the manner of regulating public utilities; ~~and~~

6. The relationship between staffing levels and quality of care and maintaining high-quality care; ~~and be it further~~

7. Mechanisms for providing consumer participation in decisions on the reimbursement for nursing facility care under the Medicaid program; and

8. Salaries, dividends and management fees in nursing facilities; and be it further

**Sec. 7. Report. Resolved:** That the commission shall submit its report, together with any necessary implementing legislation, to the ~~Second Regular Session of the~~ 118th Legislature no later than

~~December 15, 1997~~ November 20, 1998. If the commission requires an extension, it may apply to the Legislative Council, which may grant the extension; and be it further

**Sec. 4. Retroactivity. Resolved:** That that section of this resolve that amends Resolve 1997, c. 81, section 7 applies retroactively to December 15, 1997; and be it further

**Sec. 5. Appropriation. Resolved:** That the following funds are appropriated from the General Fund to carry out the purposes of this resolve.

| | 1997-98 |
|---|---|
| **LEGISLATURE** | |
| **Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities** | |
| Personal Services | $2,640 |
| All Other | 4,860 |
| Provides funds for the per diem and expenses of legislative members, funding for consultants and miscellaneous costs of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities. | |
| **LEGISLATURE TOTAL** | $7,500 |

**Emergency clause.** In view of the emergency cited in the preamble, this resolve takes effect when approved.

# APPENDIX F

## Nursing facility occupancy by payment source, 1993, 1995, 1997

# Nursing Facility Occupancy
# By Payment Source
# 1993, 1995, 1997

| | Medicaid | | Medicare | | Other | | Total Residents | Total Beds | Occupancy Rate |
|---|---|---|---|---|---|---|---|---|---|
| Date | Count | % | Count | % | Count | % | | | |
| 12/93 | 7,362 | 76% | 506 | 5% | 1,871 | 19% | 9,739 | 10,139 | 96% |
| 12/95 | 6,522 | 75% | 816 | 9% | 1,410 | 16% | 8,748 | 9,969 | 88% |
| 12/97 | 5,595 | 72% | 839 | 11% | 1,320 | 17% | 7,754 | 9,266 | 84% |

Source: Muskie Institute Case Mix Demonstration Project: Resident Counts by Source of Payment
Bureau of Medical Services: Division of Licensing and Certification: Total Beds

*File Name: nfoccup939597.lwp*

# APPENDIX G

## Private pay rates as submitted by the provider, Fall, 1998

| | Private rates as submitted by the Provider | | | |
|---|---|---|---|---|
| | | Effective | Semi | |
| | | Date | Prvt. | Prvt. |
| 1 | Amenity Manor | 01/01/96 | 142.00 | 147.00 |
| 2 | Aroostook Medical Center The(AHC) | 01/01/97 | 119.00 | N/A |
| 3 | Aroostook Medical Center The(CGH) | 01/01/97 | 130.00 | N/A |
| 4 | Auburn Nursing Home | 01/01/97 | 121.00 | 130.00 |
| 5 | Augusta Convalescent Center | 04/01/98 | 128.00 | n/a |
| 6 | Bangor City Nursing Facility | 08/30/96 | 144.00 | N/A |
| 7 | Bangor Convalescent Center | 04/01/98 | 137.00 | 156.50 |
| 8 | Atlantic Rehab. (Barnard NH) | 01/01/98 | 115.50 | N/A |
| 9 | Barron Center | 07/01/96 | 142.00 | 160.00 |
| 10 | Birch Grove Nursing Care Center | 01/01/96 | 131.00 | N/A |
| 11 | Bodwell - Mid Coast Hospital | 10/01/97 | 325.00 | N/A |
| 12 | Bolster Heights Health Care | 07/01/97 | 120.00 | 125.00 |
| 13 | Borderview Manor | 01/01/96 | 129.00 | 145.00 |
| 14 | Brentwood Manor | 04/01/98 | 157.00 | 175.00 |
| 15 | Brewer Rehab & Living Center | 04/01/98 | 152.00 | 168.00 |
| 16 | Bridgton Hlth. Care Center | 01/01/97 | 143.00 | N/A |
| 17 | Brunswick Convalescent Center | 01/01/96 | 146.00 | 150.00 |
| 18 | Calais Regional Hospital | 10/01/94 | 250.00 | N/A |
| 19 | Camden Health Care Center | 01/01/97 | 129.00 | 143.00 |
| 20 | Caribou Nursing Home | 01/01/98 | 138.00 | 153.00 |
| 21 | Cedar Ridge Nursing Care Center | 01/01/98 | 145.00 | 175.00 |
| 22 | Cedars Nursing Care Center | 07/01/95 | 161.00 | 188.00 |
| 23 | Charles A. Dean Memorial Hospital | 07/01/97 | 127.00 | N/A |
| 24 | Clover Manor, Inc. | 12/01/95 | 140.00 | 157.00 |
| 25 | Coastal Manor | 01/01/96 | 130.00 | N/A |
| 26 | Collier's Health Care Center | 01/01/98 | 129.00 | 137.00 |
| 27 | Colonial Acres Nursing Home | 01/01/98 | 119.00 | N/A |
| 28 | Country Manor Nursing Home | 02/01/98 | 135.00 | 142.00 |
| 29 | Courtland Living Center | 07/01/98 | 141.00 | 154.00 |
| 30 | Cove's Edge | 11/01/98 | 177.00 | 204.00 |
| 31 | Cummings Health Care Facility | 09/01/92 | 120.00 | N/A |
| 32 | Dexter Nursing Home | 01/01/98 | 118.00 | N/A |
| 33 | Dionne Commons (Brunswick CC) | 01/01/96 | 146.00 | 150.00 |
| 34 | Dixfield Health Care Center | 07/01/97 | 116.50 | N/A |
| 35 | Eastport Memorial Nursing Home | 03/01/94 | 126.00 | 131.00 |
| 36 | Edgewood Manor | 07/01/98 | 147.00 | 161.00 |
| 37 | Evergreen Manor | 01/01/97 | 122.00 | 136.00 |
| 38 | Falmouth By The Sea | 01/01/98 | 165.00 | 225.00 |
| 39 | Fieldcrest Manor Nursing Home | 04/01/98 | 144.00 | 156.00 |
| 40 | Forest Hill Manor | 08/01/97 | 125.00 | N/A |
| 41 | Freeport Nursing Home | 01/01/97 | 132.00 | 147.00 |
| 42 | Fryeburg Health Care Center | 01/01/97 | 137.00 | 163.00 |
| 43 | Gardiner Nursing Home | 01/01/96 | 103.00 | 117.00 |
| 44 | Gorham House | 01/01/93 | 170.00 | 180.00 |
| 45 | Gorham Manor | 07/15/95 | 177.00 | 187.00 |
| 46 | Greenwood Center | 07/01/97 | 155.00 | 170.00 |
| 47 | Harbor Hill | 01/01/97 | 136.00 | 145.00 |
| 48 | Harbor Home | 06/01/98 | 150.00 | 160.00 |
| 49 | Hawthorne House | 01/01/98 | 144.00 | 156.00 |
| 50 | Heritage Manor | 07/01/98 | 129.00 | 136.00 |
| 51 | Hibbard Nursing Home | 12/01/96 | 120.00 | 140.00 |
| 52 | High View Manor | 08/01/96 | 108.00 | 119.00 |
| 53 | Hillcrest Manor Division - Newton Center Rehab. | 06/01/98 | 140.00 | 175.00 |
| 54 | Homestead, Inc. | 06/01/96 | 150.00 | 160.00 |
| 55 | Island Nursing Home | 07/01/96 | 123.95 | 127.22 |
| 56 | Jackman Region Health Center | 05/07/96 | N/A | 115.56 |
| 57 | Katahdin Nursing Home | 07/01/98 | 140.00 | N/A |

| | Private rates as submitted by the Provider | Effective Date | Semi Prvt. | Prvt. |
|---|---|---|---|---|
| 58 | Ken. Long Term Care G.Birch | 07/01/98 | 130.00 | n/a |
| 59 | Kennebec Long Term Care Glenridge | 07/01/98 | 130.00 | n/a |
| 60 | Kennebec Valley Medical Center Gardiner | 07/01/98 | 260.00 | n/a |
| 61 | Kennebunk Nursing Home | 09/01/98 | 152.00 | 180.00 |
| 62 | Knox Center for Long Term Care | 04/01/98 | 142.00 | 157.00 |
| 63 | Lakewood Manor Nursing Home | 01/01/96 | 134.00 | 155.00 |
| 64 | Lamp Nursing Home The | | closed | |
| 65 | Ledgeview Nursing Home | 04/01/96 | 120.00 | 175.00 |
| 66 | Ledgewood Manor | 09/01/93 | 120.00 | 120.00 |
| 67 | Madigan Estates | 09/01/95 | 115.00 | 135.00 |
| 68 | Maine Stay Nursing Home | 10/01/95 | 152.00 | 170.00 |
| 69 | Maine Veterans Home-Augusta | 07/01/98 | 155.00 | 165.00 |
| 70 | Maine Veterans Home - Bangor | 07/01/97 | 165.00 | 175.00 |
| 71 | Maine Veterans Home-Caribou | 07/01/97 | 150.00 | 160.00 |
| 72 | Maine Veterans Home-Scar. | 07/01/98 | 165.00 | 175.00 |
| 73 | Maine Veterans Home - South Paris | 07/01/97 | 165.00 | 175.00 |
| 74 | Maplecrest Living Center | 07/01/98 | 146.00 | 173.00 |
| 75 | Market Square Health Center | 01/01/98 | 135.00 | N/A |
| 76 | Marshall's Health Care Facility | 12/01/95 | 125.00 | 150.00 |
| 77 | Marshwood Nursing Care Center | 01/01/97 | 116.00 | 120.00 |
| 78 | Mercy Home | 08/11/93 | 136.25 | 136.25 |
| 79 | Mere Point Nursing Home | 01/01/97 | 139.00 | 151.00 |
| 80 | Merrill Memorial Manor | 01/01/97 | 127.00 | 132.00 |
| 81 | Montello Manor | 01/01/96 | 145.00 | 150.00 |
| 82 | Mountain Heights Health Care Facility | 05/01/96 | 133.00 | N/A |
| 83 | Mt. St. Joseph Nursing Home | 02/01/96 | 150.00 | 165.00 |
| 84 | Narraguagus Bay Health Care Facility | 11/01/95 | 143.00 | 169.00 |
| 85 | Nicholson's Nursing Home | 07/01/94 | 95.00 | N/A |
| 86 | Norway Convalescent Center | 04/01/98 | 145.00 | 183.00 |
| 87 | Oak Grove Nursing Care Ctr. | 10/01/94 | 139.00 | 166.00 |
| 88 | Oceanview Nursing Home | 01/01/98 | 143.00 | 157.00 |
| 89 | Odd Fellow's Home of Maine | 03/01/98 | 130.00 | 140.00 |
| 90 | Orchard Park Living Center | 07/01/98 | 154.00 | 167.00 |
| 91 | Orono Nursing Home, Inc. | 10/01/97 | 126.00 | 147.00 |
| 92 | Parkview Nursing Home | 02/01/98 | 140.00 | 160.00 |
| 93 | Penobscot Nursing Home | 01/01/96 | 107.50 | 115.50 |
| 94 | Penobscot Valley Hospital | 01/01/90 | 240.00 | |
| 95 | Pine Point Nursing Care Center | 10/01/94 | 160.50 | 181.90 |
| 96 | Pleasant Hill Health Facility | 02/01/98 | 135.00 | |
| 97 | Presque Isle Nursing Home | 01/01/96 | 140.00 | 153.00 |
| 98 | Riverridge | 11/01/94 | 155.15 | 187.25 |
| 99 | Riverwood HCC(Renaissance) | 01/01/98 | 129.00 | n/a |
| 100 | Robinson's Hlth. Care Facility | 02/01/98 | 140.00 | N/A |
| 101 | Ross Manor | 01/01/98 | 149.00 | 163.00 |
| 102 | Rumford Community Home | 08/01/98 | 125.00 | 139.00 |
| 103 | Russell Park Manor | 07/01/97 | 128.90 | 139.64 |
| 104 | Sandy River Nursing Care Ctr. | 10/01/94 | 139.10 | 160.50 |
| 105 | Sanfield Living Center | 07/01/96 | 133.00 | 142.00 |
| 106 | Sanford Health Care Facility | 11/01/95 | 130.00 | 150.00 |
| 107 | Seaside Nursing and Ret. Home | 04/01/98 | 152.25 | 176.50 |
| 108 | Sebasticook Valley Health Care facility | 05/01/95 | 119.00 | 130.00 |
| 109 | Seville Park Plaza | 01/01/98 | 132.00 | 137.00 |
| 110 | Shore Village Nursing Center | 04/01/98 | 143.00 | 157.00 |
| 111 | So. Portland Nursing Home | 01/01/97 | 140.19 | N/A |
| 112 | Somerset Manor | 07/01/98 | 142.00 | 151.00 |
| 113 | Sonogee Estates | 07/01/98 | 142.00 | 163.00 |
| 114 | Southridge Living Center | 07/01/98 | 144.00 | 157.00 |

| | Private rates as submitted by the Provider | | | |
|---|---|---|---|---|
| | | Effective | Semi | |
| | | Date | Prvt. | Prvt. |
| 115 | Springbrook Nursing Care Center | 02/01/95 | 145.00 | 165.00 |
| 116 | St. Andre Health Care Facility | 02/01/95 | 120.00 | 130.00 |
| 117 | St. Andrews Hospital | 08/01/96 | 160.00 | N/A |
| 118 | St. Joseph Nursing Home | 01/27/98 | 125.00 | 135.00 |
| 119 | St. Joseph's Manor | 08/01/98 | 171.00 | 187.00 |
| 120 | St. Marguerite D'Youville Pav. | 01/01/98 | 126.00 | 133.00 |
| 121 | Stillwater Health Care | 02/01/98 | 135.00 | 170.00 |
| 122 | Summit House Health Care Ctr. | | Rates are adjusted monthly. Se | |
| 123 | Sunrise Residential Care Facility | 07/18/93 | 125.00 | 135.00 |
| 124 | Tallpines Health Care Facility | 09/01/95 | 144.00 | 162.00 |
| 125 | Trull Nursing Home | 09/01/98 | 118.23 | 131.41 |
| 126 | Varney Crossing Nursing Care Center | 08/01/98 | 145.00 | 168.00 |
| 127 | Victorian Villa Nursing Home | 01/01/95 | 114.00 | 120.00 |
| 128 | Viking ICF The | 10/12/95 | 155.00 | 207.00 |
| 129 | Westgate Manor | 07/01/97 | 150.00 | 170.00 |
| 130 | Willows Nursing Care Center The | 10/01/94 | 135.00 | 162.00 |
| 131 | Winship Green Nursing Center | 04/01/98 | 150.00 | n/a |
| 132 | Woodford Park Nursing Care | 04/05/98 | 150.00 | 160.00 |
| 133 | Woodlawn Nursing Home | 01/01/98 | 142.00 | 156.00 |
| 134 | York Hospital | 07/01/96 | 205.00 | 215.00 |

# APPENDIX H

## Information from the Bureau of Insurance on long-term care insurance

# The Role of Private Insurance in Financing Long-Term Care

Presentation to the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care System

September 16, 1998

Rick Diamond
Ruth Cottle
Bureau of Insurance

# Types of Insurance

- Long-Term Care Insurance
  - Covers nursing home care and home health care
- Nursing Home Care Insurance
  - Covers nursing home care
- Life Insurance
  - May cover long-term care through acceleration of death benefit
- Disability Income Insurance
  - May convert to long-term care coverage

# Policy Features

- Benefit limitations
  - Elimination period
  - Maximum benefit period
  - Maximum daily benefit
  - Lifetime maximum
- Inflation Protection
  - Optional
  - Must offer 5% compound
  - Most use fixed percentage



# Tax Incentives

- Federal
  - Must be federally qualified policy
  - Must itemize deductions and have health care expenses exceeding 7½% of income
- State
  - Must be certified long-term care policy
  - Not necessary to itemize
- Differences between federal qualification standards and state certification requirements

# APPENDIX I

## Chart of long-term care incentive programs

## State and Federal Incentives to Encourage the Purchase of Long-term Care Insurance

| Jurisdiction | Tax Deduction or Credit | | Incentive program to encourage the purchase of qualifying long-term care insurance | | Group purchase offered to employees |
|---|---|---|---|---|---|
| | Deduction | Credit | Disregard of assets or income for Medicaid eligibility? | Protection of assets from Medicaid estate recovery? | |
| Federal | Yes. Deduction subject to caps calculated by total amount of premium and comparison with adjusted gross income. | | NA | NA | Yes. Employee may purchase for self or family members. Employer does not contribute to premium. |
| Alabama | Yes | No | NA | NA | |
| California (Dollar for Dollar) | No | No | Yes. Amount paid by the policy for long-term care is disregarded. | Yes, amount paid by the policy for long-term care is exempt. | Yes. Offered to state and county employees and retirees. |
| Connecticut (Dollar for Dollar) | No | No | Yes. Amount paid by the policy for long-term care is disregarded. | Yes, amount paid by the policy for long-term care is exempt. | Yes. Offered to state employees. |
| Illinois (combination of Dollar for Dollar and Total State Assets) | No | No | Yes | No. | |
| Indiana (combination of Dollar for Dollar and Total State Assets) | No | No | Yes. After full payment by a qualifying insurance policy, all assets are disregarded. | Yes. All assets. | |
| Iowa (Dollar for Dollar) | No | No | Yes. Amount paid by the policy for long-term care is disregarded. | Yes, amount paid by the policy for long-term care is exempt. | |
| Maine | Yes | No | NA | NA | |
| Massachusetts (hybrid) | No | No | Some asset disregard, otherwise standard Medicaid eligibility. | Yes, protection for some disregarded assets. | |
| New York (Total State Assets) | No | No | Yes. After full payment by a qualifying insurance policy, all assets are disregarded. | Yes. All assets. | |
| North Dakota | No | Yes, tax credit up to $100. | * | * | |
| Washington (Dollar for Dollar) | No | No | Yes. Amount paid by the policy for long-term care is disregarded. | No | |

OBRA '93 prohibits states from exempting assets from Medicaid estate recovery. State programs encouraging the purchase of long-term care that were approved prior to the effective date of OBRA '93 are allowed. As a result of OBRA '93, Missouri, North Dakota*, Oregon and Rhode Island did not implement their programs. Colorado, Maryland and Michigan enacted programs conditional on the repeal of the provisions of OBRA '93 prohibiting exemption from Medicaid estate recovery).

# APPENDIX J

## Medicaid Principles of Reimbursement for Nursing Facilities

10-144: DEPARTMENT OF HUMAN SERVICES
Chapter 101: MAINE MEDICAL ASSISTANCE MANUAL
Chapter III:
Section 67: PRINCIPLES OF REIMBURSEMENT FOR NURSING FACILITIES

# STATE OF MAINE

# DEPARTMENT OF HUMAN SERVICES

# PRINCIPLES OF REIMBURSEMENT

# FOR

# NURSING FACILITIES

# EFFECTIVE JULY 1, 1998

Maine Medical Assistance Manual, Chapter III, Section 67
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INTRODUCTION
GENERAL PROVISIONS

10 PURPOSE
The purpose of these principles is to comply with Section 1902 (a) (13) (A) of the Social Security Act and the Rules and Regulations published thereunder (42 CFR Part 447), namely: to provide for payment of nursing care facility services (provided under Maine's Medicaid Program in accordance with Title XIX of the Social Security Act) through the use of rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. These principles incorporate the requirements concerning nursing home reform provisions set forth by the Omnibus Budget and Reconciliation Act of 1987 (OBRA '87). Accordingly, these rates take into account the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well being of each Medicaid resident.

11 AUTHORITY
The Authority of the Department of Human Services to accept and administer any funds which may be available from private, local, State or Federal sources for the provision of the services set forth in the Principles of Reimbursement is established in Title 22 of the Maine revised Statutes Annotated, Section 10 and 12. The regulations themselves are issued pursuant to authority granted to the Department of Human Services by Title 22 of the Maine Revised Statutes Annotated Section 42(1).

12 GENERAL DESCRIPTION OF THE RATE SETTING SYSTEM
A prospective case mix payment system for nursing facilities is established by these rules in which the payment rate for services is set in advance of the actual provision of those services. The rate is established in a two step process. In the first step, a facility's base year cost report is reviewed to extract those costs which are allowable costs. A facility's costs may fall into an allowable cost category, but be determined unallowable because they exceed certain limitations. Once allowable costs have been determined and separated into four components - direct, indirect, routine and fixed costs, the second step is accomplished in which the costs which must be incurred by an efficiently and economically operated facility are identified.

13 EFFECTIVE DATE
These principles apply to reimbursement for all nursing facility services occurring on or after July 1, 1998.

14 REQUIREMENTS FOR PARTICIPATION IN MEDICAID PROGRAM
14.1 Nursing facilities must satisfy all of the following prerequisites in order to be reimbursed for care provided to Medicaid recipients:
14.11 be licensed and certified by the Maine Department of Human Services, pursuant to Title 22, Section 1811 and 42 CFR, Part 442, Subpart C, and
14.12 have a provider Agreement with the Department of Human Services, as required by 42 CFR, Part 442, Subpart B.
14.2 Medicaid payments shall not be made to any facility that fails to meet all the requirements of Subsection 14.1.

15 RESPONSIBILITIES OF OWNERS OR OPERATORS
The owners or operators of a nursing facility shall prudently manage and operate a residential health care program of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Commissioner or a duly authorized representative shall in any way relieve the owner or operator of a nursing facility from full responsibility for compliance with the requirements and standards of the Department of Human Services or Federal requirements and standards.

16 DUTIES OF THE OWNER OR OPERATOR
In order to qualify for Medicaid reimbursement the owner or operator of a nursing facility, or a duly authorized representative shall:
16.1 Comply with the provisions of sections 15 and 16 and this section setting forth the requirements for participation in the Medicaid Program.
16.2 Submit master file documents and cost reports in accordance with the provisions of sections 30 and 32 of these Principles.
16.3 Maintain adequate financial and statistical records and make them available when requested for inspection by an authorized representative of the Department of Human Services, the state, or the Federal government.

16.4 Assure that annual records are prepared in conformance with Generally Accepted Accounting Principles (GAAP), except where otherwise required.
16.5 Assure that the construction of buildings and the maintenance and operation of premises and programs comply with all applicable health and safety standards.
16.6 Submit, such data, statistics, schedules or other information which 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 152 of these Principles.

20 ACCOUNTING REQUIREMENTS
20.1 ACCOUNTING PRINCIPLES
20.11 All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules require specific variations in such principles and Medicare Provider Reimbursement Regulations HIM-15.

20.12 The provider shall establish and maintain a financial management system which provides for adequate internal control assuring the accuracy of financial data, safeguarding of assets and operation efficiency.
20.13 The provider shall report on an accrual basis, unless it is a state or municipal institution that operates on a cash basis. The provider whose records are not maintained on an accrual basis shall develop accrual data for reports on the basis of an analysis of the available documentation. The provider shall retain all such documentation for audit purposes.

21 PROCUREMENT STANDARDS
21.1 Providers shall establish and maintain a code of standards to govern the performance of its employees engaged in purchasing Capital Assets. Such standards shall provide, and providers shall implement to the maximum extent practical, open and free competition among vendors.
Providers are encouraged to participate in group purchasing plans when feasible.
21.2 If a provider pays more than a competitive bid for a Capital Asset an amount over the lower bid which cannot be demonstrated to be a reasonable and necessary expenditure it is a nonallowable cost. In situations not competitively bid, providers must act as a prudent buyer as referenced in Subsection 24.2 in these principles.
See cost to related organizations Section 24.9.

22 COST ALLOCATION PLANS AND CHANGES IN ACCOUNTING METHODS
With respect to the allocation of costs to the nursing facility and within the nursing facility, the following rules shall apply:
22.1 Providers that have costs allocated from related entities included in their cost reports shall include as a part of their cost report submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements which must also be submitted with the Medicaid cost report. In the case of a home office, related management company, or real estate management company, this would include a completed Home Office Cost Statement which show the costs that are removed which are unallowable. The provider shall submit this reconciliation with the Medicaid cost report. If the nursing facility is a Medicare provider, the Medicare Home Office Cost report may be used to identify the unallowable costs that are removed, if the Medicare Home Office Cost report is completed in sufficient detail to allow the Department to make its findings.
22.2 No change in accounting methods or basis of cost allocation may be made without prior written approval of the Bureau of Medical Services.
22.3 Any application for a change in accounting method or basis of cost allocation, which has an effect on the amount of allowable costs or computation of the per diem rate of payment, shall be made within the first 90 days of the reporting year. The application shall specify:
22.31 the nature of the change;
22.32 the reason for the change;
22.33 the effect of the change on the per diem rate of payment; and
22.34 the likely effect of the change on future rates of payment.
22.4 The Department of Human Services shall review each application and within 60 days of the receipt of the application approve, deny or propose modification of the requested change. If no action is taken within the specified period, the application will be deemed to have been approved.
22.5 Each provider shall notify the Department of Human Services of changes in statistical allocations or record keeping required by the Medicare Intermediary.
22.6 The capital component (any element of fixed cost that is included in the price charged by a supplier of goods or services) of purchased goods or services, such as plant operation and maintenance, utilities, dietary, laundry, housekeeping, and all others, whether or not acquired from a related party, shall be considered as costs for the particular good or service and not classified as Property and Related costs (fixed costs) of the nursing facility.
22.7 Costs allocated to the nursing facility shall be reasonable and necessary, as determined by the Maine Department of Human Services pursuant to these rules.
22.8 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. A rate schedule may be submitted to the Department by the nursing facility to satisfy this requirement if the schedule allows the Department the ability to determine with certainty the charge structure of the nursing facility.
22.9 All year end accruals must be paid by the facility within six (6) months after the end of the fiscal year in which the amounts are accrued. If the accruals are not paid within such time, these amounts will be deducted from allowable costs incurred in the first field or desk audit conducted following that six month period.
22.10 The unit of output for cost finding shall be the costs of routine services per patient day. The same cost finding method shall be used for all long-term care facilities. Total allowable costs shall be divided by the actual days of care to determine the cost per bed day. Total allowable costs shall be allocated based on the occupancy data reported and the following statistical bases:
22.10.1 Nursing Salaries. Services provided and hours of nursing care by licensed personnel and other nursing staff.
22.10.2 Other Nursing Costs. Nursing salaries cost allocations.
22.10.3 Plant operation and maintenance. Square feet serviced.
22.10.4 Housekeeping. Square feet serviced.
22.10.5 Laundry. Patient days, or pounds of laundry whichever is most appropriate.
22.10.6 Dietary. Number of meals served.
22.10.7 General and Administrative and Financial and Other Expenses. Total accumulated costs not including General and Administrative and Financial Expense.

23 ALLOWABILITY OF COST

23.1 If these principles do not set forth a determination of whether or not a cost is allowable or sufficiently define a term used reference will be made first, to the Medicare Provider Reimbursement Manual (HIM-15) guidelines followed by the Internal Revenue Service Guidelines in effect at the time of such determination if the HIM-15 is silent on the issues.

24 COST RELATED TO PATIENT CARE

24.1 Principle. Federal law requires that payment for long term care facility services provided under Medicaid shall be provided through the use of rates which are reasonable and adequate to meet costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Costs incurred by efficiently and economically operated facilities include costs which are reasonable, necessary and related to patient care, subject to principles relating to specific items of revenue and cost.

24.2 Costs must be ordinary and necessary and related to patient care. They must be of the nature and magnitude that prudent and cost conscious management would pay for a specific item or service.

24.3 Costs must not be of the type conceived for the purpose of circumventing the regulations. Such costs will be disallowed under Section 26.

24.4 Costs that relate to inefficient, unnecessary or luxurious care or unnecessary or luxurious facilities or to activities not common and accepted in the nursing home field are not allowable.

24.5 Compensation to be allowable must be reasonable and for services that are necessary and related to patient care and pertinent to the operation of the facility. The services must actually be performed and must be paid in full. The compensation must be reported to all appropriate state and federal tax authorities to the extent required by law for income tax, social security, and unemployment insurance purposes.

24.6 Costs which must be incurred to comply with changes in federal or state laws and regulations and not specified in these regulations for increased care and improved facilities which become effective subsequent to October 1, 1993 are to be considered reasonable and necessary costs. These costs will be reimbursed as a fixed cost until the Department calculates the Statewide peer group mean cost of compliance from the facility's fiscal year data following the fiscal year the cost was originally incurred. Following the second fiscal year the facility will be reimbursed the statewide average cost of compliance. The statewide average cost for this regulation/law will be built into the appropriate cost component in subsequent years.

24.7 Costs incurred for patient services that are rendered in common to Medicaid patients as well as to non-Medicaid patients, will be allowed on a pro rata basis, unless there is a specific allocation defined elsewhere in these Principles.

24.8 Lower of Cost or Charges. In no case may payment exceed the facility's customary charges to the general public for the lowest semi-private room rate in the nursing facility. These charges must be billed to private pay residents during the operating period they are incurred.

24.9 Cost to Related Organizations Principle. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable costs of the provider at the cost to the related organization. However, such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. Providers should reference Section 21 of these Principles.

25 UPPER PAYMENT LIMITS

25.1 Aggregate payments to nursing facilities pursuant to these rules may not exceed the limits established for such payments in 42 CFR. §447.272, using Medicare principles of reimbursement.

25.2 If the Division of Audit projects that Medicaid payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division of Audit shall limit some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit as set forth in subsection 25.4.

25.3 In computing the projections that Medicaid payments in the aggregate are within the Medicare Upper Limit, any facility exceeding 112% of the State mean allowable routine service costs, may be notified that additional information is required to determine allowable costs under the Medicare Principles of Reimbursement including any exceptions as stated in 42 CFR 413.30(f). This information may be requested within 30 days of the effective date of these regulations, and thereafter, at the time the interim rates are set.

25.4 Facility Rate Limitations if Aggregate Limit is Exceeded. If the Department projects that the Medicaid payments to nursing homes in the aggregate exceed the Medicare upper limit, the Department shall limit payments to those facilities whose projected Medicaid payments exceed what would have been paid using Medicare Principles of Reimbursement. The Department will notify the facilities when the Department projects that the Medicaid payments to nursing homes in the aggregate exceed the Medicare upper limit and that the Department must limit payments to those facilities to the level that would reduce the aggregate payments to the Medicare upper limit.

26 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.

27 RECORD KEEPING AND RETENTION OF RECORDS

27.1 Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the cost report, and must, upon request, make these records available to the Department, or the U.S. Department of Health and Human Services, and the authorized representatives of either agency.

27.2 Complete documentation means clear evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service charge schedule and amounts of income received by service, or any other record which is necessary to provide the Commissioner with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty,

management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.
27.3 The provider shall maintain all such records for at least three years from the date of filing, or the date upon the which the fiscal and statistical records were to be filed, whichever is the later. The Division of Audit shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers 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 shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.
27.4 When the Department of Human Services determines that a provider is not maintaining records as outlined above for the determination of reasonable cost under the program, the Department, upon determination of just cause, shall send a written notice to the provider that in thirty days the Department intends to reduce payments, unless otherwise specified, to a 90% level of reimbursement as set forth is Section 152 of these Principles. The notice shall contain an explanation of the deficiencies. Payments shall remain reduced until the Department is assured that adequate records are maintained, at which time reimbursement will be reinstated at the full rate from that time forward. If, upon appeal, the provider documents that there was not just cause for the reduction in payment, all withheld amounts will be restored to the provider.

30 FINANCIAL REPORTING

31 MASTER FILE
The following documents concerning the provider or, where relevant, any entity related to the Provider, will be submitted to the Department at the time that the cost report is filed. Such documents will be updated to reflect any changes on a yearly basis with the filing of a cost report. Such documents shall be used to establish a Master file for each facility in the Maine Medicaid program:
31.1 Copies of the articles of incorporation and bylaws, of partnership agreements of any provider or any entity related to the provider;
31.2 Chart of accounts and procedures manual, including procurement standards established pursuant to Section 21;
31.3 Plant layout if available;
31.4 Terms of capital stock and bond issues;
31.5 Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing and bonus agreements;
31.6 Schedules for amortization of long-term debt and depreciation of plant assets;
31.7 Summary of accounting principles, cost allocation plans, and step-down statistics used by the provider;
31.8 Related party information on affiliations, and contractual arrangements;
31.9 Tax returns of the nursing facility; and
31.10 Any other documentation requested by the Department for purposes of establishing a rate or conducting an audit.
If any of the items listed in Subsections 31.1 - 31.10 are not submitted in a timely fashion the Department may impose the deficiency per diem rate described in Section 152 of these Principles.

32 UNIFORM COST REPORTS
32.1 All long-term care facilities are required to submit cost reports as prescribed herein to the State of Maine Department of Human Services, Division of Audit, State House Station 11, Augusta, ME, 04333. Such cost reports shall be based on the fiscal year of the facility. If a nursing facility determines from the as filed cost report that the nursing facility owes moneys to the Department of Human Services, a check equal to 50% of the amount owed to the Department will accompany the cost report. If a check is not received with the cost report the Department may elect to offset the current payments to the facility until the entire amount is collected from the provider.
32.2 Forms. Annual report forms shall be provided or approved for use by long-term care facilities in the State of Maine by the Department of Human Services.
32.3 Each long-term care facility in Maine must submit an annual cost report within three months of the end of each fiscal year on forms prescribed by the Division of Audit. If available, the long-term care facility can submit a copy of the cost report on a computer disk. The inclusive dates of the reporting year shall be the 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 a cost report in the time prescribed above may result in the Department imposing the deficiency per diem rate described in Section 152.
32.4 Certification by operator. The cost report is to be certified by the owner and administrator of the facility. If the return is prepared by someone other than the facility, the preparer must also sign the report.
32.5 The original and one copy of the cost report must be submitted to the Division of Audit. All documents must bear original signatures.
32.6 The following supporting documentation is required to be submitted with the cost report:
32.61 Financial statements,
32.62 Most recently filed Medicare Cost Report (if a participant in the Medicare Program),
32.63 Reconciliation of the financial statements to the cost report.
32.7 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.

33 ADEQUACY AND TIMELINESS OF FILING
33.1 The cost report and financial statements for each facility shall be filed not later than three months after the fiscal year end of the provider. When a provider fails to file an acceptable cost report by the due date, the Department may send the provider a notice by certified mail, return receipt requested, advising the provider that all payments are suspended on receipt of the notice until an acceptable cost report is filed. Reimbursement will then be reinstated at the full rate from that time forward but, reimbursement for the suspension period shall be made at the deficiency rate of 90%.

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

33.3 Extensions for filing of the cost report beyond the prescribed deadline must be requested as follows:

33.31 All requests for extension of time to file a cost report must be in writing, and must be received by the Division of Audit 15 days prior to the due date. The provider must clearly explain the reason for the request and specify the date on which the Division of Audit will receive the report.

33.32 The Division of Audit will not grant automatic extensions. Such extensions will be granted for good cause only, at the Director of the Division of Audits sole discretion, based on the merits of each request. A "good cause" is one that supplies a substantial basis for the delay or an intervening action beyond the providers control. The following are not considered "good cause"; ignorance of the rule, inconvenience, or a cost report preparer engaged in other work.

34 REVIEW OF COST REPORTS BY THE DIVISION OF AUDIT

34.1 Uniform Desk Review

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

34.12 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, allowable costs and a summary of the results of the review. The Division of audit will schedule an on-site audit or will prepare a settlement based on the findings determined by the uniform desk review.

34.13 Uniform desk reviews shall be completed within 180 days after receipt of an acceptable cost report filing, including financial statements and other information requested from the provider except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider.

34.14 Unless the Division of Audit intends to schedule an on-site audit, it shall issue a written summary report of its findings and adjustments upon completion of the uniform desk review.

34.2 On-site Audit

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

34.22 The Division of Audit will base its selection of a facility for an on-site audit on factors such as but not limited to: length of time since last audit, changes in facility ownership, management, or organizational structure, random sampling, evidence or official complaints of financial irregularities, questions raised in the uniform desk review, failure to file a timely cost report without a satisfactory explanation, and prior experience.

34.23 The audit scope will be limited so as to avoid duplication of work performed by a facility's independent public accountant, provided such work is adequate to meet the Division of Audits requirements.

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

35 SETTLEMENT OF COST REPORTS

35.1 Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division of Audits decision to reopen shall be based on: (1) new and material evidence submitted by the provider or discovered by the Department; or, (2) evidence of a clear and obvious material error.

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

35.21 At the request of either the Department, or a provider within the applicable time period set out in paragraph 35.5; and,

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

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

35.4 A determination or decision may only be re-opened within three years from the date of notice containing the Division of Audits determination, or the date of a decision by the Commissioner or a court, except that no time limit shall apply in the event of fraud or misrepresentation.

35.5 The Division of Audit may also require or allow an amended cost report any time prior to a final audit settlement to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, however, the provider is bound by its elections. The Division of Audit shall not accept an amended cost report to avail the provider of an option it did not originally elect.

37 REIMBURSEMENT METHOD

37.1 Principle. Nursing care facilities will be reimbursed for services provided to recipients under the program based on a rate which the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards.

37.2 Nursing facilities costs will be periodically rebased by the Department of Human Services when the Commissioner of the Department of Human Services determines that the rates paid to nursing facilities are in danger of failing to meet the residents needs or are in excess of costs which must be incurred by economic and efficient nursing facilities.

40 COST COMPONENTS

40.1 In the prospective case mix system of reimbursement, allowable costs are grouped into cost categories. The nature of the expenses dictate which costs are allowable under these Principles of Reimbursement. The costs shall be grouped into the following four cost categories:

40.11 Direct Patient Care Costs,
40.12 Indirect Patient Care Costs,
40.13 Routine Costs, and
40.14 Fixed Costs.

Sections 41- 49 describe the cost centers in each of these categories, the limitations and allowable costs placed on each of these cost centers.

41 DIRECT PATIENT CARE COST COMPONENT

The basis for reimbursement within the direct care cost component is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them.

41.1 Direct patient care costs include salary, wages, and benefits for:

41.11 registered nurses,
41.12 licensed practical nurses,
41.13 nurse aides,
41.14 patient activities personnel,
41.15 ward clerks,
41.16 payroll tax,
41.17 the following fringe benefits for the positions listed above: payroll taxes, qualified retirement plan contributions, group health, dental, and life insurance's, cafeteria plans and flexible spending plans,
41.18 the salary and related benefits of the position of Director of Nursing shall be excluded from the calculation of direct patient care costs and shall be included in the indirect patient care cost component.

41.2 Resident assessments

The Resident Assessment Instrument (RAI) is the assessment tool approved by the Department of Human Services to provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. It is comprised of the Minimum Data Set currently specified for use by HCFA (hereinafter, referred to as "MDS") and the Resident Assessment Protocols (RAPs).

The MDS provides the basis for resident classification into one of 44 case mix classification groups. An additional unclassified group is assigned when assessment data are determined to be incomplete or in error. Resident assessment protocols (RAPs) are structured frameworks for organizing MDS elements and gathering additional clinically relevant information about a resident that contributes to care planning.

All residents admitted to a Nursing Facility (NF), regardless of payment source, shall be assessed using the MDS.

41.21 Schedule for MDS submissions

Facilities shall submit by the 25th day of the month a copy of the MDS assessments and discharge log. MDS assessments with a start date and discharges dated between and including the 16th day of the prior month and the 15th day of the current month must be submitted to the Department of Human Services or the Department's designated agent. Beginning October 1, 1994 all submissions must be made on electronic media. Failure to submit on electronic media on or after October 1, 1994 may result in reimbursement as described in Section 152.

41.22 Electronic Submission of the MDS Information

Effective with the implementation of version 2.0 of the MDS by the Bureau of Medical Services, all submissions must be made via electronic submission/modem. No paper copies will be accepted by the Department. Should extraordinary conditions arise whereby the nursing facility is unable to submit electronically, a request to submit MDS information via diskette shall be submitted to the Bureau of Medical Services. This request must be made a minimum of five (5) days prior to the required date of submission of the MDS assessment data.

41.23 Quality review of the MDS process

41.23.1 Definitions

(1) "MDS assessment review" is a review conducted at nursing facilities (NFs) by the Maine Department of Human Services, for review of assessments submitted in accordance with Section 41.2 to ensure that assessments accurately reflect the resident's clinical condition.

(2) "Effective date of the Rate" is the first day of the payment quarter.

(3) "Assessment review error rate" is the percentage of unverified Case Mix Group Record in the drawn sample. Samples shall be drawn from Case Mix Group Record completed for residents who have Medicaid reimbursement.

(4) "Verified Case Mix Group Record" is a NF's completed MDS assessment form, that has been determined to accurately represent the resident's clinical condition, during the MDS assessment review process. Verification activities include reviewing resident assessment forms and supporting documentation, conducting interviews, and observing residents.

(5) "Unverified Case Mix Group Record" is one which, for reimbursement purposes, the Department has determined does not accurately represent the resident's condition, and therefore results in the resident's inaccurate classification into a case mix group that increases the case mix weight assigned to the resident.

(6) "Unverified MDS Record" is one which, for clinical purposes, does not accurately reflect the resident's condition.

41.23.2 Criteria for Assessment Review

NFs may be selected for a MDS assessment review by the Department based upon but not limited to any of the following:

(1) The findings of a licensing and certification survey conducted by the Department indicate that the facility is not accurately assessing residents.

(2) An analysis of the case mix profile of NFs included but not limited to changes in the frequency distribution of their residents in the major categories or a change in the facility average case mix score.

(3) Prior resident assessment performance of the provider, including, but not limited to, ongoing problems with assessments submission deadlines, error rates, and incorrect assessment dates.

41.23.3 Assessment Review Process

(1) Assessment reviews shall be conducted by staff or designated agents of the Department.

(2) Facilities selected for assessment reviews must provide reviewers with reasonable access to residents, professional and non-licensed direct care staff, the facility assessors, clinical records, and completed resident assessment instruments as well as other documentation regarding the residents' care needs and treatments.

(3) Samples shall be drawn from MDS assessments completed for residents who have Medicaid reimbursement.

(4) At the conclusion of the on-site portion of the review process, the Departments reviewers shall hold an exit conference with facility representatives. Reviewers will share written findings for reviewed records.

41.23.4 Sanctions

The Department shall compute the quarterly facility average case mix index, as described in Section 80.3 of these principles. The following sanctions shall be applied to the allowable case mix adjusted direct care cost component for the subsequent quarter for all Medicaid residents of the facility, for which the following assessment review error rates are determined. Such sanctions shall be a percentage of the total direct care cost component after the case mix index and upper limit has been applied.

(1) A 2% decrease in the total direct care cost component will be imposed when the NF assessment review results in a an error rate of 35.853% or greater, but is less than 40.569%.

(2) A 5% decrease in the total direct care cost component will be imposed when the NF assessment review results in an error rate of 40.569% or greater, but is less than 45.284%.

(3) A 7% decrease in the total direct care cost component will be imposed when NF assessment review results in an error rate of 45.284% or greater, but is less than 50%.

(4) A 10% decrease in the total direct care cost component will be imposed when the NF assessment review results in an error rate of 50% or greater.

41.23.5 Failure to complete reassessments by the nursing facility staff within 7 days of a written request by staff of the Bureau of Medical Services may result in the imposition of the deficiency per diem as specified in Principle 152 of these Principles of Reimbursement. Completed MDS assessments, as defined in Section 41.2, shall be submitted to the Department or its designee on the regular submission schedule, as outlined in Section 41.21.

41.23.6 Appeal Procedures: A facility may administratively appeal a Bureau of Medical Services rate determination for the direct care cost component. An administrative appeal will proceed in the following manner:

(1) Within 30 days of receipt of rate determination, the facility must request, in writing, an informal review before the Director of the Bureau of Medical 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 of 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 Bureau of Medical 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 Patient Care component of the rate shall include:

41.31 Direct Patient Care Cost. The base year costs for direct patient care costs shall be the actual audited direct patient care costs incurred by the facility in the fiscal year beginning on or after October 1, 1992 (subject to upper limits). Bonuses are not recognized as allowable costs by the Department.

For nursing facilities that began their first year of operations in a fiscal year beginning on or after October 1, 1993 and are not subject to Section 80.6 of these Principles of Reimbursement the pro-forma cost report supplied with the approved certificate of need shall be the basis for computing the Medicaid rate; subject to upper limits in all cost components.

This determination will exclude any compensation that does not reasonably represent annual, ongoing wage and salary expenses. Contractual labor will be included in the calculation of the number of hours of labor provided in the base year. Costs for contractual labor in the base year will be an allowable cost up to the average hourly wage paid for similar staff within the nursing facility

42 INDIRECT PATIENT CARE COST COMPONENT

42.1 Allowable cost for the Indirect Patient Care Cost component shall include reasonable costs associated with expenses related to indirect patient care. The base year costs for the indirect patient care component shall be the costs incurred by the facility in the fiscal year beginning on or after October 1, 1992.(subject to upper limits). Indirect patient care costs include:

42.11 food, vitamins and food supplements,
42.12 director of nursing, and fringe benefits,
42.13 social services, and fringe benefits,
42.14 medical supplies, equipment and drugs which are supplied as part of the regular rate of reimbursement. See Maine Medical Assistance Manual, Section 67, Appendix #1. Excluded are costs which are an integral part of another cost center.

42.14.1 Inventory items shall include, but are not limited to, medical supplies and food.

42.2 These types of consultative services will be considered as part of the allowable indirect patient care costs and be built into the base year indirect patient care cost components subject to the limitations outlined in subsections 42.21 - 42.23.

42.21 Pharmacist Consultants

Pharmacist consultant fees paid directly by the facility in the base year, will be included in the indirect patient care cost component for inclusion in the facilities per diem rate. 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.

42.22 Dietary Consultants

Dietary Consultants 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 built into the base year indirect patient care cost component for inclusion in the facilities per diem computation.

42.23 Medical Directors

The base year costs 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 $1,200.

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 patient care component shall be the costs incurred by the facility in the fiscal year beginning on or after October 1, 1992 (subject to upper limits).

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 patients are required to be expensed in the year used. Inventory in excess of the amount used are not an allowable cost. 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 means the regular room, dietary and nursing 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.

43.41 fiscal services, (not to include accounting fees)
43.42 administrative services and professional fees not to exceed the administrative and management ceiling,
43.43 plant operation and maintenance including utilities,
43.44 grounds,
43.45 laundry and linen,
43.46 housekeeping,
43.47 medical records,
43.48 subscriptions related to patient care,
43.49 all employee education, except wages related to initial and on-going nurse aide training as required by OBRA,
43.410 dietary, excluding food,
43.411 motor vehicle operating expenses,
43.412 clerical,
43.413 transportation, (excluding depreciation),
43.414 office supplies/telephone,
43.415 conventions and meetings within the state of Maine,
43.416 EDP bookkeeping/payroll,
43.417 fringe benefits,
43.418 payroll taxes,
43.419 one association dues, the portion of which is not related to lobbying

See the explanations in Section 43.42.1 - 43.44 for a more complete description of allowable cost 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.

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 appropriate to the operation of patient care 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 which 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 patient admission policies
d) planning of expansion and financing

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, owners, or other employees throughout the entire 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 patient 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 Medicaid patients.

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 which 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.

43.5 Principle. Research Costs incurred for research purposes, over and above patient care, 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 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.

43.71 Principle. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

43.71.1 Discounts. Discounts, in general, are reductions granted for the settlement of debts.

43.71.2 Allowances. Allowances are deductions granted for damages, delay, shortage, imperfections, or other causes, excluding discounts and returns.

43.71.3 Refunds. Refunds are amounts paid back or a credit allowed on account of an over-collection.

43.72 Reduction of Costs. All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

43.73 Application of Discounts Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase, but rather from a sale or an exchange, and the purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

43.74 All discounts, allowances, and rebates received from the purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party organizations paying on the basis of costs.

43.8 Principle. Advertising Expenses. The reasonable and necessary expense of newspaper or other public media advertisements for the purpose of securing necessary employees is an allowable cost. No other advertising expenses are allowed.

43.9 Insurance. Reasonable and necessary costs of insurance involved in operating a facility are considered allowable costs (real estate insurance including liability and fire insurance are included as fixed costs - see subsection 44.1.4). Premiums paid on property not used for patient care are not allowed. Reasonable health insurance premiums on employees are an allowable cost. Qualified retirement plans and life insurance plans for employees are an allowable cost. Life insurance's premiums related to insurance on the lives of officers and key employees where the provider is a direct or indirect beneficiary are not allowable costs. A provider is a direct beneficiary where, upon the death of the insured officer or key employee the insurance proceeds are payable directly to the provider. An example of a provider as an indirect beneficiary is the case where insurance on the lives of officers is required as part of a mortgage loan agreement entered into for a building program, and, upon the death of an insured officer the

proceeds are payable to the lending institution as a credit against the loan balance. In this case, the provider is not a direct beneficiary because it does not receive the proceeds directly, but is, nevertheless, an indirect beneficiary since its liability on the loan is reduced.

43.10 Legal Fees. Legal fees to be allowable costs must be directly related to patient care. Fees paid to the attorneys for representation against the Department of Human Services are not allowable costs. Retainers paid to lawyers are not allowable costs. Legal fees paid for organizational expenses, are to be amortized over a 60 month period.

43.11 Costs Attributable to Asset Sales. Costs attributable to the negotiation or settlement of a sale or purchase of any capital asset (by acquisition or merger) are not allowable costs. Included among such unallowable costs are: legal fees, accounting and administrative costs, appraisal fees, costs of preparing a certificate of need, banking and broker fees, good will or other intangibles, travel costs and the costs of feasibility studies.

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

44 FIXED COSTS COMPONENT

44.1 All allowable costs not specified for inclusion in another cost category pursuant to these rules shall be included in the Fixed Cost component subject to the limitations set forth in these Principles. The base year costs for the fixed cost component shall be the costs incurred by the facility in the most recently audited fiscal year. Fixed Costs include:

44.1.1 depreciation on buildings, fixed and movable equipment and motor vehicles,
44.1.2 depreciation on land improvements and amortization of leasehold improvements,
44.1.3 real estate and personal property taxes,
44.1.4 real estate insurance, including liability and fire insurance,
44.1.5 interest on long term debt,
44.1.6 return on equity capital for proprietary providers,
44.1.7 rental expenses,
44.1.8 amortization of finance costs,
44.1.9 amortization of start-up costs and organizational costs,
44.1.10 motor vehicle insurance,
44.1.11 facility's liability insurance, including malpractice costs and workers compensation,
44.1.12 administrator in training,
44.1.13 water & sewer fees necessary for the initial connection to a sewer system/water system,
44.1.14 portion of the acquisition cost for the rights to a nursing facility license.

See the explanations in Sections 44.2 - 44.10 for a more complete description of allowable costs in each of these cost centers.

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

44.2.1 Depreciation. Allowance for Depreciation Based on Asset Costs.
44.2.2 Identified and recorded in the provider's accounting records.
44.2.3 Based on historical cost and prorated over the estimated useful life of the asset using the straight-line method.
44.2.4 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 |

44.22 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.

44.23 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 lessor 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.

44.24 Special Reimbursement Provisions for Energy Efficient Improvements

44.24.1 For the Energy Efficient Improvements listed below which are made to existing facilities, depreciation will be allowed based on a useful life equal to the higher of the term of the loan received (only if the acquisition is financed) or the period by the limitations listed below:

CAPITAL EXPENDITURE
Up to $5,000.00 - Minimum depreciable period 3 years
From $5001.00-$10,000.00 - Minimum depreciable period 5 years
$10,000.00 and over - Minimum depreciable period 7 years

44.24.2 The above limitations are minima and if a loan is obtained for a period of time in excess of these minima the depreciable period becomes the length of the loan, provided that in no case shall the depreciable period exceed the useful life as spelled out in the American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets".

44.24.3 If the total expenditures exceeds $25,000.00, then prior approval for such an expenditure must be received in writing from the Department. A request for prior approval will be evaluated by the Department on the basis of whether such a large expenditure would decrease the actual energy costs to such an extent as render this expenditure reasonable. The age and condition of the facility requesting approval will also be considered in determining whether or not such an expenditure would be approvable.

44.24.4 The reasonable Energy Efficient Improvements are listed below:

1. Insulation (fiberglass, cellulose, etc.)
2. Energy Efficient Windows or Doors for the outside of the facility, including insulating shades and shutters.
3. Caulking or Weather stripping for windows or doors for the outside of the facility.
4. Fans specially designed for circulation of heat inside the building.
5. Wood and Coal burning furnaces or boilers (not fireplaces).
6. Furnace Replacement burners that reduce the amount of fuel used.
7. Enetrol or other devices connected to furnaces to control heat usage.
8. A Device or Capital Expenditures for modifying an existing furnace that reduces the consumption of fuel.
9. Solar active systems for water and space heating.
10. Retrofitting structures for the purpose of creating or enhancing passive solar gain, if prior approved by the Department regardless of amount of expenditure. A request for prior approval will be evaluated by the Department on the basis of whether energy costs would be decreased to such an extent as to render the expenditure reasonable. The age and condition of the facility requesting approval will be also considered.
11. Any other energy saving devices that might qualify as Energy Efficient other than those listed above must be prior approved by the Department for this Special Reimbursement provision. The Department will evaluate a request for prior approval under recommendations from the Division of Energy Programs on what other items will qualify as an energy efficient device and that the energy savings device is a reliable product and the device would decrease the energy costs of the facility making the expenditure reasonable in nature.

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

44.25 Recording of depreciation. Appropriate recording of depreciation encompasses the identification of the depreciable assets in use, the assets' historical costs, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation. The American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets" 1983 edition is to be used as a guide for the estimation of the useful life of assets.

44.25.1 For new buildings constructed after April 1, 1980 the minimum useful life to be assigned is listed below:

| | |
|---|---|
| Wood Frame, Wood Exterior | 30 years |
| Wood Frame, Masonry Exterior | 35 years |
| Steel Frame, or Reinforced Concrete Masonry Exterior | 40 years |

If a mortgage obtained on the property exceeds the minimum life as listed above, then the terms of the mortgage will be used as the minimum useful life.

44.25.2 For facilities providing two levels of care the allocation method to be used for allocating the interest, depreciation, property tax, and insurance will be based on the actual square footage utilized in each level of care. However, when new construction occurs that is added on to an existing facility the complete allocation based on square footage will not be used. Discrete costing will be used to determine the cost of the portion of the building used for each level of care and related fixed cost will be allocated on the basis of that cost.

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

44.27 Funding of depreciation. Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciation assets, and coordinate their planning of capital expenditures with area wide planning of activities of community and state agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

44.28 Replacement reserves. Some lending institutions require funds to be set aside periodically for replacement of fixed assets. The periodic amounts set aside for this purpose are not allowable costs in the period expended, but will be allowed when withdrawn and utilized either through depreciation or expense after considering the usage of these funds. Since the replacement reserves are essentially the same as funded depreciation the same regulations regarding interest and equity will apply.

44.28.1 If a facility is leased from an unrelated party and the ownership of the reserve rests with the lessor, then the replacement reserve payment becomes part of the lease payment and is considered an allowable cost in the year expended. If for any reason the lessee is allowed to use this replacement reserve for the replacement of the lessee's assets then during that year the allowable lease payment will be reduced by that amount. The Lessee will be allowed to depreciate the assets purchased in this situation.

44.28.2 If a rebate of a replacement reserve is returned to the lessee for any reason, it will be treated as a reduction of the allowable lease expense in the year review.

44.29 Gains and Losses on disposal of assets. Gains and losses realized from the disposal of depreciable assets are to be included in the determination of allowable costs. The extent to which such gains and losses are includable is calculated on a proration basis recognizing the amount of depreciation charged under the program in relation to the amount of depreciation, if any, charged or assumed in a period prior to the provider's participation in the program, and in the current period.

44.29.1 The recapture will be made in cash from the seller. During the first eight years of operation, all depreciation allowed on buildings and fixed equipment by the Department will be recaptured from the seller in cash at the time of the sale. From the 9th to the 15th year all but 3% per year will be recaptured and from the 16th to the 25th year, all but 8% per year will be recaptured, not to exceed 100%. Accumulated depreciation is recaptured to the extent of the gain on the sale.

44.29.2 The buyer must demonstrate how the purchase price is allocated between depreciable and non-depreciable assets. The cost of land, building and equipment must be clearly documented. Unless there is a sales agreement specifically detailing each piece of moveable equipment, the gain on the sale will be determined by the total selling price of all moveable equipment compared to the book value at the time of the sale. No credits are allowed on moveable equipment.

44.29.3 Accumulated depreciation is recaptured to the extend of the gain on the sale. In calculating the gain on the sale the entire purchase price will be compared to net book value unless the buyer demonstrates by an independent appraisal that a specific portion of the purchase price reflects the cost of non-depreciable assets.

44.29.4 Depreciation will not be recaptured if depreciable assets are sold to a purchaser who will not use the assets for a health care service for which future Medicare, Medicaid, or State payments will be received. The purchaser must use the assets acquired within five years of the purchase. The purchaser will be liable for recapture if the purchaser violates the provisions of this rule.

44.210 Limitation on the participation of capital expenditures. Depreciation, interest, and other costs are not allowable with respect to any capital expenditure in plant and property, and equipment related to patient care, which has not been submitted to the designated planning agency as required, or has been determined to be consistent with health facility planning requirements.

44.3 Purchase, Rental, Donation and Lease of Capital Assets

44.3.1 Purchase of facilities from related individuals and/or organization Where a facility, through purchase, converts from a proprietary to a nonprofit status and the buyer and seller are entities related by common and/or ownership, the purchaser's basis for depreciation shall not exceed the seller's basis under the program, less accumulated depreciation if the following requirements are met:

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

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

(1) a child

(2) a grandchild

(3) a brother or sister

(4) a spouse of a child, grandchild, or brother or sister, or

(5) an entity controlled by a child, grandchild, brother, sister or spouse of child, grandchild or combination brother or sister thereof; or

44.3.1.2 Accumulated depreciation of the seller under the program shall be considered as incurred by the purchaser for purposes of computing gains and applying the depreciation recapture rules Subsection 44.29 to subsequent sales by the buyer. There will be no recapture of depreciation from the seller on a sale between stipulated related parties since no set-up in the basis of depreciable assets is permitted to the buyer.

44.3.1.3 One-time exception to subsection 44.3.1.2 At the election of the seller, subsection 44.3.1.1 will not apply to a sale made to a buyer defined in subsection 44.3.1.2 if:

(a) the seller is an individual or any entity owned or controlled by individuals or related individuals who were selling assets to a "related party" as defined in subsection 44.3.1.1 or 44.3.1.2, and

(b) the seller has attained the age of 55 before the date of such sale or exchange; and

(c) during the twenty-year period ending on the day of the sale, the seller has owned and operated the facility for periods aggregating ten years or more; and

(d) the seller has inherited the facility as property of a deceased spouse to satisfy the holding requirements under subsection 44.3.1.3c

(e) if the seller makes a valid election to be exempted from the application of 44.3.1.2 the allowable basis of depreciable assets for reimbursement of interest and depreciation expense to the buyer will be determined in accordance with the historical cost as though the parties were not related. This transaction is subject to depreciation recapture if there is a gain on the sale.

44.3.1.4 The one exception to subsection 44.3.1.2 applies to individual owners and not to each facility. If an individual owns more than one facility he must make the election as to which facility he wished to apply this exception to.

44.3.1.5 Limitation in the application of subsection 44.3.1.3

44.3.1.5.1 Subsection 44.3.1.3 shall not apply to any sale or exchange by the seller if an election by the seller under subsection 44.3.1.3 with respect to any other sale or exchange has taken place.

44.3.1.5.2 Subsection 44.3.1.3 shall not apply to any sale or exchange by the seller unless the seller:

44.3.1.5.2.1 immediately after the sale has no interest in the nursing home (including an interest as officer, director, manager or employee) other than as a creditor, and

44.3.1.5.2.2 does not acquire any such interest within 10 years after the sale of this or any other facility and

44.3.1.5.2.3 agrees to file an agreement with the Department of Human Services to notify the Department that any acquisition as defined by the subsection 44.3.1.5.2.2 has occurred.

44.3.1.6 If subsection 44.3.1.5.2 is satisfied, subsection 44.3.1.1 and subsection 44.3.1.2 will also be satisfied.

44.3.1.7 If the seller acquires any interest defined by subsection 44.3.1.5.2.2, then pursuant to the agreement the basis will revert to what the seller's basis would be if the seller had continued to own the facility, the amounts paid by the Title XIX program for depreciation, interest and return of owner's equity from the increase in basis will be immediately recaptured, and an interest rate of

nine percent per annum on recaptured moneys will be paid to the Department for sellers' use of Title XIX moneys. A credit against this, of the original amount of depreciation recapture from the seller, will be allowed, with any remaining amount of the original depreciation recapture becoming the property of the Department.

44.3.2 Basis of assets used under the program and donated to a provider. Where an asset that has been used or depreciated under the program is donated to a provider, the basis of depreciation for the asset shall be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program. The net book value of the asset is defined as the depreciable basis used under the program by the asset's last participating owner less the depreciation recognized under the program.

44.3.3 Allowances for depreciation on assets financed with Federal or Public Funds. Depreciation is allowed on assets financed with Hill Burton or other Federal or Public Funds.

44.4 Leases And Operations Of Limited Partnerships

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

44.4.1.1 A copy of the signed lease agreement is required.

44.4.1.2 An annual copy of the federal income tax return of the lessee will be made available to Representatives of the Department and of the U.S. Department of Health and Human Services in accordance with Section 27.

44.4.1.3 If the lease is for the use of a building and/or fixed equipment, the articles and bylaws of the corporation, trust indenture partnership agreement, or limited partnership agreement of the lessor is required.

44.4.1.4 If the lease is for the use of a building and/or fixed equipment, the annual federal income tax return of the lessor will be made available to representatives of the Department and the U.S. Department of Health and Human Services in accordance with section 27.

44.4.1.5 A copy of the mortgage or other debt instrument of the lessor will be made available to representatives of the Department and the U.S. Department of Health and Human Services. The lessor will furnish the Department of Human Services a copy of the bank computer printout sheet on the lessor's mortgage showing the monthly principle and interest payments.

44.4.1.6 The lease must be for a minimum period of 25 years if an unrelated organization is involved. If the lessor was to sell the property within the 25 year period to a nursing home operator or the lessee, the historical cost for the new owner would be determined in accordance with the definition of historical costs, and the portion of the lease payment made in lieu of straight line depreciation will be recaptured in accordance with subsection 44.29.

44.4.2 Lease Arrangements Between Individuals or Organizations Related by Common Control and/or Ownership. A provider may lease a facility from a related organization within the meaning of the Principles of Reimbursement. In such case, the rent paid to the lessor by the provider is not allowed as a cost. The provider, however, would include in its costs the costs of ownership of the facility. Generally, these would be costs of the lessor such as depreciation, interest on the mortgage, real estate taxes and other expenses attributable to the leased facility. The effect is to treat the facility as though it were owned by the provider.

44.4.3 Leased Arrangement Between Individuals or Organizations Not Related by Common Control or Ownership. A provider may lease a facility from an unrelated organization within the meaning of the Principles of Reimbursement. The allowable cost between two unrelated organizations is the lesser of:

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

44.4.3.2 The actual lease payments made by the lessee to the lessor.

44.4.3.3 The above principle applies unless the lessor refinances and reduces the cost of ownership below the cost of lease payments and the lessee remains legally obligated to make the same lease payment despite the refinancing. This limitation of the general rule shall not apply to any lease entered into, renewed, or renegotiated after January 1, 1990. If this limitation applies, the allowable cost shall be the actual lease payments made by the lessee to the lessor.

44.4.3.4 If the cost as defined in subsection 44.4.3.2 are less than the costs as defined in subsection 44.4.3.1, then the difference can be deferred to a subsequent fiscal period. If in a later fiscal period, costs as defined in section 44.4.3.2 exceed costs as defined in section 44.4.31, the deferred costs may begin to be amortized. Amortization will increase allowable costs up to the level of the actual lease payments for any given year. These deferred costs are not assets of the provider for purposes of calculating allowable costs of interest or return of owners equity and, except as specified, do not represent assets that a provider or creditor of a provider may claim is a monetary obligation from the Title XIX program.

44.4.3.5 A lease payment to an unrelated party for moveable furnishings and equipment is an allowable cost, but it shall be limited to the cost of ownership.

44.4.4 Sale and Leaseback Agreements-Rental Charges. Rental costs specified in sale and leaseback agreements incurred by providers through selling physical plant facilities or equipment to a purchaser not connected with or related to the provider, and concurrently leasing back the same facilities or equipment, are includable in allowable cost.

However, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs, had he retained legal title to the facilities or equipment, such as interest on mortgage, taxes, depreciation, insurance and maintenance costs.

44.5 Interest Expense

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

44.5.2 Interest. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the costs incurred for funds borrowed for a relatively short term, usually one (1) year or less, but in no event more than fifteen (15) months. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans. Except as provided in subsection 44.5.4.6, interest does not include interest and penalties charged for failure to pay accounts when due.

44.5.3 Necessary. In order to be considered "necessary", interest must:

44.5.3.1 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

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

44.5.3.3 Proper. Proper requires that interest:

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

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

44.5.3.4 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.

44.5.4 Borrower-lender relationship

44.5.4.1 To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement with higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arm's-length transactions with lending institutions. The 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. However, interest on first or second mortgages held by stockholders, owners, relatives or related organizations of the provider, will be treated as an allowable cost if it is in line with the interest rates charged by lending institutions at the inception of the loan. 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.

44.5.4.2 Exceptions to the general rule regarding interest on loans from controlled sources of funds. Where the general fund of a provider borrows from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money borrowed from the funded depreciation account of the provider. In addition, if a provider of a facility operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost. Interest paid by the provider cannot exceed interest earned by the above subject funds.

44.5.4.3 Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, or payment of long-term debt principle once the principle payment exceeds the straight-line depreciation allowed under the Principles of Reimbursement, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation.

44.5.4.4 Loans not reasonably related to patient care. Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost are not considered to be for a purpose reasonably related to patient care.

44.5.4.5 Interest expense of related organizations. Where a provider leases facilities from a related organization and the rental expense paid to related organization is not allowable as a cost, costs of ownership of the leased facility are allowable as in interest cost to the provider. Therefore, in such cases, mortgage interest paid by the related organization is allowable as an interest cost to the provider.

44.5.4.6 Interest on Property Taxes. Interest charged by a municipality for late payment of property taxes is an allowable cost when the following conditions have been met:

44.5.4.6.1 The rate of interest charged by the municipality is less than the interest which a prudent borrower would have had to pay in the money market existing at the time the loan was made;

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

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

44.5.4.6.4 Approval in writing has been given by the Department prior to the time period in which the interest is incurred. Any requests for prior approval must be received by the Department at least two weeks prior to the desired effective date of the approval.

44.5.4.7 Limitation on the participation of capital expenditures. Interest is not allowable with respect to any capital expenditure in plant and property, and equipment related to patient care, which did not receive a required Certificate of Need Review approval.

44.5.5 The Department will make adjustments to the nursing facility's fixed cost component of the per diem rate to reflect the effect of refinancing which results in lower interest payments.

44.6 Return on Equity Capital of Proprietary Providers

44.6.1 Principle. A reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to the beneficiaries by proprietary providers. The amount on an annual basis is eight percent (8%).

44.6.2 For purposes of this subpart, the term "propriety providers" means providers, whether sole proprietorships, partnerships or corporations organized and operated with the expectation of earning profits for the owners, as distinguished from providers organized and operated on a non-profit basis.

44.6.3 For the purpose of computing the allowable return, the provider's equity capital means:

44.6.3.1 The provider's investment in plant and property and equipment related to patient care (net of depreciation) and funds deposited by a provider who leases plant, property, or equipment related to patient care and is required by the terms of the lease to deposit such funds (net or noncurrent debt related to such investment or deposited funds) and,

44.6.3.2 Net working capital maintained for necessary and proper operation of patient care activities.

44.6.3.3 Notwithstanding anything in Subsection 44.6.3.1 and 44.6.3.2 debt representing loans from partners, stockholders, or related organizations, on which interest payments would be allowable as costs but for Subsection 44.5.4.1 is included in computing the amount of

equity capital in order that the proceeds from such loans be treated as a part of the provider's equity capital. In computing the amount of equity capital upon which a return is allowable, investment in facilities is recognized on the basis of the historical cost.

44.6.4 Acquisitions. For facilities or tangible assets acquired, the excess of the purchase price paid for a facility or assets over (1) the historical cost of the tangible assets, or (2) the cost basis of the tangible asset, whichever is applicable, is not includable in the computation of equity capital. Loans made to finance such excess portion of the cost of such acquisitions are similarly not includable in the computation of equity capital.

44.6.5 Computation of return on equity capital. For purposes of computing the allowable return, the amount of equity capital is the average investment during the reporting period. Return on investment as an element of allowable costs is subject to apportionment in the same manner as other elements of allowable costs.

44.6.6 Unapproved capital expenditures. With respect to any capital expenditure, a provider's investment in plant, property and equipment related to patient care, and funds deposited by a provider which leases plant, property, or equipment related to patient care which are found to be expenditures which have not been submitted to the designated planning agency as required, or have been determined to be inconsistent with health facility planning requirements, are not included in the provider's equity capital for computing the allowance for a reasonable return on equity capital.

44.6.7 Exclusion from Computation of Average Equity Capital. For the purpose of computing average equity capital, the following are examples of items not to be included in the computation:

44.6.7.1 Notes and loans receivable from owners or related organizations.

44.6.7.2 Goodwill.

44.6.7.3 Unpaid capital surplus.

44.6.7.4 Treasury Stock.

44.6.7.5 Unrealized capital appreciation surplus.

44.6.7.6 Cash surrender value of life insurance policies.

44.6.7.7 Prepaid premiums on life insurance policies.

44.6.7.8 Assets acquired in anticipation of expansion and not presently used in the provider's operation or in the maintenance of patient care activities during the rate period.

44.6.7.9 Inter-company accounts.

44.6.7.10 The portion of the value of any motor vehicle that is attributed to personal use.

44.6.7.11 Any other assets not directly related to or necessary for the provision of patient care to publicly-aided patients.

44.6.7.12 Funded Depreciation.

44.6.7.13 Accrued interest on related party loans and cash invested in money market accounts or savings accounts for a period of over six months.

44.7 Worker's Compensation Insurance premiums paid to an admitted carrier; application fees, assessments and premiums paid to an authorized fully-funded trust; and premiums paid to an individual self-insured program approved by the State of Maine for facility fiscal years that began on or after October 1, 1992, and deductibles paid by facilities related to such cost are allowable fixed costs. Estimated amounts for workers compensation insurance audit premiums will not be accepted as an allowable cost. The Department will require the facility to be a prudent and cost conscious buyer of worker's compensation insurance. In those instances where the Department finds that a facility pays more than the usual and customary rate or does not try to minimize costs, in the absence of clear justification, the Department may exclude excess costs in determining allowable costs under Medicaid. Allowable costs are subject to an experience modifier of 1.4; that is, cost associated with an experience modifier of 1.4 or under are allowable. Workers compensation costs incurred above the experience modifier of 1.4 shall be considered unallowable and will be settled at time of audit.

44.7.1 The costs of Loss-Prevention and Safety Services are allowable costs to a maximum of $40.00 per covered employee per year for nursing facilities with an experience modifier greater than .9. The costs of Loss-Prevention and Safety Services are allowable costs to a maximum of $70.00 per covered employee per year for nursing facilities with an experience modifier equal to or less than .9. Allowable costs shall include the cost of educational programs and training classes, transportation to and from those classes, lodging when necessary to attend the classes, materials needed in the preparation and presentation of the classes (when held at the nursing facility), and equipment (e.g.: lifts) which lead towards accomplishing the established goals and objectives of the facility's safety program. Non-allowable costs include salaries paid to individuals attending the safety classes and personal gifts such as bonuses, free passes to events or meals, and gift baskets.

44.7.2 The wages and fringes paid to workers engaged in formal Modified or Light-Duty Early-Return-To-Work Programs are allowable costs only to the extent that they cause a nursing facility to exceed its staffing pattern. Rehabilitation eligibility assessments are a cost to a limit of $300.00 per indemnity claimant. (Rehabilitation services provided to eligible injured workers are to be paid for by their employers insurer.)

44.8 Administrator in Training. The reasonable salary of an administrator in training will be accepted as an allowable cost for a period of six months provided there is a set policy, in writing, stating the training program to be followed, position to be filled, and provided that this individual obtain an administrator's license and serve as an administrator of a facility in the State of Maine. Prior approval in writing, from the Department, must be issued in advance of the date of any salary paid to an administrator in training. A request for prior approval must be received by the Department at least two (2) weeks prior to the desired effective start date of the administrator in training program. Failure to receive approval from the Department for the Administrator in Training salary will deem that salary an unallowable cost at time of audit. Failure to become an administrator within one year following completion of the examination to become a licensed administrator will result in the Department of 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.

44.9 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.
44.10 Occupancy Adjustment. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of ninety percent (90%). The 90% occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after 7/1/95, and shall be cost settled at the time of audit. For all new providers coming into the program, the 90% 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. 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 first 30 days of operation. It will, however, apply to the remaining months of their initial operating period.

50 PUBLIC HEARING
The State of Maine will provide for public hearings as necessary in our State Plan, according to State procedures.

60 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.

70 SPECIAL SERVICE ALLOWANCE
70.1 Principle. A special ancillary service is to be distinguished from a service generally provided in the nursing facility.
70.1.1 A special ancillary service is that of an individual nature required in the case of a specific patient. This type of service is limited to professional services such as physical therapy, occupational therapy, and speech and hearing services. Special services of this nature must be billed monthly to the Department as separate items required for the care of individual recipients.

71 OMNIBUS RECONCILIATION ACT OF 1987 (OBRA 87)
OBRA 1987 has eliminated the distinction between ICFs and SNFs and the method of payment by such classifications. The statute provides for only one type of nursing facility. All nursing homes are now classified as a "nursing facility" with a single payment methodology.

80 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE
80.1 Principle. For facility fiscal years beginning on or after July 1, 1995 the Department will establish a prospective per diem rate to be paid to each facility until the end of its fiscal year. Each nursing facility's cost components for the fiscal year that begins on or after October 1, 1992, as determined from the audited cost report (or as filed cost report until an audit is completed) will be the basis for the base year computations (subject to upper limits).
The base year direct, indirect and routine patient care cost component costs will be trended forward using the inflationary factors from the table "HCFA Nursing Home Without Capital Market Basket" from the publication Health Care Costs published by DRI/McGraw-Hill as described in Section 91. Inflation factor data for salaries will be acquired from the Maine Health Care Facility Economic Trend Factor. The inflation factors will be based on the most recent DRI publications available at the times the rates are determined. Beginning October 1, 1993 the determination of the direct care cost component of each facility's base year rate will be computed by calculating the facility's case mix adjusted cost per day pursuant to Section 80.3. The 1992 (fiscal year beginning on or after 10/1/92) base year indirect component costs, will be used to compute the median costs, upper limits and incentive payments that will be the basis for computing each facility's rate. The 1992 fiscal year (beginning on or after 10/1/92) routine care component costs, adjusted for the 1993 statewide average accounting fees, will be the basis for computing the median routine care component costs and upper limits that will be the basis for computing each facility's rate. The nursing facility's direct, indirect and routine cost components allowable rate will be inflated to the end of the nursing facilities current fiscal year. The prospective rate shall consist of four components : the direct patient care cost component as defined in Section 41; the indirect patient care cost component as defined in Section 42, the routine cost component as defined in Section 43, and the fixed cost component as defined in Section 44.
80.2 FIXED COST COMPONENT
The fixed cost component shall be determined from the most recent audited or, if more recent information is approved by the Department, it shall be based on that more recent information using allowable costs as identified in Section 44. As described in Section 44, fixed costs will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to fixed costs shall be based upon a theoretical level of occupancy of ninety percent (90%). For all new providers coming into the program, the 90% occupancy adjustment will not apply for the first 30 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 first 30 days of operation. It will, however, apply to the remaining months of their initial operating period.

80.3 DIRECT PATIENT CARE COST COMPONENT

80.3.1 Case Mix Reimbursement System

80.3.1.1 The direct resident 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 45 case mix resident classification groups, including one resident classification group used when residents can not be classified into one of the 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 VERY HI/ADL 14-18 | 2.171 |
| REHAB VERY HI/ADL 8-13 | 1.605 |
| REHAB VERY HI/ADL 4-7 | 1.427 |
| REHAB HI/ADL 15-18 | 2.022 |
| REHAB HI/ADL 12-14 | 1.623 |
| REHAB HI/ADL 8-11 | 1.491 |
| REHAB HI/ADL 4-7 | 1.350 |
| REHAB MED/ADL 16-18 | 1.886 |
| REHAB MED/ADL 8-15 | 1.426 |
| REHAB MED/ADL 4-7 | 1.337 |
| REHAB LOW/ADL 12-18 | 1.350 |
| REHAB LOW/ADL 4-11 | 1.202 |
| EXTENSIVE | |
| EXTENSIVE 3/ADL 7-18 | 3.968 |
| EXTENSIVE 2/ADL 7-18 | 2.424 |
| EXTENSIVE 1/ADL 7-18 | 1.673 |
| SPECIAL CARE | |
| SPECIAL CARE/ADL 17-18 | 1.534 |
| SPECIAL CARE/ADL 14-16 | 1.375 |
| SPECIAL CARE/ADL 7-13 | 1.279 |
| CLINICALLY COMPLEX | |
| CLIN. COMP W/DEP/ADL 17-18 | 1.356 |
| CLIN. COMP ADL 17-18 | 1.323 |
| CLIN. COMP W/DEP/ADL 11-16 | 1.193 |
| CLIN. COMP/ADL 11-16 | 1.128 |
| CLIN. COMP W/DEP/ADL 6-10 | 1.127 |
| CLIN. COMP/ADL 6-10 | 0.996 |
| CLIN. COMP W/DEP/ADL 4-5 | 0.958 |
| CLIN. COMP/ADL 4-5 | 0.799 |
| IMPAIRED COGNITION | |
| COG. IMPAIR W/RN REHAB/ADL 6-10 | 1.021 |
| COG. IMPAIR/ADL 6-10 | 0.919 |
| COG. IMPAIR W/RN REHAB/ADL 4-5 | 0.794 |
| COG. IMPAIR/ADL 4-5 | 0.688 |
| BEHAVIOR PROBLEMS | |
| BEHAVE PROB W/RN REHAB/ADL 6-10 | 1.021 |
| BEHAVE PROB/ADL 6-10 | 0.900 |
| BEHAVE PROB W/RN REHAB/ADL 4-5 | 0.715 |
| BEHAVE PROB/ADL 4-5 | 0.610 |
| PHYSICAL FUNCTIONS | |
| PHYSICAL W/RN REHAB/ADL 16-18 | 1.145 |
| PHYSICAL/ADL 16-18 | 1.099 |
| PHYSICAL W/RN REHAB/ADL 11-15 | 1.076 |
| PHYSICAL/ADL 11-15 | 1.008 |
| PHYSICAL W/RN REHAB/ADL 9-10 | 0.918 |
| PHYSICAL/ADL 9-10 | 0.896 |

| | |
|---|---|
| PHYSICAL W/RN REHAB/ADL 6-8 | 0.807 |
| PHYSICAL/ADL 6-8 | 0.716 |
| PHYSICAL W/RN REHAB/ADL 4-5 | 0.686 |
| PHYSICAL ADL 4-5 | 0.563 |
| UNCLASSIFIED | 0.563 |

80.3.3 Base Year Direct Resident Care Cost Component

80.3.3.1 Source of base year cost data. The source for the direct resident care cost component of the base year cost data is the audited cost report (as filed cost report until an audit is completed) for the nursing facilities fiscal year beginning on or after October 1, 1992. At the point of time that audited report data is available for the base year, the nursing facility rate for subsequent quarters will be based on those figures. Recalculation of the upper limits shall not occur until subsequent rebasing of all components occurs.

80.3.3.2 Case Mix Index

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

(a) For each facility the number of Medicaid residents in each case mix classification group shall be determined from the most recent MDS completed for all residents as of March 31, 1993.

(b) For each facility, the Bureau will multiply the number of Medicaid residents in each case mix classification group excluding the residents 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 Medicaid residents excluding the residents in the unclassified group equals the facility's case mix index.

80.3.3.3 Base year case mix adjusted Medicaid cost per day

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

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

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

For each peer group, the Bureau shall array all nursing facilities case mix adjusted costs per day inflated to June 30, 1995 from high to low and identify the median.

Facilities that have level A deficiencies cited by the Division of Licensing and Certification in the base year are excluded from the array for purposes of identifying the median.

80.3.3.5 Limits on the base year case mix adjusted cost per day

The upper limit on the base year case mix adjusted cost per day shall be the median plus fifteen per cent (15%). The upper limit on the base year case mix adjusted cost per day shall be the median plus twelve per cent (12%) for the facilities fiscal year that begins on or after July 1, 1995.

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

80.3.4 Quarterly Calculation of the Direct Resident Care Component

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

80.3.4.1 Calculation of the case mix index

The Bureau of Medical Services shall compute each facility's case mix index for the rate period as follows:

For each facility the number of Medicaid residents in each case mix classification group shall be determined from the assessment date on the MDS on all Medicaid 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 Medicaid residents with an assessment date of June 15.)

For each facility, the Bureau will multiply the number of Medicaid 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 Medicaid residents equals the facility's case mix index. The roster sent 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 receiving the roster and submit such corrections to the Department or it's designee.

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 Medicaid 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 resident care rate per day

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

80.3.4.3 The direct cost, as defined in Section 41, shall be determined by adjusting the allowable necessary and reasonable direct patient care costs (subject to the limitations cited in Section 41) from the base year by the inflationary factor defined in Section 91.

80.3.5 Direct Patient Care Cost Savings. Managers of facilities who operate in an efficient and economical manner and thereby limit their direct patient care costs during their fiscal year to less than the amounts paid through the direct patient care cost component of the final prospective rate will share with the Department in the resulting savings the resulting savings.

For fiscal years beginning on or after July 1, 1995 direct patient care cost savings will result in the facility retaining 25% of this savings as long as residents needs are determined to be met and the facilities comply with all relevant state and federal requirements.

Facilities which incur direct patient care costs during their fiscal year in excess of the direct patient care cost component of the prospective rate will receive no more than the amount allowed by the prospective rate.

80.4 INDIRECT PATIENT CARE COST COMPONENT

Indirect Care Patient Care Cost component base year rates shall be computed as follows:

80.4.1 Using each facility's base year (fiscal year beginning on or after 10/1/92) cost report, the provider's base year total allowable Indirect Patient Care costs shall be determined in accordance with Section 42.

80.4.2 The base year per diem allowable Indirect Patient Care costs for each facility shall be calculated by dividing the base year total allowable indirect patient care costs by the total base year resident days.

80.4.3 The Bureau of Medical Services will array all nursing facility's base year per diem allowable Indirect Patient Care costs adjusted to a common fiscal year by the appropriate inflationary factor, from low to high and identify the median.

80.4.4 The per diem limit shall be the median plus 10 percent for facilities fiscal year beginning on or after July 1, 1995.

80.4.5 Each facility's Base Year Indirect Patient Care cost per diem rate shall be the lesser of the limit set in subsection 80.4.4 or the facility's base year per diem allowable indirect patient care costs.

80.5 ROUTINE CARE COST COMPONENT

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

80.5.1 Using each facility's base year (fiscal year beginning on or after 10/1/92) cost report, the provider's base year total allowable routine care 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 Bureau of Medical Services will array all nursing facility's base year per diem allowable routine costs adjusted to a common fiscal year by the appropriate inflationary factor, from low to high and identify the median.

80.5.4 The per diem limit shall be the median plus 8 percent for fiscal year beginning on or after July 1, 1995.

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.

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 Medicaid 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, indirect 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 Bureau of Medical Services (also see Section 44.25.2).

80.6.1.1 For a facility sold after October 1, 1993, the direct, indirect 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 Medicaid 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 Bureau of Medical Services.

80.6.2 Nursing facility's not required to file a certificate of need application, currently participating in the Medicaid 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 facility's 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, 42.1, 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.

80.7 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 pro forma step down cost report for the year in which the bed conversion will take place or the first full fiscal year in which the facility will operate with both nursing facility and residential care facility levels of care will be submitted to the Bureau of Elder and Adult Services and to the Division of Reimbursement and Financial Services of the Bureau of Medical 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 97% occupancy level, whichever is greater. For conversions with an effective date of July 1, 1998 or after, 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, indirect, and routine care cost components will be inflated forward to the end of the fiscal year of the pro forma cost report submitted as required in Section 80.71.1.

80.71.6 The reimbursement rates set, as stated in Sections 80.71.1 -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, indirect, and routine components will be inflated to the current year, subject to the peer group cap.

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.
80.71.8 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 indirect and 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.

82 FINAL PROSPECTIVE RATE.
Upon final audit of all nursing facility's base year cost reports, the Department will determine a final prospective rate. The final prospective rate will be used as the basis for determining any adjustment that is required to adjust the computation of the median and upper limits for the indirect cost and routine cost components for subsequent fiscal years.
82.1 Adjustments to the Median Base Year and Upper Limit Computation for the Indirect and Routine Cost Components. The Department of Human Services in computing the base year median and upper limits for the routine and indirect cost components will rely on the most recent available data from cost report data files. To the extent that the data on this file is unaudited data, the computation will be recomputed when base year audits on all nursing facilities have been settled to determine the variance between the initial computations and the audited data computations. If the variance is material (+ or - 1%) the rates in a subsequent period following the recalculation of the median will be adjusted to reflect the audited data.
82.2 A cost report is settled if there is no request for reconsideration of the Division of Audits 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.

84 FINAL AUDIT OF FIRST AND SUBSEQUENT PROSPECTIVE YEARS.
84.1 Principle. All facilities will be required to submit a cost report in accordance with Section 32 at the end of their fiscal year on cost report forms approved by the Department. The Department will conduct a final audit of each facility's cost report, which may consist of a full scope examination by Department personnel and which will be conducted on an annual basis.
84.2 Upon final audit of a facility's cost report for the first and subsequent prospective years, the Department will:
84.2.1 determine the actual allowable fixed costs incurred by the facility in the prior fiscal year,
84.2.2 determine the occupancy levels of the nursing facility,
84.2.3 The Division of Audit can make determinations required to implement these Principles of Reimbursement. The following are examples of such determinations:
84.2.3.1 Savings for the direct patient care cost component, to be determined by computing the difference between the actual costs and the direct patient care cost component rates paid during the facilities year.
84.2.3.2 Nursing facilities that transfer a cost center from one cost component to another cost component resulting in increased Medicaid costs will have the affected cost components adjusted at time of audit.
84.2.3.3 calculate a final rate,
84.2.3.4 calculate any adjustments necessary to the current prospective rates for all nursing facility's based on the above determination, and
84.2.3.5 after adjusting for the base year audited cost reports specified in 82.1 above, subsequent fiscal years costs in the indirect and routine cost components will only be adjusted for inflation using the factors specified in Section 91 of these Principles.
Upon final audit of a facility's cost report, the Department will calculate a final prospective rate and determine the lump sum settlement amounts either due to or from the nursing facility.
84.2.4 The Division of Audit final audit adjustment to the nursing facilities annual cost report will consider the impact of days waiting placement as specified in the Principles of Reimbursement for Residential Care Facilities. Fixed cost reimbursement for the nursing facility will not be affected by days waiting placement reimbursement to the nursing facilities.

85 SETTLEMENT OF FIXED EXPENSES
85.1 The Department will reimburse facilities for the actual allowable fixed costs which are incurred during a fiscal year. Upon final audit of a facility's cost report, if the Department's share of the allowable fixed costs actually incurred by the facility is greater than the amount paid by the Department (the fixed cost component of the final prospective rate multiplied by the number of days of care provided to Medicaid beneficiaries), the difference will be paid to the facility by the Department. If, the Department's appropriate share of the allowable fixed costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.
85.2 Federal regulations state that during the first year of implementing the nursing home reform requirements, the new costs which a facility must incur to comply with these requirements will be treated as a fixed cost. The facility must maintain the appropriate documentation in order for these costs to be identified at the time of the facility's final audit.
The cost associated with meeting the Nursing Home Reform Act of 1987 requirements will continue to be treated as a fixed cost through the facility's first full fiscal year after September 30, 1991 and will not be included in the determination of incentive payments which the facility might be entitled to receive as a result of its performance during that year. Thereafter, the cost associated with implementing the Nursing Home Reform Act of 1987 will be considered in the appropriate cost component and will be added to the facility's final prospective rate.

Upon final audit of a facility's cost report, if the Department's share of the allowable OBRA costs actually incurred by the facility is greater than the amount paid by the Department, the Department will pay the facility the difference. If on the other hand, the Department's appropriate share of the allowable OBRA costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.

86 ESTABLISHMENT OF PEER GROUP AND INCENTIVE PAYMENTS

86.1 Establishment of Peer Group. All Nursing care facilities will be included in one of two peer groups. Hospital based nursing facilities (excluding governmental institutions) will comprise one peer group, all other nursing facilities will be included in the second peer group. Please refer to Appendix C for a description of a hospital based nursing facility. It should be noted that the establishment of these two peer groups in developing a payment model is not an accepted model in determining the upper limits as established by Federal Statute. The Federal Statute recognizes free standing nursing facilities in determining the upper limit. The upper limit for hospital based facilities is based on one-half the routine costs of freestanding facilities and one-half the costs of hospital based facilities. Therefore, the appropriate Medicare upper limit test will be applied to all nursing facilities.

86.2 The relationship between each facility's direct, indirect and routine allowable cost per day as determined in Section 80 of these Principles and those of its peers will be determined once a year. The peer groups will form the basis for determining the median indirect and routine costs. The peer groups will be subject to the same upper limits.

87 SECOND AND SUBSEQUENT YEAR FINAL PROSPECTIVE RATE.

Upon final audit of a facility's cost report, the Department will calculate a final prospective rate and determine the lump sum settlement amounts either due to or from the nursing facility.

"Second and Subsequent Year" for purpose of this section shall mean the second full twelve (12) month fiscal year of the facility's operation following implementation of the October 1,1992 Principles of Reimbursement.

88 CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS.

Upon determination of the final rate as outlined in section 84 above, the Department will calculate the net amount of any overpayments or underpayments made to the facility.

If the Department determines that it has underpaid a facility, the Department will estimate the amount due and forward the result to the facility within thirty days. If the Department determines that it has overpaid a facility, the Department will so notify the facility. Facilities will pay the total overpayment within sixty (60) days of the notice of overpayment or request the Department to reduce facility payments during the balance of its fiscal year by the amount of the overpayment. Facilities that do not notify the Department of the method by which they intend to repay the overpayment will, beginning 60 days after their receipt of the notice of overpayment, have their subsequent payments from the Department reduced by the amount of overpayment.

If a facility appeals a determination of overpayment, the facility must repay within sixty (60) days of the notice of overpayment all portions of the determined overpayment except those that are expressly disputed and for which specific dollar values are identified. Repayment of each such specifically disputed portion and identified amount shall be stayed pending resolution of the dispute with respect thereto. The amount of money in dispute must be identified in the manner outlined in Section 150.

The net amount of any over or underpayment made to the facility will be based on 1) the calculation of actual fixed expenses incurred in the prior year, 2) the amount of savings, if any, earned by a facility and 3) the estimated difference in amount due or paid based on the interim versus final prospective rate.

89 BEDBANKING OF NURSING FACILITY BEDS

89.1 Any bedbanking request must be submitted to the Department for review by the Bureau of Elder and Adult Services and the Bureau of Medical Services. Nursing facilities are permitted to bank nursing facility beds, according to the guidelines contained in Title 22, Section 304, providing the space left vacant in the facility is not used for the creation of private rooms. In addition to those guidelines, a floor plan must be submitted to the Bureau of Elder and Adult Services which describes the intended use of the banked bed spaces. This floor plan will be reviewed by the Department. Reimbursement of costs associated with the banked beds will be allowed to the extent that such costs have been approved by the Department. Reasons that the Department may deny the space as reimbursable under these Principles includes, but is not limited to, the following:

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

89.12 the proposed purpose of the use of the space has already been designated by other space within the facility and this would constitute duplication of use,

89.13 the proposed use of the space is not deemed to be in the best interest of the physical, emotional, and safety needs of the residents (In this case, a recommendation by the Department may be made for an alternative use of the space).

89.2 Pursuant to Title 22, Section 304, the following cost components shall be decreased by a percentage equal to the percentage of bed days decreased by the banking of the beds. Total bed days used to calculate this percentage will be the audited days (as filed if audited days are not available) from the base year cost report. (e.g. If a facility decreased the number of beds by 25%, and the total bed days in the base year equals 40000 and the facility was at 90% occupancy = 36000 days, then the bed days used in the calculation of the rate after the bedbanking would equal 90% of 30000 days or 27000 days.) This percentage decrease would be used in the calculation of the new rate for the following cost components based on what the total audited costs (as filed, if audited costs are not available) in the base year:

89.21 Indirect Patient Care Cost Component

89.21.1 Food Costs

89.21.2 Medical Supplies

89.22 Routine Cost Component
89.22.1 Administrative and Management Ceiling.
89.22.2 Housekeeping Supplies
89.22.3 Laundry Supplies
89.22.4 Dietary Supplies
89.22.5 Patient Activity Supplies
89.22.6 Medicine and Drugs

89.3 Direct Patient Care Cost Component - The Direct Patient Care Cost Component will be decreased, subject to Licensing and Certification Regulations, by a percentage equal to 50% of the total percentage decrease based on the audited costs (as filed, if audited costs are not available) in the base year for the following areas:

89.31 RNs
89.32 LPNs
89.33 CNAs, CMAs
89.34 Contract Nursing
89.35 Payroll Benefits and taxes for 89.31 through 89.34

(e.g. Using the example in 89.2 of a 25% decrease, if the total audited costs (as filed, if audited costs are not available) of the RNs, LPNs, CNAs, CMAs, Contract Nursing, and benefits and taxes were $400,000 in the base year, the allowable costs for this component would be reduced by $50,000 or 12.5%. The ratio of labor costs to benefits and taxes as contained in the base year cost report would be used in the determination of the amounts decreased in each of those areas.)

90 DECERTIFICATION/DELICENSING OF NURSING FACILITY BEDS

90.1 Pursuant to Title 22, Section 304, any request for delicensing/decertification of nursing facility beds must be submitted to the Department for review by Bureau of Medical Services. In addition to those guidelines, a floor plan must be submitted to the Bureau of Medical Services which describes the intended use, if any, of the space that the beds previously occupied. This floor plan will be reviewed by the Department. Reasons that the Department may deny the space as reimbursable under these Principles includes, but is not limited to, the following:

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

90.12 the proposed purpose of the use of the space has already been designated by other space within the facility and this would constitute duplication of use,

90.13 the proposed use of the space is not deemed to be in the best interest of the physical, emotional, and safety needs of the residents (In this case, a recommendation by the Department may be made for an alternative use of the space).

90.2 The following cost components shall be decreased by a percentage equal to the percentage of bed days decreased by the delicensing/decertification of the beds. Total bed days used to calculate this percentage will be the audited days (as filed if audited days are not available) from the base year cost report. The example used in Section 89.2 to also applicable to this section. This percentage decrease would be used in the calculation of the new rate for the following cost components based on what the total audited costs (as filed, if audited costs are not available) in the base year:

90.21 Indirect Patient Care Cost Component
90.21.1 Food Costs
90.21.2 Medical Supplies and Drugs

90.22 Routine Cost Component
90.22.1 Administrative and Management Ceiling.
90.22.2 Housekeeping Supplies
90.22.3 Laundry Supplies
90.22.4 Dietary Supplies
89.22.5 Patient Activity Supplies
89.22.6 Medicine and Drugs

90.3 Direct Patient Care Cost Component - The Direct Patient Care Cost Component will be decreased, subject to Licensing and Certification Regulations, by a percentage equal to 50% of the total percentage decrease based on the audited costs (as filed, if audited costs are not available) in the base year for the following areas:

90.31 RNs
90.32 LPNs
90.33 CNAs, CMAs
90.34 Contract Nursing
90.35 Payroll Benefits and taxes for 90.31 through 90.34.

(e.g. Using the example in 89.2 of a 25% decrease, if the total audited costs (as filed, if audited costs are not available) of the RNs, LPNs, CNAs, CMAs, Contract Nursing, and benefits and taxes were $400,000 in the base year, the allowable costs for this component would be reduced by $50,000 or 12.5%. The ratio of labor costs to benefits and taxes as contained in the base year cost report would be used in the determination of the amounts decreased in each of those areas.)

91 INFLATION ADJUSTMENT

91.1 The Maine Health Care Facility Economic Trend Factor will be used to forecast the expected increases in the cost of the goods and services which must be purchased by nursing care facilities.

The cost components, weights, proxies and method by which the Maine Health Care Facility Economic Trend Factor will be calculated are as follows:

91.1.1 Cost components: 1) wages and salaries, 2) employee benefits, 3) food, 4) fuel and other utilities, and 5) other expenses.

91.1.2 Cost component weights: The Department will use the most recent Nursing Facility Weights as published by Data Resources, Inc., of Washington, D.C.

91.1.3 Cost compensation proxy: The Department will use the most recent Nursing Facility %MOVAVG, published by Data Resources, Inc., of Washington, D.C., for all cost components except for employee wages and salaries.

The proxy for wages and salaries to be used in the Maine Health Care Facility Economic Trend Factor which will be calculated by the Department. The proxy for wages and salaries will equal the sum of the Maine specific weights for professional and technical workers and service workers times the cost compensation proxies used by the Maine Health Care Finance Commission for the same category of workers. The relative weights will be calculated every three years by the Department based on a study of the relative total costs of these categories of workers in all Maine nursing homes for the most recent available year.

91.1.4 The Maine Health Care Facility Economic Trend Factor is equal to the sum of the product of a) the cost component weight, and b) the cost compensation proxy component.

The Division of Audit shall use the most recent available publications of the applicable compensation cost proxies as published by Data Resources, Inc., for the Maine Health Care Finance Commission.

92 REGIONS

The regions shall be the regions defined by the Maine Health Care Finance Commission for hospitals. The regions are:
Region I - Cumberland County, Knox County, Lincoln County, Sagadahoc County, and York County.
Region II - Androscoggin County, Franklin County, Kennebec County, Oxford County, and Somerset County.
Region III - Penobscot County, Piscataquis County, Waldo County, Hancock County, and Washington County.
Region IV - Aroostook County

93 DAYS WAITING PLACEMENT

Reimbursement to nursing facilities for days waiting placement are governed by the regulations specified in the Principles of Reimbursement for Residential Care Facilities.

120 EXTRAORDINARY CIRCUMSTANCE ALLOWANCE

Facilities which experience unforeseen and uncontrollable events during a year which result in unforeseen or uncontrollable increases in expenses may request an adjustment to a prospective rate in the form of an extraordinary circumstance allowance. Extraordinary circumstances include, but are not limited to:

* events of a catastrophic nature (fire, flood, etc.)
* unforeseen increase in minimum wage , Social Security, or employee retirement contribution expenses in lieu of social security expenses
* changes in the number of licensed beds
* changes in licensure or accreditation requirements

If the Department concludes that an extraordinary circumstance existed, an adjustment will be made by the Department in the form of a supplemental allowance.

The Department will determine from the nature of the extraordinary circumstance whether it would have a continuing impact and therefore whether the allowance should be included in the computation of the base rate for the succeeding year.

121 Certificate of Need Extraordinary Circumstance Allowance

121.1 Based on findings made by the Commissioner of the Department of Human Services (hereinafter, the Commissioner), the Department may approve extraordinary indirect, routine, and fixed costs in excess of the provider's approved Certificate of Need (CON) that are within the upper limits established by the Department for the indirect and routine components, when all of the following conditions are met:

121.1(a) Costs would ordinarily be allowable under Federal Regulations and these Principles of Reimbursement;

121.1(b) Costs would have been allowable under the CON had a CON amendment been filed within the time constraints as outlined in the CON statutes and approved by the Department;

121.1(c) Approval is necessary in order for the Provider to obtain favorable refinancing, as determined by the Department;

121.1(d) Failure to approve may adversely affect patient care; and

121.1(e) In the Department's judgment, approval will further the Department's goal of ensuring that public funds are only expended for services that are necessary for the well being of the citizens of Maine.

121.2 Department approved costs, as determined in Section 121.2, from the CON will be recognized at the time the Department approves the Certificate of Need Extraordinary Circumstance Allowance for a nursing facility.

121.3 The Department may require that the Provider(s) or owner of the Provider(s) who have been granted a Certificate of Need Extraordinary Circumstance Allowance under these Principles, be subject to the following conditions:

121.3(a) Be managed through an unrelated management company;

121.3(b) Hire a licensed administrator, through an unrelated management company, who is approved by the DHS Division of Licensing and Certification; and

Sections 121.3(a) and 121.3(b) will be in effect for a period of time determined by the Department.

121.4 If the provider fails to obtain the acceptable refinancing described in Section 121 within 15 months of the date the Commissioner made the findings under Section 121.1, the Department may 1) recapture costs approved under Section 121 at time of audit; or 2) withdraw the Extraordinary Circumstance Allowance under Section 121.

130 ADJUSTMENTS

130.1 Adjustment for Unrestricted Grants or Gifts. Unrestricted Federal or State grants or gifts received by a facility and which have been deducted from operating costs for purposes of reimbursement will be added back to the direct patient care, indirect patient care and routine cost component for purposes of calculating a base rate.

130.2 Adjustment for Appeal Decisions. The Department will adjust any interim or final prospective rate to reflect appeal decisions made subsequent to the establishment of those rates.

130.3 Adjustments for Capital Costs. The Department will adjust the fixed cost component of an interim or final prospective rate to reflect increases or decreases in capital costs. For example costs which have been approved under the Maine Certificate of Need Act or refinancing.

140 APPEAL PROCEDURES - START UP COSTS - DEFICIENCY RATE - RATE LIMITATION

140.1 Appeal Procedures

140.1.1 A facility may administratively appeal any of the following types of Division of Audit determinations:

1. Audit Adjustment
2. Calculation of final prospective rate
3. Adjustment of final prospective rate or a refusal to make such an adjustment pursuant to these Principles.

140.1.2 An administrative appeal will proceed in the following manner:

1. Within 30 days of receipt of an audit or other appealable determination, the facility must request, in writing, an informal review before the Director of the Division of Audit or his/her designee. The facility must forward, with the request, any and all specific information it has relative to the issues in dispute, note the monetary amount each issue represents and identify the appropriate principle supporting the request. Only issues presented in this manner and timeframe will be considered at an informal review or at a subsequent administrative hearing.
2. The Director or his/her designee shall notify the facility in writing of the decision made as a result of the informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer 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 audit report or prospective rate will be corrected.
4. To the extent the Department upholds the original determination of the Division of Audit, review of the results of the administrative hearing is available in conformity with the Administrative Procedures Act, 5 M.R.S.A. §11001 et seq.

150 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 patient is admitted for treatment, or where the start-up costs apply only to nonrevenue-producing patient care functions or nonallowable 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 patient 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 provider's facility prepared during different time periods. Moreover, if a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas.

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the Department need not be capitalized, but rather will be 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 patient 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 patient 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 patient care area, depreciation should start with the month the first patient is admitted for treatment. If the portion of the facility is a nonrevenue - producing patient care area or nonallowable 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.

151 COST TREATMENT FOR REIMBURSEMENT

151.1 Where a provider prepares all portions of its facility for patient 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 patient is admitted for treatment.

151.2 Where a provider prorates portions of its facility for patient 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 patient care services during different periods of time.

152 DEFICIENCY PER DIEM RATE.

When a facility is found not to have provided the quality of service or level of care required, reimbursement will be made on 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:

152.1 Staffing over a period of two weeks or more does not meet the Federal Certification and State Licensing requirements, except where there is written documentation of a good faith effort to employ licensed nurses to meet the licensed nurse requirements over and above the full time director of nursing;

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

152.3 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;

152.4 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;

152.5 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 deficiencies per diem rate. The deficiency per diem rate for these items will go into effect immediately upon receipt of written notification from the Department of Human Services.

152.6 Failure to correct MDS as requested in writing and submit within the specified time outlined in Section 41.21 of these Principles of Reimbursement.

A reduction in rate because of deficiencies shall remain in effect until the deficiencies have been corrected, as verified by representatives of the Department of Human Services, following written notification by the provider that the deficiencies no longer exist. No retroactive adjustments to the full rate shall be made for the period that the deficiency rate is in effect unless the provider demonstrates to the satisfaction of the Department that there was no just cause for the reduction in payment.

160 INTENSIVE REHABILITATION NF SERVICES FOR TRAUMATIC BRAIN INJURED INDIVIDUALS (TBI)

It has been determined that the reasonable cost of comprehensive rehabilitative services of traumatic brain injury is an allowable cost. This requires that the facility possess characteristics, both in terms of staffing and physical design, which create a unique unit providing comprehensive rehabilitative TBI services.

The Department will require that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with the TBI unit from the Bureau of Medical 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 Bureau of Medical Services authorizing such a change to its staffing pattern.

The Department will recognize a NF-TBI unit when it is a distinct part of a dual-licensed nursing facility. The facility will be reimbursed for the average annual per diem cost for TBI rehabilitative services provided to those individuals classified in need of intensive rehabilitative nursing services.

160.1 Principle. A nursing facility which has a recognized TBI unit will be reimbursed for services provided to recipients 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.

160.2 Cost. The Department's payments made for allowable TBI services provided will be based on the actual cost of services provided to The allowable per diem cost for TBI services will include a routine service component and a rehabilitative ancillary service component.

160.2.1 The direct, indirect and routine cost component rates, that is, (The direct, indirect and routine costs less fixed costs and ancillary service costs) will be increased annually by the rate of inflation, for cash flow purposes only, at the beginning of a facilities fiscal year. This per diem rate is subject to audit and will be adjusted to actual costs at year end.

160.2.2 Rehabilitative ancillary services included in the care of a traumatically brain injured individual residing in a recognized TBI unit shall be considered an allowable cost. Covered ancillary services must meet the requirements and definitions under Medicare regulations.

160.3 Rehabilitative ancillary services are not subject to the routine service cost limitations.

Rehabilitative ancillary services include:

- Physical Therapy Services
- Occupational Therapy Services
- Speech Pathology Services
- Respiratory Therapy Services
- Recreational Therapy Services
- Physiatry Evaluation and Consultation Services
- Neuropsychology Evaluation and Consultation Services
- Psychology Evaluation and Consultation Services

160.4 Cost Reporting. Costs will be reported on forms provided by the Department which will segregate NF-TBI routine costs and TBI ancillary costs from standard NF costs.

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

171 COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS

COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS PROVIDING SERVICES UNDER CONTRACT WITH THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (DMHMRSAS) TO FORMER PATIENTS OF THE AUGUSTA MENTAL HEALTH INSTITUTE (AMHI) AND THE BANGOR MENTAL HEALTH INSTITUTE (BMHI).

The Department may designate specialty nursing facility units that provide special services under contract with the Department of Mental Health and Mental Retardation and Substance Abuse 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 patients.

Such designated specialty units shall be subject to the provision of these rules, except for the rate limitations contained in Sections 80-87.

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 Bureau of Medical 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 Bureau of Medial Services authorizing such a change to its staffing pattern.

171.1 Principle. A nursing facility which 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.

171.2 Cost. The Department's payments made for allowable services provided will be based on the actual allowable cost of services provided to such residents. The allowable per diem cost for the services will be increased annually by the rate of inflation at the beginning of each facility's fiscal year. 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.

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

For the purpose of calculating the reimbursement rate for such residents in the specialty unit, whether interim or final, a facility that has been designated as a specialty unit under this section of the Principles for a distinct part shall allocate the costs of such residents in the distinct part as if the distinct part were licensed as a separate level of care.

All other sections of theses Principles pertaining to the allowability, recording, and reporting of costs shall apply.

APPENDIX A: DEFINITIONS

The term Department as used throughout these principles is the State of Maine Department of Human Services.

The term State Licensing and Federal Certification as used throughout these principles are the "Regulations Governing the Licensing and Functioning of Nursing Facilities" and the Federal Certification requirements for nursing care facilities that are in effect at the time the cost is incurred.

Accrual method of accounting means that revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

AICPA: American Institute of Certified Public Accountants

Allowable costs are those costs which Medicaid will reimburse under these Principles of Reimbursement.

Ancillary Services: 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: A fiscal period for which the allowable costs are the basis for the case mix prospective rate.

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

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

Cash method of accounting means the revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

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

Community Integrated Rehabilitation: Individuals in this category may be able to achieve sufficient function to live adaptively and manage his/her environment in a community-based setting of choice and is expected to tolerate 3 - 5 hours of rehabilitative services within the first 20 days of residence. The individual needs intensive rehabilitative services from one or more of the following disciplines: PT, OT, SPT, RT, Social Work, and Psychological Services. The individual has potential for a discharge destination which is a more community integrated setting.

Compensation: 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.

Comprehensive Rehabilitation (Progressive Rehabilitation/Transitional Rehabilitation): Individuals in this category are able to achieve stability of function in physical health and self care to move to a more community integrated setting and is expected to tolerate 3 hours of rehabilitative services within the first 20 days of residence. The individual needs intensive rehabilitative services from one or more of the following disciplines: PT, OT,

SPT, Social Work, and Psychological Services and/or Recreational Therapy. The individual has potential for a discharge destination which is a more community integrated setting.
Control: Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.
Cost finding: the processes of segregating costs by cost centers and allocating indirect cost to determine the cost of services provided.
Days of Care means total number of days of care provided whether or not payment is received and the number of any other days for which payment is made. (Note: Bed held days and discharge days are included only if payment is received for these days.)
Direct Costs: costs which are directly identifiable with a specific activity, service or product of the program.
Discrete Costing: The specific costing methodology that calculates the costs associated with new additions/renovations of nursing facilities. None of the historical basis of costs from the original building are allocated to the addition/renovation.
Donated Asset: an asset acquired without making any payment in the form of cash, property or services.
DRI: Data Resources Institute Incorporated national forecasts of hospital, nursing home, and home health agency market baskets as published by McGraw- Hill.
Experience Modifier: This is the rating number given to nursing facilities based on worker's compensation claims submitted for the previous three years. The lower the rating number, the better the worker's compensation claims ratio.
Fair Market Value: The fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been communicated for assets of like type, quality, and quantity in a particular market at the time of acquisition.
Fixed Cost: The fixed cost component shall be determined based upon actual allowable costs incurred by an economically and efficiently operated facility.
Free Standing Facility: a facility that is not hospital-affiliated.
Fringe Benefits: shall include payroll taxes, qualified retirement plan contributions, group health, dental, and life insurance's, cafeteria plans and flexible spending plans.
Generally accepted accounting principles means accounting principles approved by the American Institute of Certified Public Accountants. (GAAP): 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.
Health Care Financing Administration (HCFA): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.
Historical cost: Historical cost is the cost incurred by the present owner in acquiring the asset. The historical cost shall not exceed the lower of:

* current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase;
* fair market value at the time of the purchase;
* the allowable historical cost of the first owner of record on or after July 18, 1984.

In computing the historical cost the four categories of assets will be evaluated, Land, Building, Equipment and Motor Vehicles. Each category will be evaluated based on the methods listed above.
Hospital-affiliated facility: a facility that is a distinct part of a hospital provider, located within the same building as the hospital unit or licensed as a hospital facility.
Land (non-depreciable): Land (non-depreciable) includes the land owned and used in provider operations. Included in the cost of the land are costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider and other land expenditures of a non-depreciable nature.
Land Improvements (depreciable): Depreciable land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the provider).
Leasehold improvements: Leasehold improvements include betterment's and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.
MDS as used throughout these Principles means the Minimum Data Set that is currently specified by the Health Care Financing Administration for use by Nursing Facilities.
Necessary and proper costs are those which are for services and items that are essential to provide appropriate patient care and patient activities at an efficient and economically operated facility. They are costs for services and items which are commonly provided and are commonly accepted as essential for the type of facility in question.
Net Book Value: The net book value of the asset is defined as the depreciable basis used under the program by the asset's last participation owner less the depreciation recognized under the program.
Nursing Facility: a nursing home facility licensed and certified for participation in the Medicaid Program by the State of Maine.
Owners: Owners include any individual or organization with 10% equity interest in the provider's operation and any members of such individual's family or his or her spouse's family. Owners also include all partners and all stockholders in the provider's operation and all partners and stockholders or organizations which have an equity interest in the provider's operation.
Per Diem Rate means total allowable costs divided by days of care. The prospective per diem rate, as described by days of care for Medicaid recipients, will determine reimbursement.
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:

The financial management of the facility.
The establishment of personnel policies.
The planning of patient admission policies.
The planning of expansion and financing thereof.

Prospective Case-Mix Reimbursement System: A method of paying health care providers rates that are established in advance. These rates take into account the fact that some residents are more costly to care for than others.

Reasonable costs are those which a prudent and cost-conscious buyer would pay for services and items that are essential for patient care and patient activities at the facility. If any of a provider's costs are determined to exceed by a significant amount, those that a prudent and cost-conscious buyer would have paid, those costs of the provider will be considered unreasonable in the absence of a showing by the provider that those costs were unavoidable.

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

Stand Alone Nursing Facility: a facility that is not physically located within a hospital.

Straight-line method: Under the straight-line method of depreciation, the cost or other basis (e.g., fair market value in the case of donated assets) of the assets, less its estimated salvage value, if any, is determined first. Then this amount is distributed in equal amounts over the period of the estimated useful life of the asset.

Sustained Rehabilitation: Individuals in this category demonstrate that there is no further potential for ability to develop stability of function in specific domains. The discharge destination would be a long term care facility or 24 supervised living arrangements.

Total Patient Census: Total number of residents residing in a nursing facility during the facility's fiscal year.

APPENDIX B

Supplies and Equipment provided to a recipient by a NF as part of regular rate of reimbursement are listed in Maine Medical Assistance Manual, Section 67, Chapter II.

APPENDIX C:

CERTIFIED NURSES AIDE TRAINING PROGRAMS

Principle. The median plus 10% of costs per student paid by the Department for state fiscal year 1993 to qualify individuals as certified nurses aides is reimbursable under the Maine Medicaid Program. These programs must be conducted in accordance with the requirements of the Maine Board of Nursing for education programs for nurses aides. To be allowable these programs must be conducted within a licensed nursing facility within the State of Maine or under contract with an educational institute whereby the classroom instruction may be provided in the educational facility, but the supervised clinical experience must be within the licensed nursing facility receiving reimbursement under the Principles of Reimbursement for Long-Term Care Facilities".

Definitions

1. Allowable Programs. All CNA programs must be approved by the Department of Education in order for a nursing facility to be reimbursed for a CNA training program.

The Department will reimburse for the number of courses needed to meet the facility's needs, or the needs of a group of facilities on a prorated basis, which is expected to be no more than three CNA courses per year, unless it is found that three courses in not enough to meet the facility's needs. However, costs for classes of four or fewer students will be allowed no more than twice a year.

2. Allowable Costs.

a) qualified instructor for classroom instruction and clinical instruction, not to exceed 150 hours.
b) instructor preparation time, not to exceed 15 hours.
c) additional clinical instructor time when number of students in program exceeds 10.
d) one "Train the Trainer Program" per facility per year.
e) training materials, books and supplies necessary for providing the CNA program.
f) liability insurance
g) competency examinations, if Department of Education no longer provides the competency examinations.
h) administrative overhead expenses shall be limited to 10% of the total allowable CNA training budget.

The cost per student cannot exceed the cost of tuition in a program offered through the Department of Education that is reasonably accessible. If it is determined that any of the CNA training programs offered by a facility has not met or does not presently meet the requirements of the Maine Board of Nursing or is not an approved program through the Department of Education, the Department will initiate action to recoup all reimbursement.

All income received from these programs must be used to reduce the overall cost of the programs.

Reimbursement. In order for a nursing facility to be reimbursed for conducting an approved CNA training program, the facility must submit a formal request for reimbursement to the Director of the Bureau of Medical Services, 11 State House Station, Augusta, Maine, 04333-0011. All requests must be received by the Department before the end of the facility's current fiscal year in which the CNA program began. Any request that is not received before the end of the facility's current fiscal year in which the CNA program begins will not be considered as an allowable cost under the Maine Medicaid Program.

All requests must include:

1. A completed schedule "Request for Budget Approval" available from the Bureau of Medical Services.
2. Copies of the letters of intent to employ for non-employees participating in the training program.
3. Copy of the Department of Education "Notice of Status" letter.

The Department will reimburse a nursing facility the median plus 10% of costs per student paid by the Department for state fiscal year 1993 for CNA training. The allowable cost of approved CNA training programs conducted at a nursing facility will not be included in the calculation of the facility's prospective rate, but will be reimbursed in a lump sum payment upon approval by the Bureau of Medical Services.
The Division of Audit will audit all CNA training costs at the time of the facility's final audit. Therefore it is very important that the facility maintain accurate records of the CNA training programs conducted by the nursing facility.

APPENDIX D: Bedbanking - State Law: Title XX, Chapter 103.
§ 304-F. Procedures after voluntary nursing facility reductions.
1. Procedures. A nursing home that voluntarily reduces the number of its licensed beds for any reason except to create private rooms may convert the beds back and thereby increase the number of nursing facility beds to no more than the previously licensed number of nursing facility beds, after obtaining a certificate of need in accordance with this section. To convert beds back to nursing facility beds under this section, the nursing facility must:
A. Give notice of its intent to preserve conversion options to the department no later than 30 days after the effective date of the license reduction; and
B. Obtain a certificate of need to convert beds back under Section 309, except that if no construction is required for the conversion of beds back, the application must be processed in accordance with subsection 2.
2. Expedited Review. Except as provided in subsection 1, paragraph B, an application for a certificate of need to reopen beds reserved in accordance with this section must be processed on an expedited basis in accordance with rules adopted by the Department providing for shortened review time and for a public hearing if requested by a directly affected person.
A. Review of applications that meet the requirements of the section must be based on the requirements of section 309, subsection 1, except that the determinations required by section 309, subsection 1, paragraph B must be based on the historical costs of operating the beds and must consider whether the projected costs are consistent with the costs of the beds prior to closure, adjusted for inflation; and
B. Conversion of beds back under this section must be requested within 4 years of the effective date of the license reduction. For good cause shown, the Department may extend the 4-year period for conversion for one additional 4-year period.
3. Effect on other Review Proceedings. Nursing facility beds that have been voluntarily reduced under this section must be counted as available nursing facility beds for the purpose of evaluating need under section 309 so long as the facility retains the ability to convert them back to nursing facility use under the terms of this section, unless the facility indicates in response to an inquiry from the department in connection with an ongoing project, that it is unwilling to convert them to meet a need identified in that project review.
EFFECTIVE DATE: July 1, 1998

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