STATE OF MAINE
126th LEGISLATURE
FIRST REGULAR SESSION

Final Report of the COMMISSION TO STUDY LONG-TERM CARE FACILITIES

December 2013

Members:
Sen. Margaret M. Craven, Chair
Sen. David C. Burns
Rep. Peter C. Stuckey, Chair
Rep. Richard R. Farnsworth
Rep. Beth Turner
Kenneth J. Albert, III
Diane M. Barnes
Philip A. Cyr
Richard Erb
Brenda Gallant
S. John Watson, Jr.

Staff:
Jane Orbeton, Senior Analyst
Anna Broome, Legislative Analyst
Office of Policy & Legal Analysis
Maine Legislature
(207) 287-1670

Table of Contents

Page

Executive Summary i

I. Introduction 1

II. Resolve 2013, Chapter 78 1

III. Commission Process 2

IV. Recommendations 9

V. Draft Legislation 11

Appendices

A. Authorizing Legislation, Resolve 2013, Chapter 78
B. Membership List
C. Berry, Dunn, McNeil and Parker Background on Shortfall
D. Presentation by Julie Fralich, Muskie School of Public Service Report
E. Testimony from direct care workers
F. Minimum Data Set, Resident Assessment and Care Screening
G. Department of Health and Human Services, Nursing Facilities Comparison of Funding & Costs
H. Public Law 1999, Chapter 731, Part BBBB
I. Department of Health and Human Services Rules, Chapter 110, Licensing and Functions of Skilled Nursing Facilities and Nursing Facilities, Chapter 9, Resident Care Staffing
J. 42 Code of Federal Regulations section 483.30
K. Letter from Charlene Harrington
L. Office of the State Auditor, Report on Cost of Care
M. Pay for Performance Models, Maine Health Care Association
N. Testimony from Leo J. Delicata, Legal Services for the Elderly
O. Department of Health and Human Services calculation for increased reimbursement for high Medicaid utilization
P. Maine Health Care Association calculations for increased reimbursement models
Q. Office of Policy and Legal Analysis, memo pay for performance program, Kristin Brawn

Executive Summary

In 2013 the 126th Maine Legislature established the Commission to Study Long-term Care Facilities with the passage of Resolve 2013, Chapter 78. The resolve established the commission, specified the duties of the commission and set December 4th, 2013 as the due date for the report of the commission to the full Legislature. A copy of Resolve 2013, Chapter 78 is included as Appendix A. The deadline for the report was extended from December 4th to December 12th by vote of the Legislative Council on November 21st pursuant to Joint Rule 353, section 7.

The President of the Senate, Speaker of the House of Representatives and Governor completed their appointments during the late summer. The members include two State Senators, three State Representatives, an owner of a long-term care facility, a representative of a statewide association of long-term care facility owners, a representative of a statewide association of long-term care facilities, a city manager, a representative of the Governor's Office, and the director of Maine's long-term care ombudsman program. A copy of the membership list of the commission is included as Appendix B. The 11 member commission met on October 11th and 25th, November 8th and 15th and December 4th. All meetings were held in the Cross State Office Building in Augusta and were open to the public and broadcast through the Legislature's public Internet system.

The commission focused its work regarding long-term care facilities on adequate funding, staffing and regulatory requirements and access to nursing facility services in rural and urban areas. The 14 recommendations of the commission include: recommendations designed to assist facilities in achieving adequate reimbursement for the care of residents whose care is reimbursed by the MaineCare program; a recommendation that Maine retain the current nursing facility staffing requirements and ratios; a recommendation to address the use of consumer life insurance as a resource to pay for nursing facility care; recommendations relating to errors in Cost of Care overpayments to facilities; and recommendations for further study of long-term care. The recommendation for further study by a Blue Ribbon Commission on Long-term Care reflects an understanding that more work needs to be done to study and make recommendations on a state plan for long-term care services in the community and in facilities. The recommendation for further study by a Commission to Continue the Study of Long-term Care Facilities reflects an understanding that further review and recommendations are needed on adequate reimbursement for facilities, ensuring access in rural and urban areas and providing incentives for high quality care through the nursing facility principles of reimbursement of the MaineCare program. Specific recommendations, including the votes for each recommendation are below.

1. Rebase to 2011 and every two years. Direct the Department of Health and Human Services to amend the Principles of Reimbursement for Nursing Facilities, Chapter 101, MaineCare Benefits Manual, Chapter III, Section 67 in the direct care cost component for nursing facilities in subsection 80.3.3(1) to establish a facility's base year by reference to the facility's 2011 audited cost report, or if the 2011 audited report is not available by reference to the facility's 2011 as filed cost report, and rebase every two years thereafter. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in the routine cost component in subsection

80.4.5.1 in a similar manner to the direct care cost component. Vote: 9 for, 0 against, 1 abstain.

2. Increase peer group upper limit. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to increase the peer group upper limit on the base year case mix and regionally adjusted cost per day to 110% of the median in the direct care cost component in subsection 80.3.3.4(b) and in the routine cost component in subsection 80.5.4. Vote: 8 for, 2 against.

3. Repeal administrative and management ceiling. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 43.4.2(A) to repeal the administrative and management ceiling in the routine cost component. Vote: 7 for, 3 against.

4. Cost of living adjustment included in budget request. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 91.1 to require the Department of Health and Human Services to set the inflation adjustment cost of living percentage change in reimbursement on an annual basis and by reliance on a publicly available index such as the Consumer Price Index Medical Care Services Index and to require that budget requests submitted by the Department of Health and Human Services include that annual adjustment. Vote: 9 for, 0 against.

5. Health insurance as fixed cost component. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to move health insurance costs for nursing facility personnel in subsection 41.1.7(3) from the direct care cost component and in subsection 43.4.1(16)(c) from the routine cost component to the fixed cost component in subsection 44. Vote: 6 for, 3 against.

6. Supplemental payment for high MaineCare census. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to provide a supplemental payment, subject to cost settlement, to nursing facilities with a MaineCare census above 70%. The supplemental payment would provide additional reimbursement to those high MaineCare census facilities of 40 cents per resident per day for each 1% MaineCare census above 70%. The supplemental payment would be enacted on an emergency basis with payments beginning July 1, 2014. Vote: 7 for, 3 against. The minority favored a supplemental payment for nursing facilities with a Medicaid census above 70% that is identical to the majority proposal but that is not cost settled.

7. Increase acuity for dementia. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 80.3.2 to increase the specific resident classification group case mix weight that is attributable to a resident who is diagnosed with dementia. Vote: 9 for, 0 against, 1 abstain.

8. Maintain current staffing ratios. Recommend that no changes be made to staffing ratios and requirements for licensed staff coverage adopted in Chapter 110, Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities, Chapter 9, subsection 9.A.3 and 9.A.4. Vote: 10 for, 0 against.

9. Support life settlement contract legislation. Recommend to the Insurance and Financial Services Committee that they consider, amend and report out favorably LD 1092, An Act to Increase the Use of Long-term Care Insurance, on life settlement policy conversion. The bill proposes to allow an owner of a life insurance policy to enter into a life settlement contract with a life care benefits company and to use the proceeds for long-term care expenses. The bill proposes amendments to the MaineCare program so that the policy and benefits under it do not disqualify the owner from eligibility for MaineCare long-term care services. Vote: 7 for, 0 against, 1 abstain.

10. Collect Cost of Care overpayments. Direct the Department of Health and Human Services to take all necessary actions to collect Cost of Care overpayments to nursing facilities and private non-medical institutions which were paid when the department's computer systems, when providing reimbursement owed by the department, failed to take into account the financial contributions paid by residents in the nursing facilities and private non-medical institutions. Vote: 10 for, 0 against.

11. Correct Cost of Care overpayments. Direct the Department of Health and Human Services to require that Molina make adjustments to the MIHMS computer system to correct and discontinue overpayments in the calculation and deduction of Cost of Care in the payment of nursing facilities and private non-medical institutions. Vote: 10 for, 0 against.

12. Cost of Care recoupment used for nursing facilities. Recommend that the first $10 million collected from Cost of Care overpayment recoupments collected under recommendation 10 be appropriated to pay for initiatives recommended by the commission. Vote: 10 for, 0 against.

13. Continue the commission. Recommend establishing a Commission to Continue the Study of Long-term Care Facilities, based on the 2013 commission, with added duties of reporting to the Blue Ribbon Commission on Long-term Care and reviewing payment methodologies and removing the duties completed in 2013. The recommendation includes the duty to report to Legislature and to the Blue Ribbon Commission on Long-term Care by October 15th, 2014. Vote: 10 for, 0 against.

14. Establish Blue Ribbon Commission on Long-term care spectrum. Recommend establishing a Blue Ribbon Commission on Long-term Care to review the State's plan for long-term care and the provision of services in the community and in nursing and residential care facilities. The recommendation includes broad representation on the commission, funding for contracted staffing and consultant services and the duty to draft a plan for long-term care for presentation to Legislature and the Department of Health and Human Services. The recommendation also includes the duty to receive and consider recommendations from the Commission to Continue the Study of Long-term Care Facilities. The Blue Ribbon Commission must submit the report to the Legislature by November 4th, 2014. Vote: 10 for, 0 against.

I. INTRODUCTION

In 2013 the 126th Maine Legislature established the Commission to Study Long-term Care Facilities with the passage of Resolve 2013, Chapter 78. The resolve established the commission, specified the duties of the commission and set December 4th, 2013 as the due date for the report of the commission to the full Legislature. A copy of Resolve 2013, Chapter 78 is included as Appendix A. The deadline for the report was extended from December 4th to December 12th by vote of the Legislative Council on November 21st pursuant to Joint Rule 353, section 7.

The President of the Senate, Speaker of the House of Representatives and Governor completed their appointments during the late summer. The members include two State Senators, three State Representatives, an owner of a long-term care facility, a representative of a statewide association of long-term care facility owners, a representative of a statewide association of long-term care facilities, a city manager, a representative of the Governor's Office, and the director of Maine's long-term care ombudsman program. A copy of the membership list of the commission is included as Appendix B. The 11 member commission met on October 11th and 25th, November 8th and 15th and December 4th. All meetings were held in the Cross State Office Building in Augusta and were open to the public and broadcast through the Legislature's public Internet system.

II. RESOLVE 2013, CHAPTER 78

The duties of the commission were outlined in Resolve 2013, Chapter 78 and included issues relating to reimbursement, staffing and regulatory requirements and access, particularly in rural communities. The specific duties and policy areas in the resolve are as follows:

- **Reimbursement.** The commission was directed to study different reimbursement mechanisms, including pay-for-performance, acuity of residents, supplemental payments for nursing facilities with a high MaineCare population, and cost of living adjustments for MaineCare reimbursement.
- **Staffing.** The commission was directed to study the development of minimum staffing requirements based on a 24-hour time period.
- **Access.** The commission was directed to study the viability of privately owned facilities in rural communities, the impact on rural populations of nursing home closures, and the possibility of collaborative agreements with critical access hospitals to share resources.

The Resolve specifically referred to other legislative bills, resolves and reports that were folded into the duties of this commission. Several of these were from the First Regular Session of the 126th Legislature (LDs 928, 1245 and 1246). The Resolve also specifically referred to the report of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities established in Resolve 1997, chapter 81 (partly enacted as Part BBBB of Public Law 1999, Chapter 731).

III. COMMISSION PROCESS

A. First Meeting

The first meeting of the commission was held on October 11th. After welcoming the public, Senator Margaret Craven and Representative Peter Stuckey, the chairs of the commission, introduced the members of the commission: Diane Barnes, Senator David Burns, Philip Cyr, Richard Erb, Representative Richard Farnsworth, Brenda Gallant and John Watson. (Kenneth Albert was unavailable for the first meeting and Representative Beth Turner was appointed to the commission between the first and second meeting.) The commission reviewed the major policy issues that led to passage of the resolve and the bills, resolves and studies that were considered by the Joint Standing Committee on Health and Human Services when they crafted the language of the resolve. Major policy areas included access in urban and rural areas, staffing and regulatory requirements and reimbursement issues. Bills, resolves and studies from 2013, the subject matter of which was incorporated into Resolve 2013, Chapter 78, included LD 928, LD 1245 and LD 1246. Also considered were the final report of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities issued in accordance with Resolve 1997, Chapter 81 and the progress report on alternatives to minimum staffing ratios from Commissioner Mary Mayhew to the Joint Standing Committee on Health and Human Services, January 7, 2013. The commission received background information from the Berry, Dunn, McNeil and Parker accountancy firm regarding the nursing facility MaineCare reimbursement shortfall between allowable costs and reimbursement. The Berry, Dunn, McNeil and Parker materials are included as Appendix C.

B. Second Meeting

The second meeting of the commission was held on October 25th. After welcoming the public and introducing the members of the commission, Senator Margaret Craven and Representative Peter Stuckey introduced Julie Fralich, Program Director on Disability and Aging at the Muskie School of Public Policy at the University of Southern Maine. Ms. Fralich provided an overview of the aging of Maine's population, reviewed Maine's long-term care system and compared it to systems in other states. She discussed trends in long-term care services, presented options for paying bonuses to nursing facilities providing particularly high quality care and introduced other initiatives regarding long-term services and supports to persons with disabilities and older persons. A copy of Ms. Fralich's materials is included as Appendix D.

The commission heard testimony from the perspective of direct care workers and a family member of a nursing facility resident. Written materials, included as Appendix E, were submitted by Michelle Heath, CNA, Helen Hanson, CNA and Roy Gedat, a personal support worker, owner of a private duty non-medical home care business and advocate for direct care workers. Together with Norman O'Halloran, husband of a nursing facility resident, they spoke with the commission and answered questions. They spoke with passion and understanding of the challenges of providing high quality care, the difficult work performed for low wages by overworked staff and the need for personalized care that meets the needs of the residents of nursing facilities.

Stephanie Rice, CPA, with the Berry, Dunn, McNeil and Parker accountancy firm in Portland, spoke with the commission and provided financial data on nursing facilities, occupancy percentages, payor mix data and an overview of the underfunding of Maine's nursing facilities for the past decade. Ms. Rice provided information about changes in nursing facility populations and reimbursement over recent years. She spoke of the increasing level of acuity of resident needs, the decreasing Medicare pay rates and the decreasing percentage of residents whose care is reimbursed through the Medicare program. Ms. Rice explained the operation of the nursing facility Principles of Reimbursement, adopted in Department of Health and Human Services rules as Chapter 101, MaineCare Benefits Manual, Chapter III, Section 67.

Ms. Rice provided information on acuity-based reimbursement using the Resident Assessment Instrument, which consists of the Minimum Data Set (MDS) specified for use by the federal Centers for Medicare and Medicaid Services and the Resident Assessment Protocols. Commission members learned that the MDS assesses residents for hearing, speech and vision, cognitive patterns, mood, behavior, preferences for customary routine and activities, functional status, bladder and bowl function, active diagnoses, health conditions, swallowing and nutritional status, skin conditions, medications, special treatments, procedures and programs, restraints and participation in assessment and goal setting. A copy of the Minimum Data Set, Version 3.0 is included as Appendix F.

MaineCare reimbursement for nursing facility services, through the Principles of Reimbursement for Nursing Facilities, is critical to the operations and financial health of Maine's nursing facilities. Of the 6,974 licensed nursing facility beds in Maine as of July 15, 2013, the occupancy rate was 90.72% or 6,327 beds. Reimbursement was provided to the nursing facilities by MaineCare, Medicare and an "other" category that includes private pay, private insurance and other payment sources. In July 2013 percentages of residents in each pay category were 67.43% MaineCare, 10.68% Medicare and 21.89% Other.

The Principles of Reimbursement provide the mechanism by which MaineCare reimburses nursing facilities' costs that are determined to be allowable and that are included in the facilities' cost reports. The mechanism includes dividing facilities into peer groups based on the facility being (1) hospital-based, (2) non-hospital-based with a licensed number of beds of up to 60, or (3) non-hospital-based with a licensed number of beds over 60. Costs that are reimbursable by the MaineCare program, called reimbursable costs, are divided into three categories: fixed costs such as capital expenses and real estate and property taxes; direct care costs such as nursing and certified nursing assistant and ward clerk salaries; and routine costs such as administrative expenses. Reasonable fixed costs are not subject to a limit except that approval for capital expenditures and expansions and additional bed capacity require the approval of the Department of Health and Human Services through the Certificate of Need process under Title 22, Maine Revised Statutes, chapter 103-A. Direct care and routine costs are limited by application of base year costs in the facility's fiscal year that ended in 2005 and by a limit of 87% of the median costs in the facility's peer group for the applicable region of the state.

Reimbursement to nursing facilities is designed to, and does, result in underpayment of allowable costs by MaineCare. Based on nursing facilities' 2011 "as filed" cost reports for their fiscal years

ending in 2011, the nursing facilities total allowable costs amounted to $300,571,792. MaineCare reimbursement totaled $271,457,438. The resulting underfunding of nursing facility care, comparing allowable costs to reimbursement, for 2011 was $29,114,354. The spreadsheet comparing allowable costs and MaineCare reimbursement prepared by the Department of Health and Human Services for the commission is included as Appendix G. Commission members noted that the $29,114,354 in underfunding is itself understated since $8,000,000 in administrative and management costs are subject to an internal cap in the routine cost component and thereby excluded in calculating underfunding. The total for underfunding for nursing facilities for 2011 then amounts to $37,114,354.

Commission members learned that delayed auditing by the Department of Health and Human Services of filed cost reports is a serious problem for nursing facilities and contributes to financial pressures. The department provided information to the commission that as of October 28, 2013, 174 cost reports for nursing facilities spanning facility fiscal years from 2010 through 2012 were awaiting auditing in the department. Payments to the providers whose cost reports await auditing are estimated to amount to $8,000,000. Timely auditing would accelerate payments to nursing facilities and reduce the gap between amounts paid and amounts owed.

Commission members reviewed MaineCare reimbursement information and discussed the mechanisms used in the Principles of Reimbursement, including the roles of the base year, the peer groups and the limitation to a percentage of median costs. Commission members learned that the base year of 2005 was established in 2010 and that since 2010 nursing facilities have received only one inflation adjustment, an increase in 2012 of 2%. Commission members learned that the chronic underfunding of nursing facilities causes a significant cost shift to private pay residents, undermines the ability of facilities to provide high quality care and places facilities at risk of financial disaster and closure.

Commission members proceeded to discuss the Department of Health and Human Services rules for nursing facility services, adopted as Chapter 101, MaineCare Benefits Manual, Chapter II, Section 67. Commission members focused in this discussion on staffing requirements. Commission members referred to the minimum staffing ratios, established pursuant to the Public Law 1999, Chapter 731, Section BBBB-11 and rules adopted in Chapter 110, Section 9.A.4 and the requirements for licensed staffing as adopted in Chapter 110, Section 9.A.3. Public Law 1999, Chapter 731 is included as Appendix H. Rule Chapter 110, Section 9 on resident care staffing is included as Appendix I. Chapter 110, Section 9.A.4 requires a minimum nursing staff to resident ratio on the day shift of one direct-care provider for every 5 residents; on the evening shift of one direct-care provider for every 10 residents; and on the night shift of one direct-care provider for every 15 residents. Chapter 110, Section 9.A.3 requires coverage by licensed nursing staff sufficient to meet the needs of the residents as determined by their levels of care. In addition, Section 9.A.3 sets a minimum standard that addresses licensed nurse staffing, allows in some circumstances the Director of Nursing to be counted, disallows counting private duty nurses and provides for variations in staffing depending on the number of beds in the nursing facility.

Nursing facilities must also comply with the federal requirement from the Department of Health and Human Services, Centers for Medicare and Medicaid Services for staffing adequate to care for the facility's residents. Specifically the federal regulation, 42 Code of Federal Regulations, section 483.30 requires that each facility "must have sufficient nursing staffing to provide nursing and related services to attain or maintain the highest practical physical, mental and psychological well-being of each resident, as determined by resident assessments and individual care plans." A copy of 42 C.F.R. section 483.30 is included as Appendix J.

In addition to the federal and state requirements for minimum staffing, nursing facilities are assessed for the number of hours of direct care provided to each resident per day by registered nurses, licensed nurses and nursing aides and assistants. A national study, "Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2005 through 2010," written by Charlene Harrington, Helen Carillo, Megan Dowdell, Paul Tang and Brandee Woleslagle Blank (published by the Department of Social and Behavioral Sciences at the University of California, San Francisco in 2011), cites the strong relationship between resident characteristics, nurse staffing time requirements and nursing costs in nursing homes and that relationship serving as the basis for the case mix reimbursement systems used in some states. In addition, the study cites reporting by the Centers for Medicare and Medicaid Services that facilities staffing below 4.1 hours per resident day for long stay residents may provide care that results in harm and jeopardy to the residents. The study also cites Institute of Medicine studies that conclude that there is a positive relationship between nursing staffing and the quality of nursing home care and the recommendation of an expert panel of minimum staffing levels that provide 4.55 hours resident day. Charlene Harrington, lead author on the "Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2005 through 2010," sent a letter to commission member Brenda Gallant dated October 8, 2013 stating that Maine's staffing requirements of 3.46 hours per resident per day are close to the recommended 4.1 level, that quality of care could decline if Maine eliminates its ratios or reduces its staffing standards and that such steps would be a serious step backward. Ms. Harrington's letter is included as Appendix K.

C. Third Meeting

The third meeting of the commission was held on November 8th. The commission heard a presentation by State Auditor Pola Buckley and Principal Auditor Amanda Spencer on the Auditor's review of cost of care amounts assessed to long-term care facility residents for the first nine months of State fiscal year 2013. The State Auditor's report on Cost of Care is included as Appendix L. For residents who receive assistance from the Department of Health and Human Services, cost of care acts as a co-payment that the residents pay directly from their own income to their facilities, both nursing facilities and private non-medical institutions. This leaves a balance that is payable by the department and this is where the State Auditor found inaccuracies estimated at over $29,000,000 in State Fiscal Year 2013.

One Department of Health and Human Services computer system, the Automated Client Eligibility System (ACES), completes eligibility determinations for persons who receive assistance from the department and calculates cost of care and the responsibilities of the department. Another department computer system, the Maine Integrated Management Solution

(MIHMS) acts as the claims processing system and actually causes the payments to the long-term care facilities to be made. The auditor's review found deficiencies in both systems and failures of communication between them. The deficiencies caused mistakes in income and expense information and the failures resulted in errors in deducting cost of care and in payment. At the completion of the review the auditors concluded that during the nine months reviewed the Department of Health and Human Services in paying long-term care facilities should have deducted $76,000,000 for cost of care paid by residents.

Applying an error rate of 29% to the proper annualized cost of care deduction of $89,000,000, the resulting overpayment amounts to $29,000,000 for State Fiscal Year 2013. The auditors noted that the department has some procedures in place to recover overpaid funds but believes that these procedures are far from adequate and do not address the root causes on a timely basis. Quoting from the State Auditor's report, the commission notes that this "overpay and recover procedure cannot mitigate the fact that at any given time about $27 million or more of State and federal money is not available for government use." The auditors conclude with recommendations that the department improve internal controls to ensure that cost of care amounts are computed correctly and implement additional controls and system corrections that allow cost of care to be properly deducted from the monthly payments that the department makes to long-term care facilities.

At the second and third meetings of the commission, members received information and discussed the challenges to access to nursing facility services in rural areas. Commission members learned that when the Atlantic Rehabilitation and Nursing Center in Calais closed in June, 2012, the disruption was felt both within and beyond the walls of the 52-bed facility. Ninety-two employees of the facility lost their jobs, all of the residents suffered through the disruption of locating nursing facility services outside of Calais and families and friends of residents faced increased travel to spend time with their loved ones.

At the third meeting the commission heard a presentation on the perspective of a rural nursing facility from owner Nathan Brown of the Oceanview Nursing Home in Lubec. Oceanview is a 31-bed facility that in July 2013 was operating at 87.10% occupancy. On that day, its Medicare census was 3.7%, its MaineCare census was 85.19%, and its "other payor" census was 11.11%. Mr. Brown spoke with passion of his commitment to Oceanview's residents and their dedicated staff and he stressed the precarious financial position that facilities are in that have high percentages of MaineCare residents and low percentages of Medicare residents. He argued for fair reimbursement from Medicaid so that costs are not shifted onto other payors and allowable costs are paid. In addition, Mr. Brown brought to the attention of the commission the financial stress caused by a resident whose medical eligibility for care changes from a residential level care to a nursing facility level of care. Because eligibility standards for the two types of care are not identical, a person can be financially and medically eligible for residential care and then become medically eligible for nursing facility care while failing to qualify financially. At the time of the third meeting, when Mr. Brown spoke with the commission, two of Oceanview's residents fell into this category.

The commission discussed LD 1092, An Act to Increase the Use of Long-term Care Insurance, a bill sponsored by Senator Craven and carried over to the Second Regular Session of the 126th Legislature for consideration by the Joint Standing Committee on Insurance and Financial Services. Christos Orestis, III, a principal in the business Life Care Funding, presented information to the commission on Medicaid life settlement policy conversion. This concept involves transferring ownership of a life insurance policy through a contract that guarantees a benefit of a stated amount through payment for long-term care, a death benefit and any remaining balance to the owner's estate. This policy option is already available but individuals are often unaware of the option. Through a Medicaid State Plan Amendment the arrangement could be tailored to benefit the owner and the MaineCare program. Mr. Orestis stressed that life settlement policy conversion enables a policy owner to continue coverage under a life insurance policy, provides benefits upon death and avoids disqualification by MaineCare because a life insurance policy is considered to be an asset and because some policy owners arrive at a point in which they are unable to continue to pay for premiums. Mr. Orestis stated that the amount of contractual benefits to the policy owner varies with the owner's life expectancy. The buyer of the life insurance policy makes a payment into an irrevocable trust that holds the owner's benefit. The exact terms and amounts are driven by the commercial market, averaging 45% and ranging from 25% to 65% of the face value of the life insurance policy. Mr. Orestis suggested that the Legislature, in considering LD 1092, review whether to exempt benefits from state taxes.

The commission reviewed information from Julie Fralich from the second meeting and information provided by Richard Erb and Holly Harmon from the Maine Health Care Association regarding pay for performance as an incentive to encourage high quality care. Materials provided by Mr. Erb and Ms. Harmon are included as Appendix M. Quality measures could include staffing levels and retention rates, consistent assignment of staff, consumer satisfaction, inspection performance, clinical quality indicators, quality of life measures, efficiency, access, employee satisfaction, family satisfaction and quality improvement that measures factors such as reported pain and use of anti-psychotic medications. Performance methods could include benchmarks, percentile rankings, annual improvements, structure versus process and risk adjustments. Administration could be complex or simple, could rely on data that is already collected or new data and could use a composite index or a simple approach. The payment method could be an addition to or a subtraction from the Principles of Reimbursement. Whatever the design of the pay for performance system, a successful system would require significant stakeholder involvement, phased-in implementation, flexibility in administration and a secure source of funding.

D. Fourth Meeting

The fourth meeting of the commission was held on November 15th. The commission received a written statement and an oral presentation from Leo Delicata from Legal Services for the Elderly and oral testimony from Lisa Harvey-McPherson from Eastern Maine Healthcare. Mr. Delicata spoke of the importance of looking at the whole continuum of long-term care and then at the individual parts of the continuum. He spoke of the importance of adequate reimbursement for long-term care facilities so that they can provide skilled staffing and ensure high quality care. A copy of Mr. Delicata's statement is included as Appendix N. Ms. Harvey-McPherson spoke of

the importance of quality staffing, strengthening every component of the provider market, impending cuts in reimbursement provided by Medicare, and shortages of nursing facility care that is specialized and serves ventilator-dependent residents, that provides geriatric, sub-acute nursing and psychiatric care and that serves rural areas.

Commission members discussed the duties of the commission and proposed preliminary recommendations. The commission also voted to request an additional meeting to finish its work.

E. Fifth Meeting

The fifth meeting of the commission was held on December 4th. At this meeting, the commission refined the recommendations that had been developed in previous meetings and took final votes on each recommendation.

The commission received information from the Department of Health and Human Services regarding the cost of proposals increase nursing facility reimbursement for high MaineCare utilization by 20 cents per patient per day for each 1% above 70% MaineCare census. The handout pricing reimbursement at 20 cents per patient per day for each 1% above 70% MaineCare census is included as Appendix O. In this discussion commission members noted that they favored a supplemental payment of 40 cents per patient per day for each 1% above 70% MaineCare census. The commission discussed the different reimbursement issues with respect to different types of nursing facilities (for example, facilities with a high MaineCare or those that are larger than 90 beds and higher acuity residents) resulting in the need for several different reimbursement recommendations in order to increase revenue for most nursing facilities. Richard Erb, Maine Health Care Association, also provided information quantifying changes to reimbursement mechanisms included as Appendix P. Mr. Brett Seekins, Baker, Newman and Noyes, presented information on the process that the Department of Health and Human Services follows in obtaining federal approval of a MaineCare State Plan Amendment. Mr. Brett Witham, Verrill Dana, L.L.P., assisted the commission with review of information on the MaineCare Principles of Reimbursement for Nursing Facilities. There was also considerable discussion about whether recommendations should reflect the large and growing gap between cost and reimbursement or be simple, incremental and affordable. The commission reviewed research information on pay-for-performance provided by Kristen Brawn of the Office of Policy and Legal Analysis. The research information is included as Appendix Q.

Commission members wish to publicly thank all those persons who provided assistance and information and who spoke from their expertise, experience and hearts to the commission. Specifically the commission thanks Ms. Fralich, Ms. Heath, Ms. Hanson, Mr. Gedat, Mr. O'Halloran, Ms. Rice, Ms. Buckley, Ms. Spencer, Mr. Brown, Mr. Orestis, Ms. Harmon, Mr. Seekins, Mr. Witham and Ms. Brawn.

The commission determined that there was still considerable work to be done regarding the duties set in Resolve 2013, Chapter 78, particularly with respect to ensuring access, providing adequate reimbursement for residents whose care is paid through the MaineCare program and

developing a state plan across the spectrum of long term care that includes home and community based services in addition to nursing facilities.

IV. RECOMMENDATIONS

The commission focused its work on long-term care facilities on adequate funding, staffing and regulatory requirements and access to nursing facility services in rural and urban areas. The 14 recommendations of the commission include recommendations: designed to assist facilities in achieving adequate reimbursement for the care of residents whose care is reimbursed by the MaineCare program; a recommendation that Maine retain the current nursing facility staffing requirements and ratios; a recommendation to address the use of consumer life insurance as a resource to pay for nursing facility care; recommendations relating to errors in Cost of Care overpayments to facilities; and recommendations for further study of long-term care. The recommendation for further study by a Blue Ribbon Commission on Long-term Care reflects an understanding that more work needs to be done to study and make recommendations on a state plan for long-term care services in the community and in facilities. The recommendation for further study by a Commission to Continue the Study of Long-term Care Facilities reflects an understanding that further review and recommendations are needed on adequate reimbursement for facilities, ensuring access in rural and urban areas and providing incentives for high quality care through the nursing facility principles of reimbursement of the MaineCare program. Specific recommendations, including the votes for each recommendation are below.

1. Rebase to 2011 and every two years. Direct the Department of Health and Human Services to amend the Principles of Reimbursement for Nursing Facilities, Chapter 101, MaineCare Benefits Manual, Chapter III, Section 67 in the direct care cost component for nursing facilities in subsection 80.3.3(1) to establish a facility's base year by reference to the facility's 2011 audited cost report, or if the 2011 audited report is not available by reference to the facility's 2011 as filed cost report, and rebase every two years thereafter. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in the routine cost component in subsection 80.4.5.1 in a similar manner to the direct care cost component. Vote: 9 for, 0 against, 1 abstain.

2. Increase peer group upper limit. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to increase the peer group upper limit on the base year case mix and regionally adjusted cost per day to 110% of the median in the direct care cost component in subsection 80.3.3.4(b) and in the routine cost component in subsection 80.5.4. Vote: 8 for, 2 against.

3. Repeal administrative and management ceiling. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 43.4.2(A) to repeal the administrative and management ceiling in the routine cost component. Vote: 7 for, 3 against.

4. Cost of living adjustment included in budget request. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 91.1 to require the Department of Health and Human Services to set the inflation adjustment cost of living percentage change in reimbursement on an annual basis and by reliance on a publicly available

index such as the Consumer Price Index Medical Care Services Index and to require that budget requests submitted by the Department of Health and Human Services include that annual adjustment. Vote: 9 for, 0 against.

5. Health insurance as fixed cost component. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to move health insurance costs for nursing facility personnel in subsection 41.1.7(3) from the direct care cost component and in subsection 43.4.1(16)(c) from the routine cost component to the fixed cost component in subsection 44. Vote: 6 for, 3 against.

6. Supplemental payment for high MaineCare census. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to provide a supplemental payment, subject to cost settlement, to nursing facilities with a MaineCare census above 70%. The supplemental payment would provide additional reimbursement to those high MaineCare census facilities of 40 cents per resident per day for each 1% MaineCare census above 70%. The supplemental payment would be enacted on an emergency basis with payments beginning July 1, 2014. Vote: 7 for, 3 against. The minority favored a supplemental payment for nursing facilities with a Medicaid census above 70% that is identical to the majority proposal but that is not cost settled.

7. Increase acuity for dementia. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 80.3.2 to increase the specific resident classification group case mix weight that is attributable to a resident who is diagnosed with dementia. Vote: 9 for, 0 against, 1 abstain.

8. Maintain current staffing ratios. Recommend that no changes be made to staffing ratios and requirements for licensed staff coverage adopted in Chapter 110, Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities, Chapter 9, subsection 9.A.3 and 9.A.4. Vote: 10 for, 0 against.

9. Support life settlement contract legislation. Recommend to the Insurance and Financial Services Committee that they consider, amend and report out favorably LD 1092, An Act to Increase the Use of Long-term Care Insurance, on life settlement policy conversion. The bill proposes to allow an owner of a life insurance policy to enter into a life settlement contract with a life care benefits company and to use the proceeds for long-term care expenses. The bill proposes amendments to the MaineCare program so that the policy and benefits under it do not disqualify the owner from eligibility for MaineCare long-term care services. Vote: 7 for, 0 against, 1 abstain.

10. Collect Cost of Care overpayments. Direct the Department of Health and Human Services to take all necessary actions to collect Cost of Care overpayments to nursing facilities and private non-medical institutions which were paid when the department's computer systems, when providing reimbursement owed by the department, failed to take into account the financial contributions paid by residents in the nursing facilities and private non-medical institutions. Vote: 10 for, 0 against.

11. Correct Cost of Care overpayments. Direct the Department of Health and Human Services to require that Molina make adjustments to the MIHMS computer system to correct and discontinue overpayments in the calculation and deduction of Cost of Care in the payment of nursing facilities and private non-medical institutions. Vote: 10 for, 0 against.

12. Cost of Care recoupment used for nursing facilities. Recommend that the first $10 million collected from Cost of Care overpayment recoupments collected under recommendation 10 be appropriated to pay for initiatives recommended by the commission. Vote: 10 for, 0 against.

13. Continue the commission. Recommend establishing a Commission to Continue the Study of Long-term Care Facilities, based on the 2013 commission, with added duties of reporting to the Blue Ribbon Commission on Long-term Care and reviewing payment methodologies and removing the duties completed in 2013. The recommendation includes the duty to report to Legislature and to the Blue Ribbon Commission on Long-term Care by October 15th, 2014. Vote: 10 for, 0 against.

14. Establish Blue Ribbon Commission on Long-term care spectrum. Recommend establishing a Blue Ribbon Commission on Long-term Care to review the State's plan for long-term care and the provision of services in the community and in nursing and residential care facilities. The recommendation includes broad representation on the commission, funding for contracted staffing and consultant services and the duty to draft a plan for long-term care for presentation to Legislature and the Department of Health and Human Services. The recommendation also includes the duty to receive and consider recommendations from the Commission to Continue the Study of Long-term Care Facilities. The Blue Ribbon Commission must submit the report to the Legislature by November 4th, 2014. Vote: 10 for, 0 against.

V. DRAFT LEGISLATION

DRAFT
An Act to Implement the Recommendations of the Commission to Study Long-term Care Facilities (Emergency Legislation)

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

Whereas, the people of the State of Maine need and deserve a variety of well-planned and financially stable long-term care services in home and community-based care settings and in nursing facilities in their communities; and

Whereas, in order to provide high quality care to Maine's elderly and disabled persons in a dignified and professional manner that is sustainable into the future through a spectrum of long-term care services prompt action is needed to correct chronic underfunding and to complete a thoughtful and thorough planning process; 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 enacted as follows:

Sec. 1. Amendment of the Principles of Reimbursement for Nursing Facilities. The Department of Health and Human Services shall amend the Principles of Reimbursement for Nursing Facilities, Chapter 101 of the MaineCare Benefits Manual, Chapter III, Section 67 as follows.

1. Facility base year. The Principles of Reimbursement must be amended, in order to establish a nursing facility's base year and increase rates beginning July 1, 2014 and every 2 years thereafter, as follows:

A. In the direct care cost component in subsection 80.3 and all other applicable divisions of subsection 80.3 in which case mix data, regional wage indices or data required for rebasing calculations are referenced by date, the principles must be amended to establish a nursing facility's base year by reference to the facility's 2011 audited cost report, or if the 2011 audited report is not available, by reference to the facility's 2011 as filed cost report, must be amended to refer to other required rebasing data no older than 2011 data and must be amended to update a facility's base year every two years thereafter; and

B. In the routine cost component in subsection 80.4 and all other applicable divisions of subsection 80.4 in which case mix data, regional wage indices or data required for rebasing calculations are referenced by date, the principles must be amended to establish a nursing facility's base year by reference to the facility's 2011 audited cost report, or if the 2011 audited report is not available by reference to the facility's 2011 as filed cost report, must be amended to refer to other required rebasing data no older than 2011 data and must be amended to update a facility's base year every two years thereafter.

2. Peer group upper limit. The Principles of Reimbursement must be amended to increase the peer group upper limit on the base year case mix and regionally adjusted cost per day for a nursing facility beginning July 1, 2014 as follows:

A. In the direct care cost component in subsection 80.3.3.4(b) the peer group upper limit must be increased to 110% of the median; and

B. In the routine cost component in subsection 80.5.4 the peer group upper limit must be increased to 110% of the median.

3. Administrative and management ceiling. The Principles of Reimbursement must be amended in the routine cost component in subsection 43.4.2(A) to repeal the nursing facility administrative and management cost ceiling, thereby allowing all allowable administrative and management costs to be included in allowable routine costs for the purposes of rebasing, rate setting and future cost settlement beginning July 1, 2014.

4. Health insurance costs. The Principles of Reimbursement must be amended to include the costs of health insurance for nursing facility personnel beginning July 1, 2014 as follows:

A. The costs of health insurance for those personnel currently included in the direct care cost component in subsection 41.1.7(3) must be included in the fixed cost component in subsection 44 and removed from the direct care cost component for the purposes of rebasing and future cost settlements; and

B. The costs of health insurance for those personnel currently included in the routine cost component in subsection 43.4.1(16)(c) must be included in the fixed cost component in subsection 44 and removed from the routine cost component for the purpose of rebasing and future cost settlements.

5. Cost of living adjustment. The Principles of Reimbursement must be amended in subsection 91.1 to set the inflation adjustment cost of living percentage change in nursing facility reimbursement on an annual basis and by reliance on the Consumer Price Index Medical Care Services Index. Beginning with the biennial budget for state fiscal year 2015 in submitting budget proposals to the Governor and the Legislature the department shall include in the budget for nursing facilities funding sufficient to cover the cost of annual inflation as calculated by reference to the Consumer Price Index Medical Care Services index.

6. Supplemental payment for high MaineCare census. The Principles of Reimbursement must be amended to provide a supplemental payment, subject to cost settlement, to nursing facilities with a MaineCare census above 70% beginning July 1, 2014.. The supplemental payment must provide additional reimbursement to those high MaineCare census facilities of 40 cents per resident per day for each 1% MaineCare census above 70%.

7. Increase acuity for dementia. The Principles of Reimbursement must be amended in subsection 80.3.2 to increase the specific resident classification group case mix weight that is attributable to a nursing facility resident who is diagnosed with dementia.

Sec. 2. Cost of care overpayment recoupment. The Department of Health and Human Services shall immediately take all necessary actions to collect cost of care overpayments to nursing facilities and private non-medical institutions which were paid when the department's computer systems, when providing reimbursement owed by the department, failed to take into account the financial contributions paid by residents in the nursing facilities and private non-medical institutions and miscalculated the amounts payable under the MaineCare program. The first $10,000,000 of revenue collected under this section in each year of the 2014-2015 biennium must be used to provide funding for section 6 of this Act.

Sec. 3. Cost of care overpayment correction. The Department of Health and Human Services shall immediately require that the department's contractor Molina Medicaid Solutions make adjustments to the Maine Integrated Health Management Solution computer system to correct and discontinue overpayments in the calculation and deduction of cost of care in the payment of nursing facilities and private non-medical institutions.

Sec. 4. Commission to Continue the Study of Long-term Care Facilities. The Commission to Continue the Study of Long-term Care Facilities, referred to herein as "the commission," is established notwithstanding Joint Rule 353. The membership, duties and functioning of the commission are subject to the following requirements.

A. The commission consists of 11 members appointed as follows:

(1) Two members of the Senate appointed by the President of the Senate, including members from each of the 2 parties holding the largest number of seats in the Legislature;

(2) Three members of the House of Representatives appointed by the Speaker of the House, including members from each of the 2 parties holding the largest number of seats in the Legislature; and

(3) Six members appointed by the Governor who possess expertise in the subject matter of the study, as follows:

(a) The director of a long-term care ombudsman program described under the Maine Revised Statutes, Title 22, section 5106, subsection 11-C;

(b) The director of a statewide association representing long-term care facilities and one representative of a 2nd association of owners of long-term care facilities;

(c) A person who serves as a city manager of a municipality in the State;

(d) A person who serves as a director or who is an owner or administrator of a nursing facility in the State; and

(e) A representative of the Governor's office or the Governor's administration.

B. The first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission. The chairs of the commission are authorized to establish subcommittees to work on the duties listed in paragraph D and to assist the commission. The subcommittees must be composed of members of the commission and interested persons who are not members of the commission and who volunteer to serve on the subcommittees without reimbursement. Interested persons may include individuals with expertise in acuity-based reimbursement systems, a representative of an agency that provides services to the elderly and any other persons with experience in nursing facility care.

C. All appointments must be made no later than 30 days following the effective date of this Act. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members and after adjournment of the 126th Legislature, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative

Council may grant authority for the commission to meet and conduct its business.

D. The commission shall study the following issues and the feasibility of making policy changes to the long-term care system:

(1) Funding for long-term care facilities, payment methodologies and the development of a pay-for-performance program to encourage and reward strong performance by nursing;

(2) Regulatory requirements other than staffing requirements and ratios;

(3) Collaborative agreements with critical access hospitals for the purpose of sharing resources;

(4) The viability of privately owned facilities in rural communities;

(5) The impact on rural populations of nursing home closures; and

(6) Access to nursing facility services statewide.

E. The Legislative Council shall provide necessary staffing services to the commission.

F. The Commissioner of Health and Human Services, the State Auditor and the State Budget Officer shall provide information and assistance to the commission as required for its duties.

G. No later than October 15, 2014, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the Blue Ribbon Commission on Long-term Care and to the First Regular Session of the 127th Legislature.

Sec. 5. Blue Ribbon Commission on Long-term Care. The Blue Ribbon Commission on Long-term Care, referred to herein as "the commission," is established to review the State's plan for long-term care and the provision of services in the community and in facilities.

1. Commission membership. The commission consists of 13 members appointed as follows:

A. Three members of the Senate appointed by the President of the Senate, including members from each of the 2 parties holding the largest number of seats in the Legislature;

B. Four members of the House of Representatives appointed by the Speaker of the House, including members from each of the 2 parties holding the largest number of seats in the Legislature: and

C. Six members appointed by the Governor who possess expertise in the subject matter of the study, as follows:

(1) The director of a long-term care ombudsman program described under the Maine Revised Statutes, Title 22, section 5106, subsection 11-C;
(2) The director of a statewide association representing long-term care facilities;

(3) A representative of a statewide organization representing consumer directed long term care services;

(4) A representative of a statewide association representing area agencies on aging;

(5) A representative of a statewide association providing legal services for the elderly; and

(6) A representative of the Governor's office or the Governor's administration.

2. Chairs. The first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission.

3. Appointments; convening of commission. All appointments must be made no later than 30 days following the effective date of this legislation. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

4. Duties. The commission shall study the following issues and the feasibility of developing or amending a state plan for the provision of long-term care in the community and in facilities:

A. Review the existing plans and programs that exist within the Department of Health and Human Services for providing long-term care services in home-based and community care settings and in nursing and residential care facilities;

B. Develop a state plan for providing long-term care services across the spectrum in a manner that provides dignity for clients and residents and is financially sustainable for individuals and the MaineCare program;

C. Receive and consider recommendations from the Commission to Continue the Study of Long-Term Care Facilities.

5. Staff assistance. The commission shall be staffed by the Legislative Council with assistance from contracted staff and expert consultant services pursuant to section 7.

6. Report. No later than November 5, 2014, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the First Regular Session of the 127th Legislature.

7. Funding. The commission shall seek funding contributions to fully fund the costs of contracted staff and expert consultant services. All funding is subject to approval by the

Legislative Council in accordance with its policies. The commission may not meet unless outside funding has been obtained and approval has been granted by the Legislative Council.

Sec. 6. Appropriations and allocations

Department of Health and Human Services
Nursing Facilities 0148
Provides funding to pay for nursing facilities services

GENERAL FUND		**2013-2014**	**2014-2015**
			$10,000,000
OTHER SPECIAL REVENUE FUNDS	(To be determined)		_____
FEDERAL EXPENDITURES FUND	(To be determined)		_____
Total	(To be determined)		_____

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

SUMMARY

This bill implements the recommendations of the Commission to Study Long-term Care Facilities. The bill includes amendments to the MaineCare Principles of Reimbursement for Nursing Facilities with regard to facility base year, peer group upper limit, administrative and management ceiling, health insurance costs, cost of living adjustment, supplemental payment for high MaineCare census and increased acuity for dementia. The bill includes a directive to the Department of Health and Human Services to collect amounts overpaid to nursing facilities and private non-medical institutions under the category of cost of care and a directive to the department to correct the computer problems that are leading to the overpayments. The bill provides funding for nursing facilities to fund the amendments to the MaineCare Principles of Reimbursement in the bill, the new funding being provided by the revenues from collection of MaineCare overpayments made because of cost of care miscalculations. The bill also includes the establishment of two study commissions: the Commission to Continue the Study of Long-term Care Facilities and the Blue Ribbon Commission on Long-term Care. No later than October 15, 2014, the Commission to Continue the Study of Long-term Care Facilities is required to submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the Blue Ribbon Commission on Long-term Care and to the First Regular Session of the 127th Legislature. No later than November 5, 2014, the Blue Ribbon Commission on Long-term Care is required to submit a report that includes its findings and recommendations, including suggested legislation, to the First Regular Session of the 127th Legislature.

APPENDIX A

Authorizing Legislation, Resolve 2013, Chapter 78

APPROVED | CHAPTER
JULY 16, 2013 | 78
BY GOVERNOR | RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND THIRTEEN

S.P. 331 - L.D. 986

Resolve, To Establish the Commission To Study 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, it is necessary that this legislation take effect immediately in order to allow sufficient time for the Commission To Study Long-term Care Facilities to conduct its work; 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 To Study Long-term Care Facilities established. Resolved: That, notwithstanding Joint Rule 353, the Commission To Study 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 11 members appointed as follows:

1. Two members of the Senate appointed by the President of the Senate, including members from each of the 2 parties holding the largest number of seats in the Legislature;

2. Three members of the House of Representatives appointed by the Speaker of the House, including members from each of the 2 parties holding the largest number of seats in the Legislature; and

3. Six members appointed by the Governor who possess expertise in the subject matter of the study, as follows:

A. The director of a long-term care ombudsman program described under the Maine Revised Statutes, Title 22, section 5106, subsection 11-C;

B. The director of a statewide association representing long-term care facilities and one representative of a 2nd association of owners of long-term care facilities;

C. A person who serves as a city manager of a municipality in the State;

D. A person who serves as a director or who is an owner or administrator of a nursing facility in the State; and

E. A representative of the Governor's office or the Governor's administration; and be it further

Sec. 3. Chairs; subcommittees. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission. The chairs of the commission are authorized to establish subcommittees to work on the duties listed in section 5 and to assist the commission. The subcommittees must be composed of members of the commission and interested persons who are not members of the commission and who volunteer to serve on the subcommittees without reimbursement. Interested persons may include representatives of nursing facilities with a high percentage of residents whose care is reimbursed through the MaineCare program, individuals with specialized knowledge in implementing an acuity-based staffing system, individuals with expertise in acuity-based reimbursement systems, a representative of an agency that provides services to the elderly and any other persons with experience in nursing facility care; and be it further

Sec. 4. Appointments; convening of commission. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business; and be it further

Sec. 5. Duties. Resolved: That the commission shall study the following issues and the feasibility of making policy changes to the long-term care system:

1. Funding for long-term care facilities, including the development of an acuity-based reimbursement system as proposed in Legislative Document 1245 of the 126th Legislature, "Resolve, Directing the Department of Health and Human Services To Create a More Equitable, Transparent Resource Allocation System for Nursing Facilities Based on Residents' Needs," and the development of a pay-for-performance program to encourage and reward strong performance by nursing facilities as proposed in Legislative Document 928 of the 126th Legislature, "An Act To Improve MaineCare Nursing Home Reimbursement To Preserve Access and Promote Quality";

2. Staffing and regulatory requirements, including the development of minimum staffing requirements based on a 24-hour time period as proposed in Legislative Document 1246 of the 126th Legislature, "An Act To Promote Greater Staffing Flexibility without Compromising Safety or Quality in Nursing Facilities";

3. Collaborative agreements with critical access hospitals for the purpose of sharing resources;

4. Reimbursement mechanisms to reimburse facilities for which the MaineCare program is the payor for a high percentage of the residents as proposed in Legislative Document 928 of the 126th Legislature, "An Act To Improve MaineCare Nursing Home Reimbursement To Preserve Access and Promote Quality";

5. The viability of privately owned facilities in rural communities; and

6. The impact on rural populations of nursing home closures.

In performing the study the commission shall review the final report of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities established by Resolve 1997, chapter 81; and be it further

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the commission; and be it further

Sec. 7. Information and assistance. Resolved: That the Commissioner of Health and Human Services, the State Auditor and the State Budget Officer shall provide information and assistance to the commission as required for its duties; and be it further

Sec. 8. Report. Resolved: That, no later than December 4, 2013, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the Second Regular Session of the 126th Legislature.

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

APPENDIX B

Membership list, Commission to Study Long-Term Care Facilities

Commission to Study Long-term Care Facilities

Resolve 2013, Ch. 78

Thursday, October 17, 2013

Appointment(s) by the Governor

Kenneth J. Albert III DHHS 41 Anthony Ave. Augusta, ME 04333 207 287-6664	Representative of Governor's Office
Diane M. Barnes P.O. Box 1273 Calais, ME 04619 207 454-2512	City Manager
Philip A. Cyr 435 Washburn Street Caribou, ME 04736 207 498-3102	Nursing facility director, owner, or administrator
Richard A. Erb 35 Melden Drive Brunswick, ME 04011 207 623-1146	Director of a statewide association representing long-term care facilities
Brenda Gallant 196 Beechnut Hill Road Wiscasset, ME 04578 207 621-1079	Director of a long-term care ombudsman program
S. John Watson Jr. 41 Craige Street Portland, ME 04102 207 221-7000	Representative of a statewide association of long-term care facility owners

Appointment(s) by the President

Sen. Margaret M. Craven - Chair 41 Russell St Lewiston, ME 04240 207 783-1897	Senate Member
Sen. David C. Burns 159 Dodge Road Whiting, ME 04691 207 733-8856	Senate Member

Appointment(s) by the Speaker

Rep. Peter C. Stuckey - Chair 20 Vaill Street Portland, ME 04103 207 773-3345	House Member
Rep. Richard R. Farnsworth 55 Old Mast Road Portland, ME 04102 207 878-9663	House Members
Rep. Beth P. Turner 74 Main Road Burlington, ME 04417 207 732-4625	House Member

---

Staff:

Jane Orbeton 287-1670
OPLA

Anna Broome 287-1670
OPLA

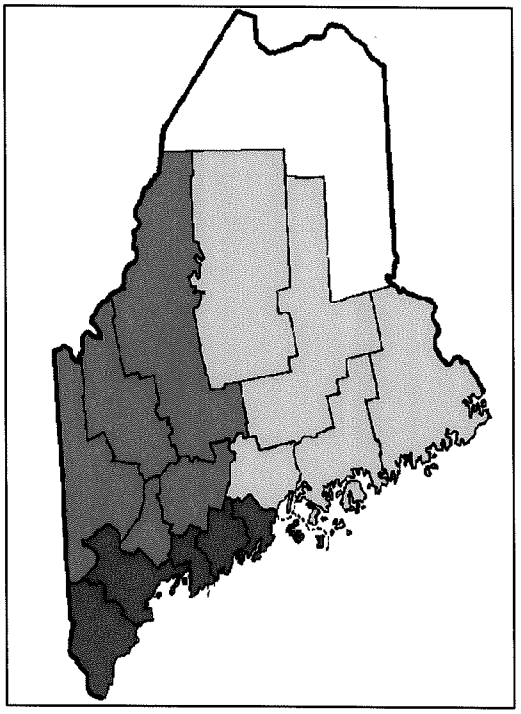
APPENDIX C

Berry, Dunn, McNeil and Parker Background on Shortfall

REGIONAL MAP

Following this document, you will find information regarding cost report data by region for the State of Maine. We have subdivided Maine into four regions organized by county. Below are listed the breakdowns by region and county so that when looking at any of our regional reports you will have a complete understanding of which facilities belong to a particular region.

Color	County	Region
Red	Lincoln	1
Red	Cumberland	1
Red	Knox	1
Red	York	1
Red	Sagadahoc	1
Green	Somerset	2
Green	Androscoggin	2
Green	Kennebec	2
Green	Franklin	2
Green	Oxford	2
Blue	Piscataquis	3
Blue	Penobscot	3
Blue	Waldo	3
Blue	Hancock	3
Blue	Washington	3
Yellow	Aroostook	4



BerryDunn

MaineCare NF Shortfall
BerryDunn's Industry Cost Data

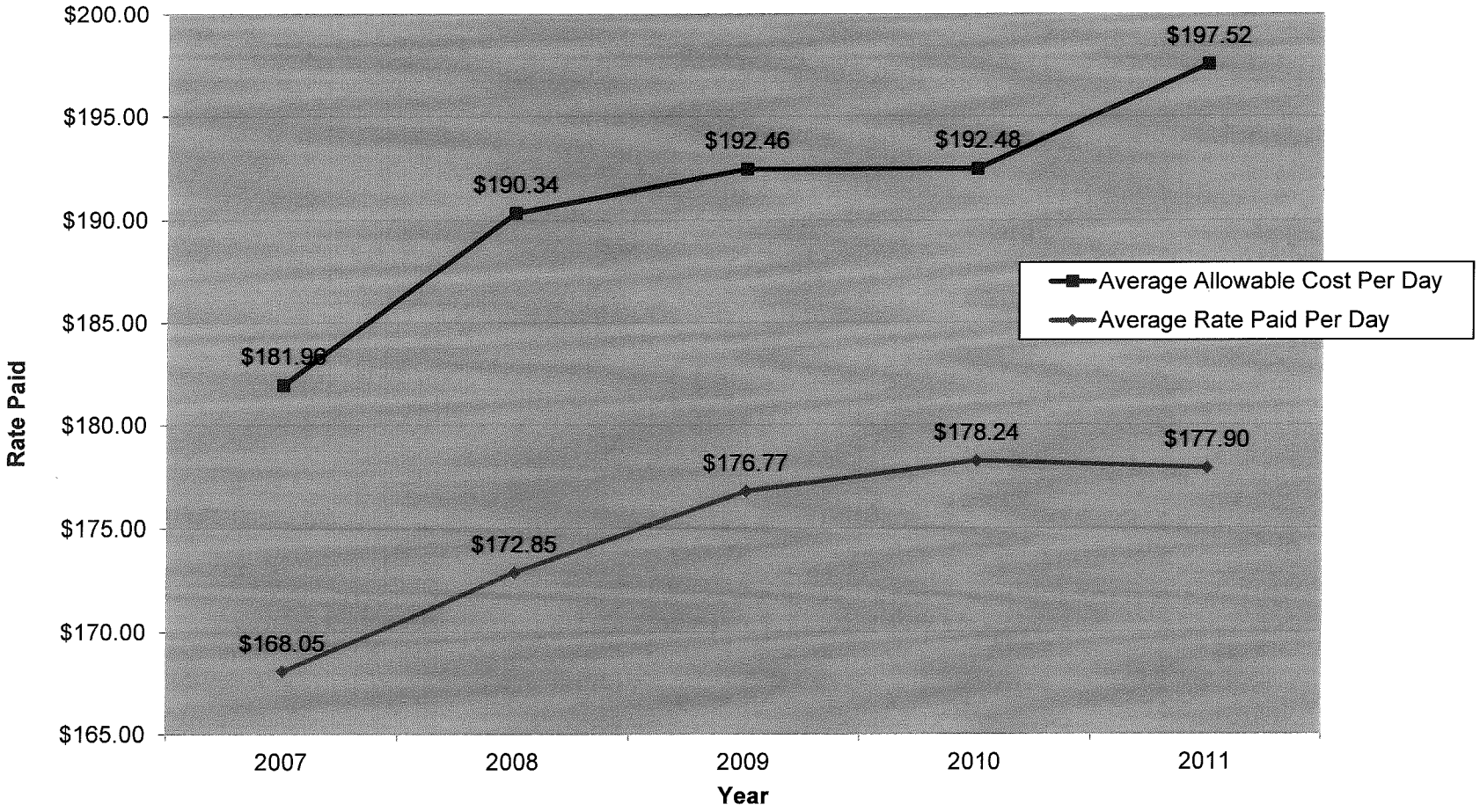
	2009		2010		2011	
	Total	Average Per Facility	Total	Average Per Facility	Total	Average Per Facility
Region 1	$ (11,432,294)	$ (326,637)	$ (9,826,386)	$ (280,754)	$ (12,734,002)	$ (363,829)
Region 2	(7,063,101)	(220,722)	(7,767,642)	(242,739)	(9,065,383)	(283,293)
Region 3	(3,366,872)	(124,699)	(3,303,672)	(122,358)	(5,398,985)	(199,962)
Region 4	(2,294,609)	(208,601)	(1,588,868)	(144,443)	(2,211,407)	(201,037)
Total	$ (24,156,876)		$ (22,486,568)		$ (29,409,777)	

Note: Based on 2009, 2010 and 2011 cost data. Shortfall represents difference between allowable costs per day and reimbursement per day.

Data includes all non hospital-based facilities and was compiled by BerryDunn utilizing "as-filed" cost reports for each reporting period.

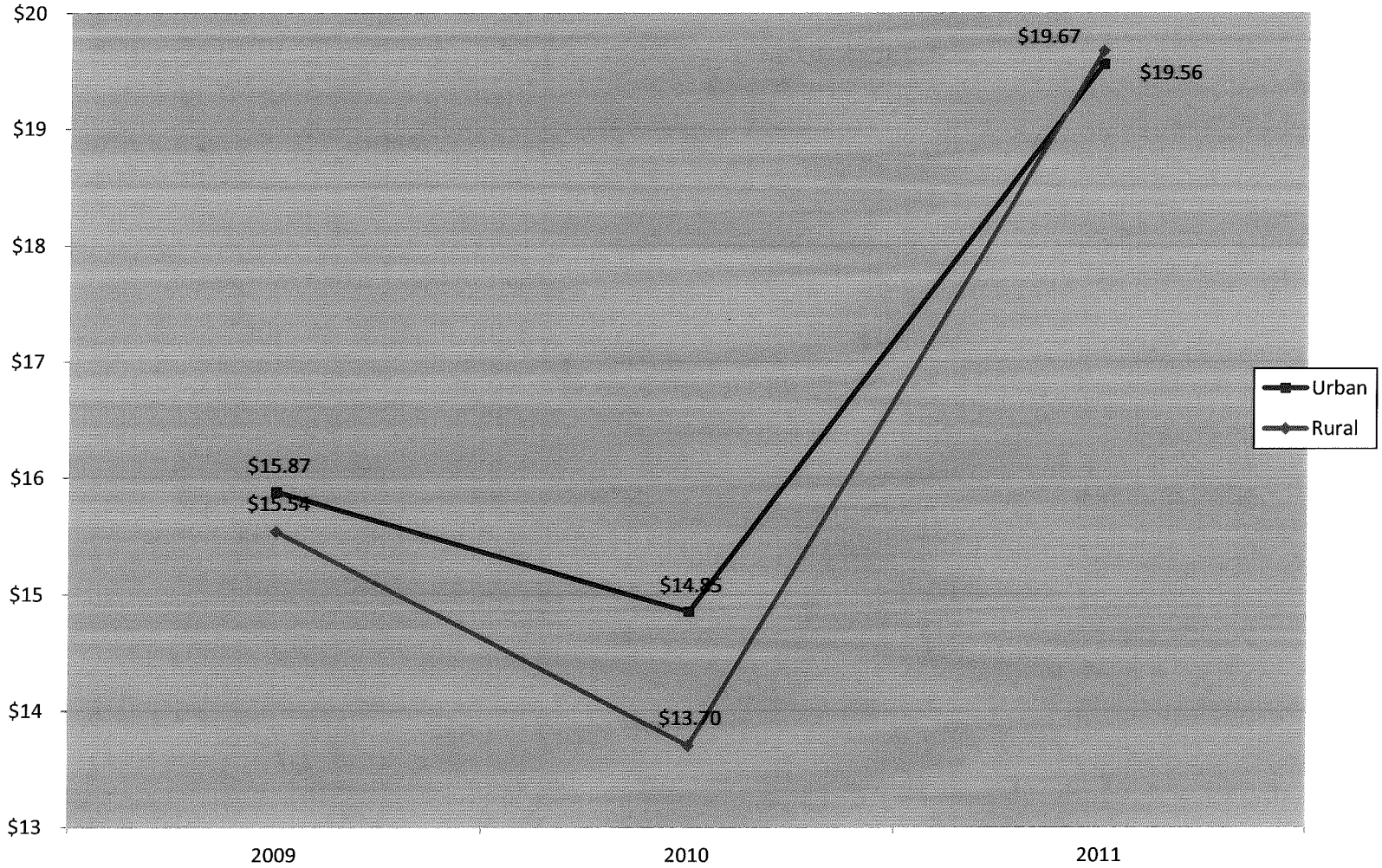
BerryDunn

Five Year Comparison of Average Medicaid Allowable Cost Per Day to Average Rate Paid to Nursing Facilities



Data includes all non hospital-based facilities and was compiled by BerryDunn utilizing "as-filed" cost reports for each reporting period.

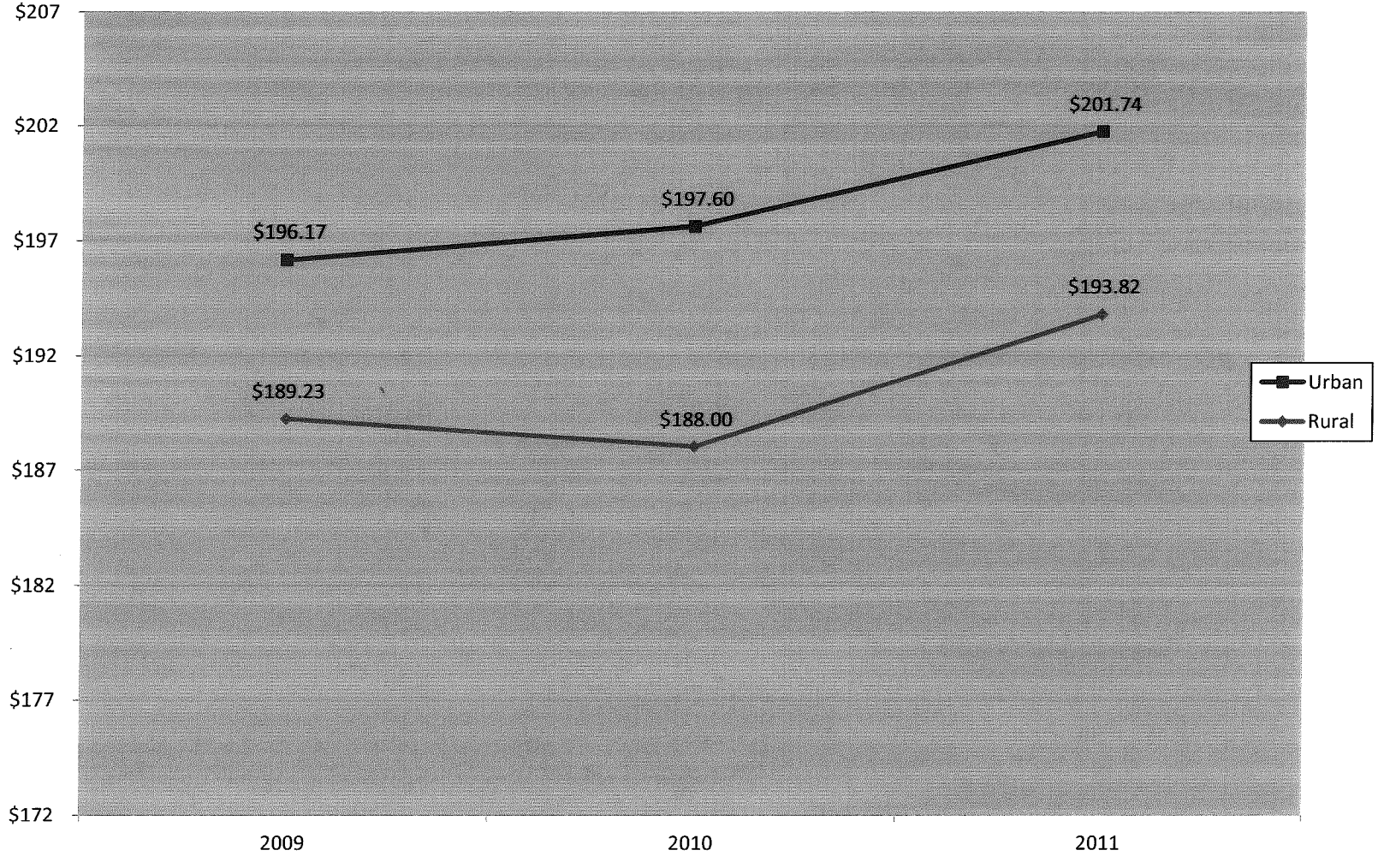
Average Medicaid Shortfall Per Day



Data includes all non hospital-based facilities and was compiled by BerryDunn utilizing "as-filed" cost reports for each reporting period.
Urban - includes providers located in Core Based Statistical Areas (CBSA's) of Penobscot County (#12620), Androscoggin Country (#30340) and Cumberland, Sagadahoc and York Counties (#38860) as defined by CMS.
Rural - includes providers located in Core Based Statistical Area (CBSA's) of Aroostook, Piscataquis, Somerset, Franklin, Oxford, Kennebec, Lincoln, Knox, Waldo, Hancock and Washington Counties (#99920) as defined by CMS.

BerryDunn

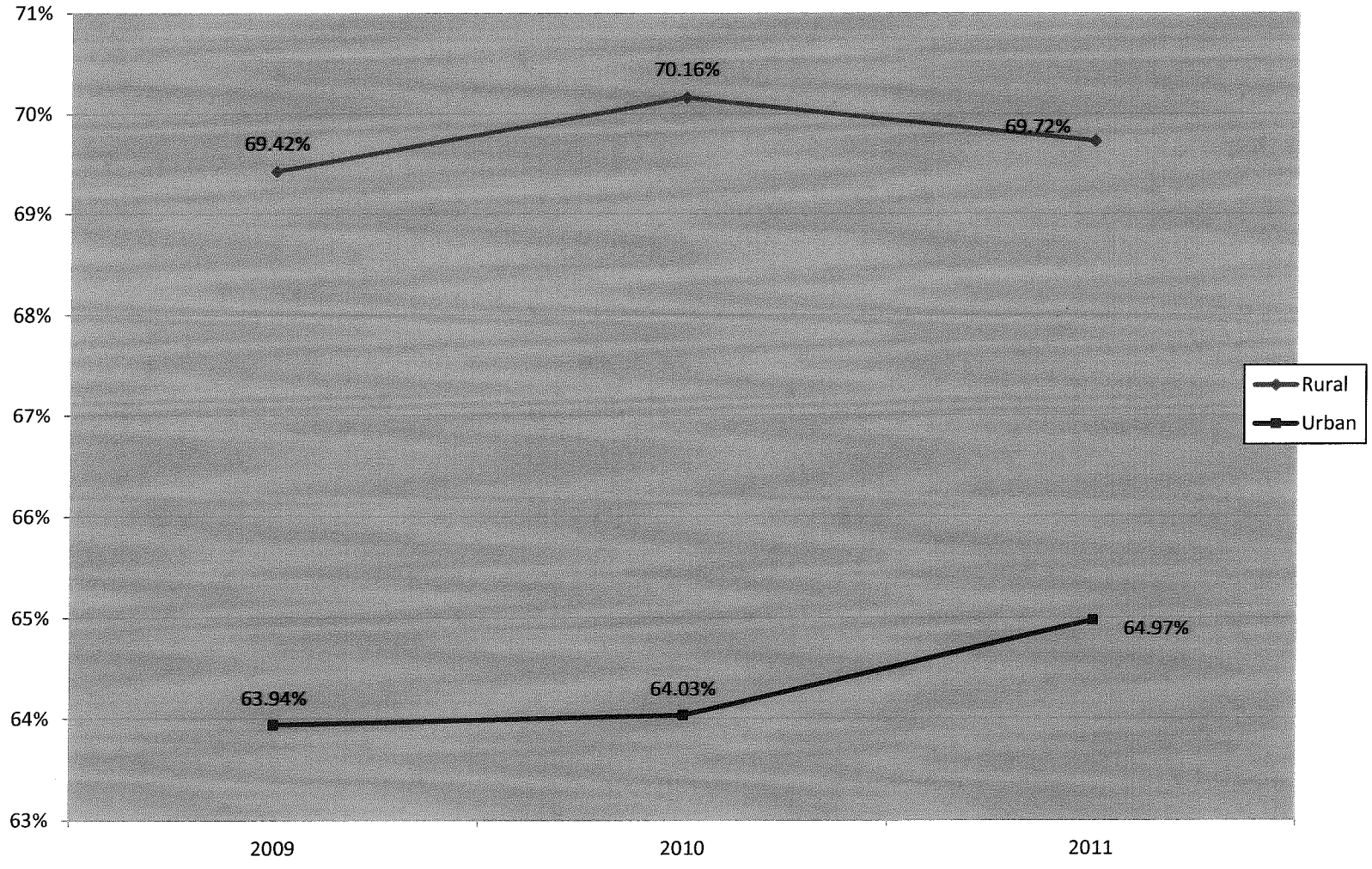
Average Medicaid Cost Per Day



Data includes all non hospital-based facilities and was compiled by BerryDunn utilizing "as-filed" cost reports for each reporting period.
Urban - includes providers located in Core Based Statistical Areas (CBSA's) of Penobscot County (#12620), Androscoggin Country (#30340) and Cumberland, Sagadahoc and York Counties (#38860) as defined by CMS.
Rural - includes providers located in Core Based Statistical Area (CBSA's) of Aroostook, Piscataquis, Somerset, Franklin, Oxford, Kennebec, Lincoln, Knox, Waldo, Hancock and Washington Counties (#99920) as defined by CMS.

BerryDunn

MaineCare Payor Percentage



Data includes all non hospital-based facilities and was compiled by BerryDunn utilizing "as-filed" cost reports for each reporting period.
Urban - includes providers located in Core Based Statistical Areas (CBSA's) of Penobscot County (#12620), Androscoggin Country (#30340) and Cumberland, Sagadahoc and York Counties (#38860) as defined by CMS.
Rural - includes providers located in Core Based Statistical Area (CBSA's) of Aroostook, Piscataquis, Somerset, Franklin, Oxford, Kennebec, Lincoln, Knox, Waldo, Hancock and Washington Counties (#99920) as defined by CMS.

APPENDIX D

Presentation by Julie Fralich, Muskie School of Public Service Report

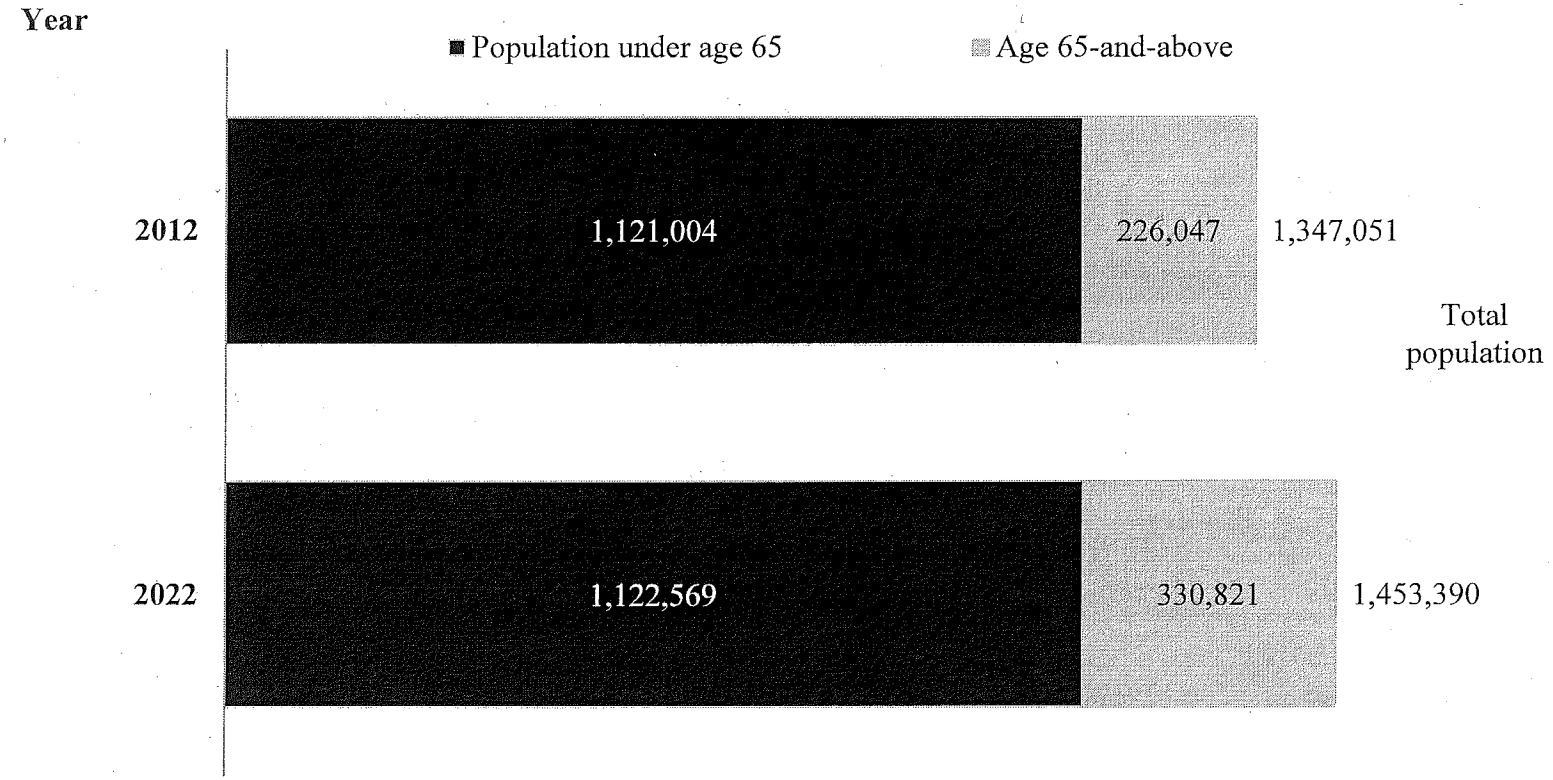
Commission to Study Long-Term Care Facilities

Julie Fralich
Muskie School of Public Service
October 25, 2013
julief@usm.maine.edu

Overview of Presentation

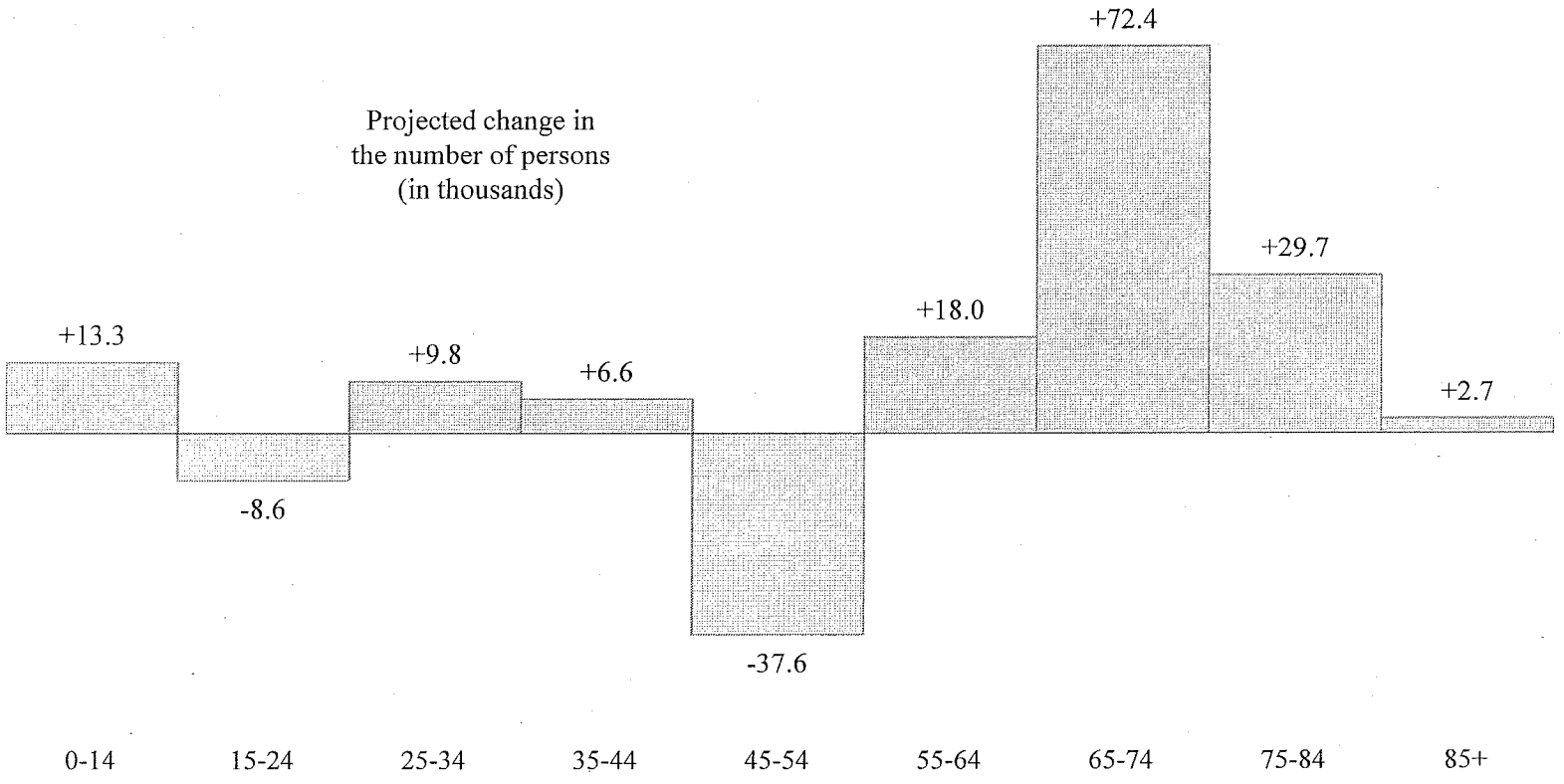
- Some Demographics for Maine
- Overview of Long Term Care System
  - Maine versus U.S.
- Nursing Facility and Residential Care Use and Supply in Maine
- Trends Across LTSS Settings in Maine
- Nursing Facility Pay for Performance and other Incentives
- Other LTSS Initiatives (Maine and US)

The number of people in Maine who are over age 65 will increase by 105,000 in 10 years.



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The greatest increase in the next 10 years is among those who are 65-74. Maine is also seeing a decline in the number of people in the age 45-54 age group.



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Comparison of Maine and U.S.

	Maine	U.S.	Rank (High to Low)
NF beds per 1000/65+, 2010	34	42	38
NF Occupancy Rate, 2008	90%	83%	9
Residents w/low care needs, 2010	2%	17%	49
Residents w/dementia, 2010	55%	46%	1
Residents with Medicare as primary payer, 2010	16%	14%	12
Percent change in NF residents (2005 to 2010)	-5%	-4%	30
Medicaid payment per day for nursing facility care, 2011	$178	$178	20

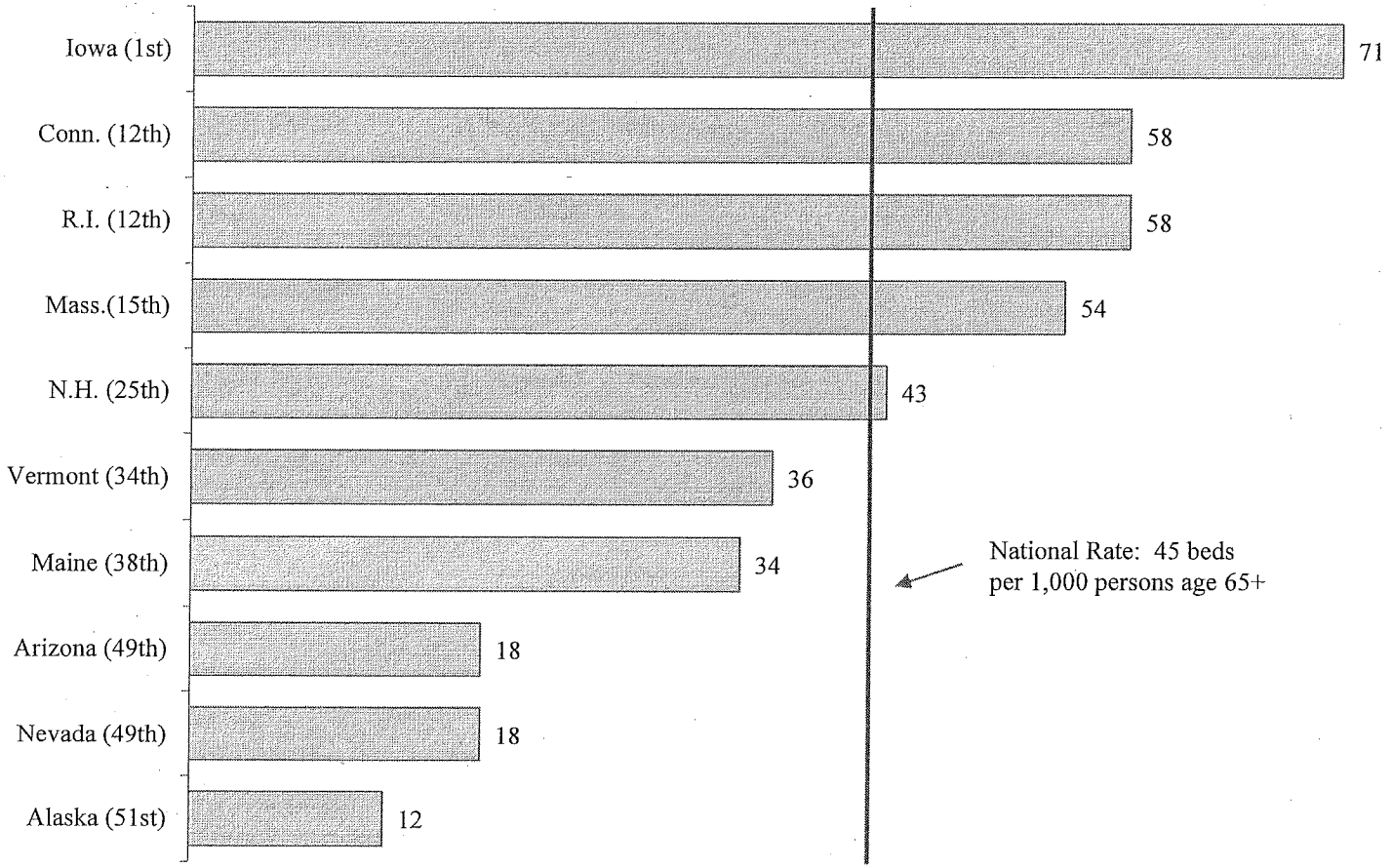
Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Comparison of LTSS Expenditures for Maine and US

	Maine	US	Rank (High To Low)
Medicaid Nursing Facility Expenditures per person served, 2008	$23,988	$29,533	44
Medicaid Aged/Disabled Waiver Expenditures per person served, 2008	$14,163	$10,710	11
ICF-MR Expenditures per person, 2008	$137,218	$123,053	19
MR/DD Waiver Services Expenditures per person served, 2008	$77,736	$42,896	3

Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Number of nursing facility beds per 1,000 persons age 65-and-above



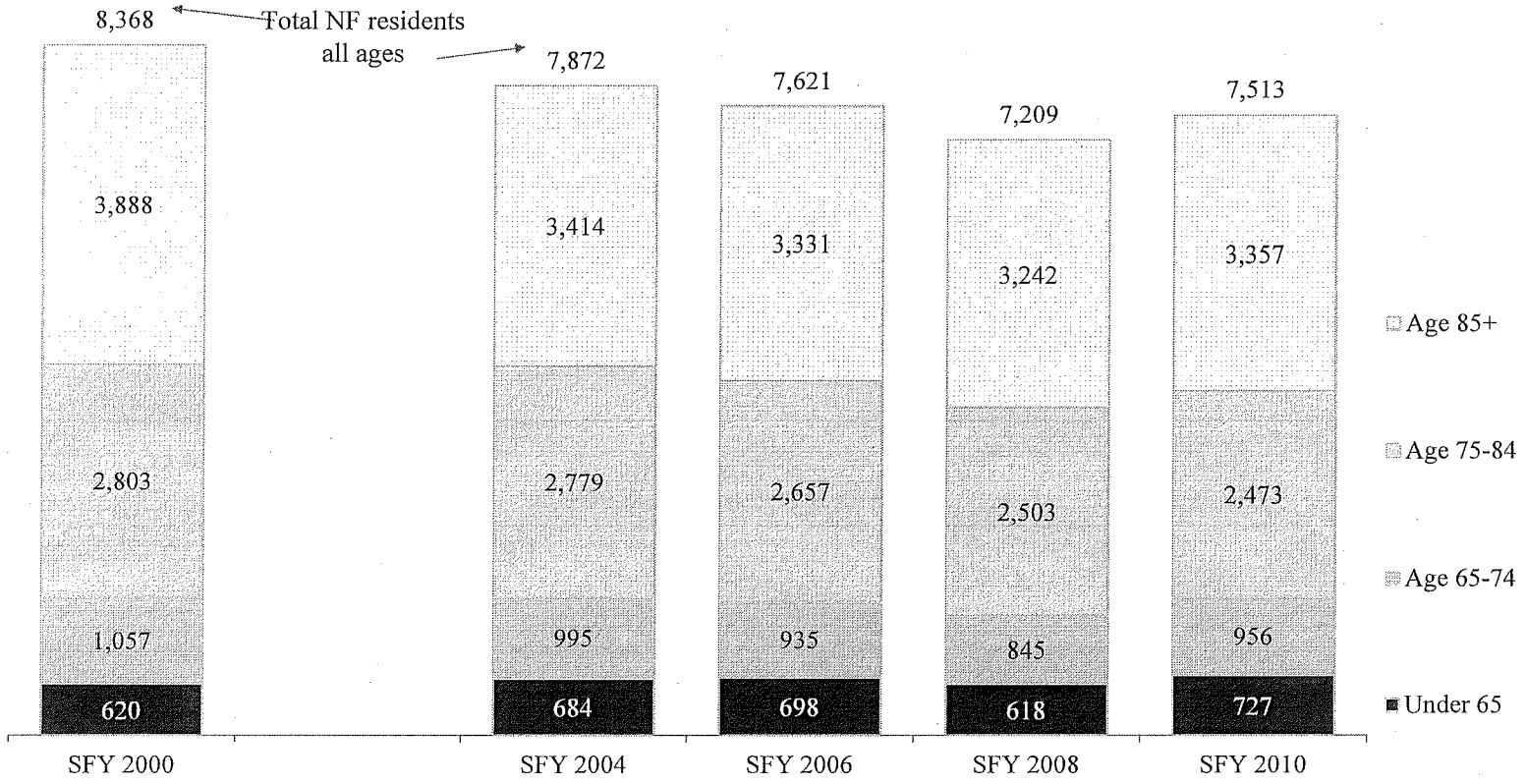
Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Change in LTSS Spending, 2004- 2009, by Service

	Maine	% Change	
		Maine	US
Nursing Facilities	+$8 million	+3%	+12%
Aged/Disabled Waivers	-$1 million	-5%	+77%
Personal Care Services and other HCBS	+$7 million	+15%	+67%
ICF/MR	+$4 million	+7%	+8%
MR/DD Waivers	+$173million	+88%	+54%

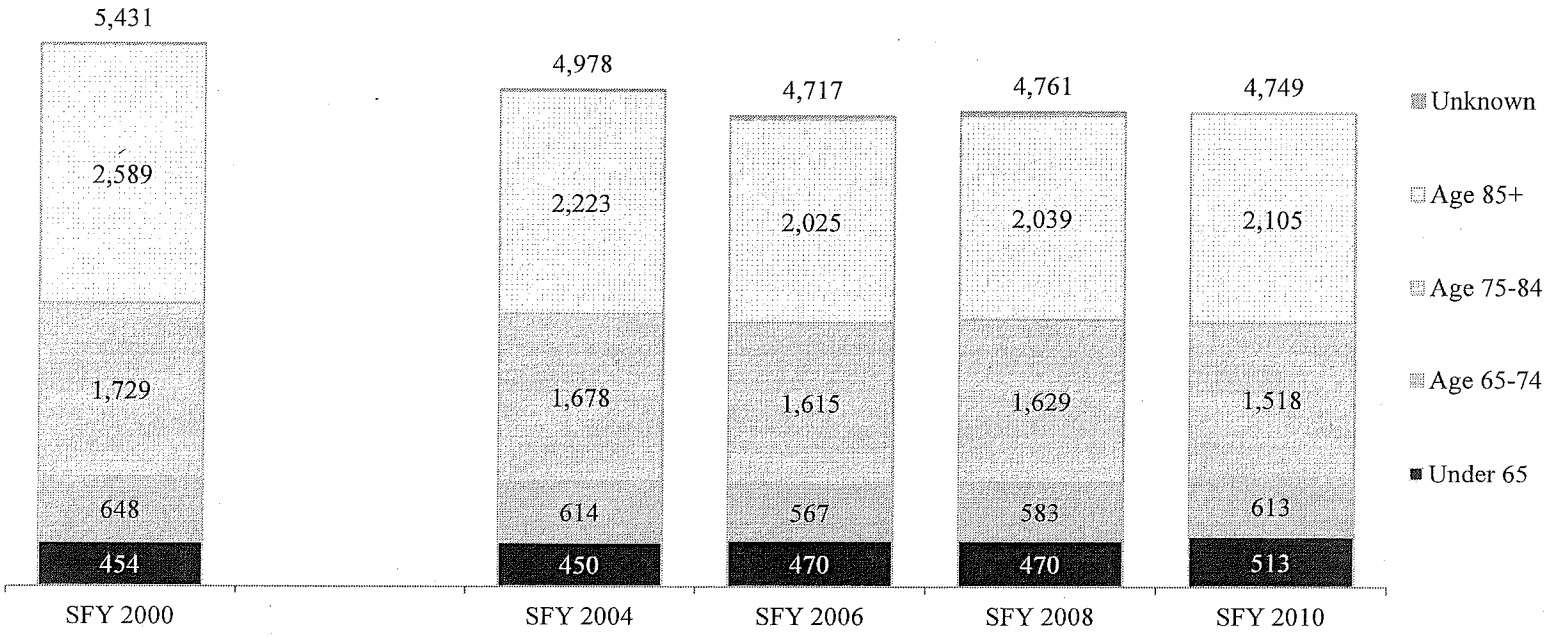
Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Maine's average monthly number of nursing facility residents declined from 2000 to 2008, then increased



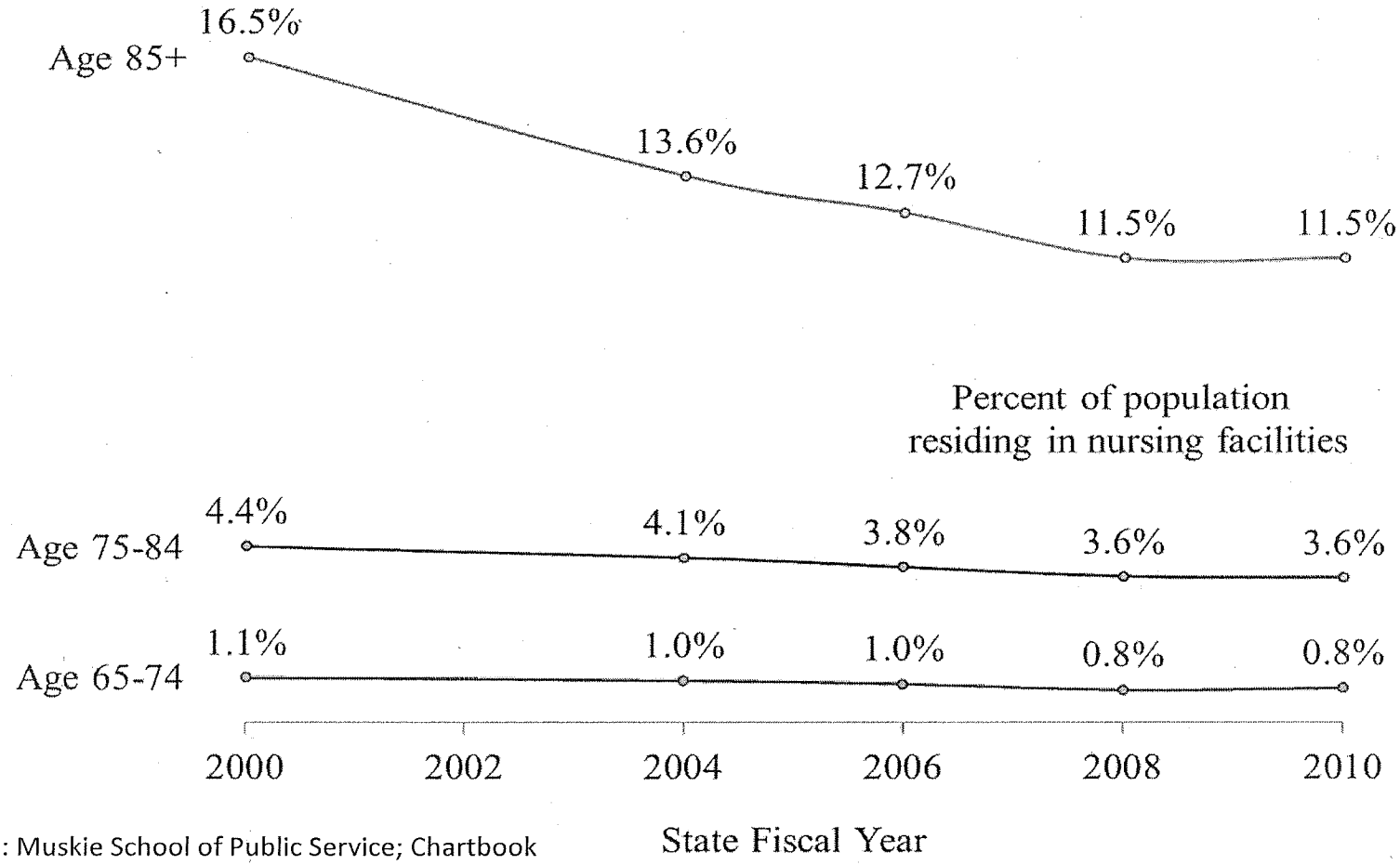
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The average monthly number of MaineCare members in nursing facilities declined from 2000 to 2010



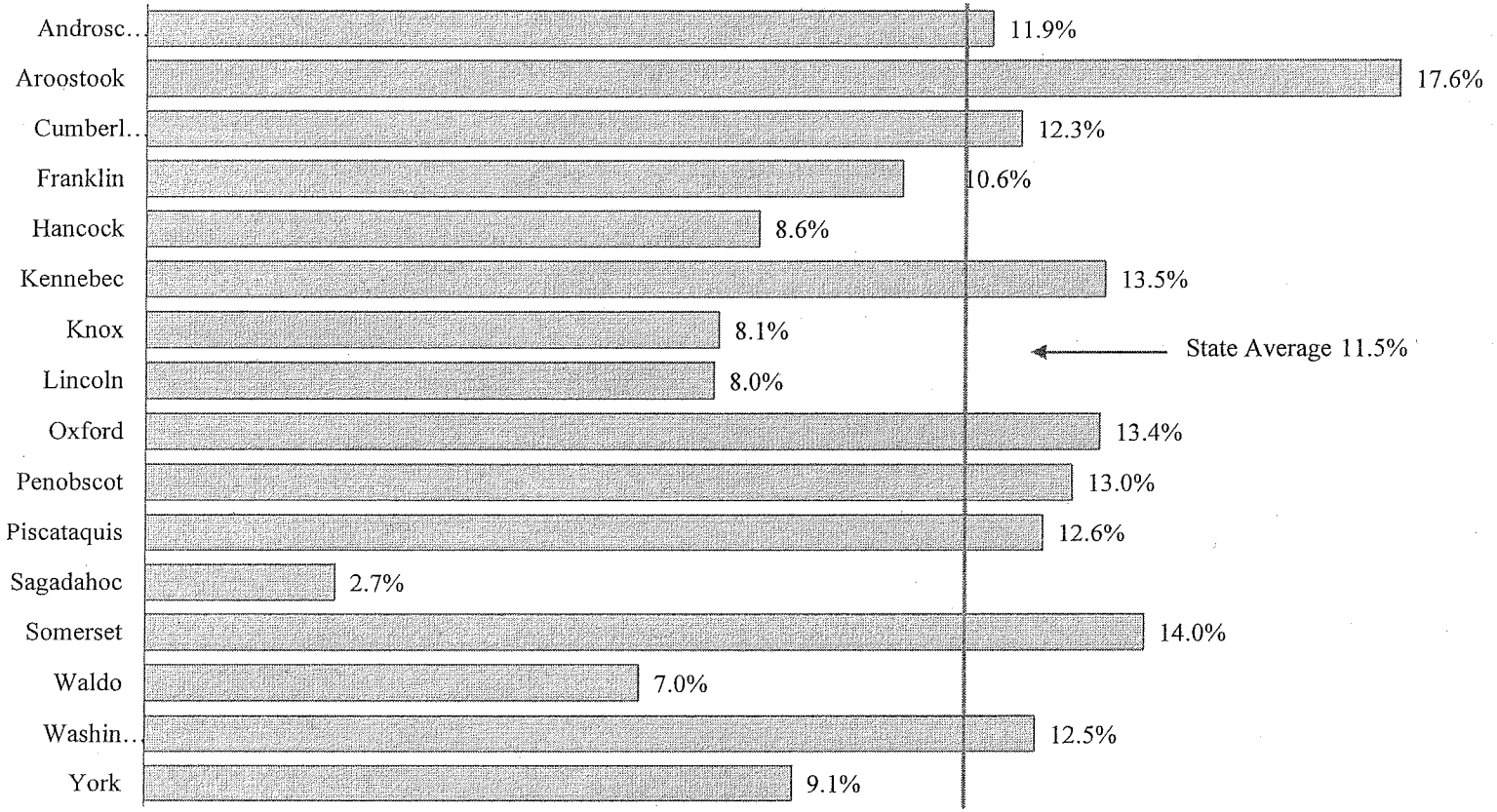
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The percent of Maine's population residing in nursing facilities (all payers) declined steadily across all age groups from 2000 to 2008, and then leveled off in 2010.



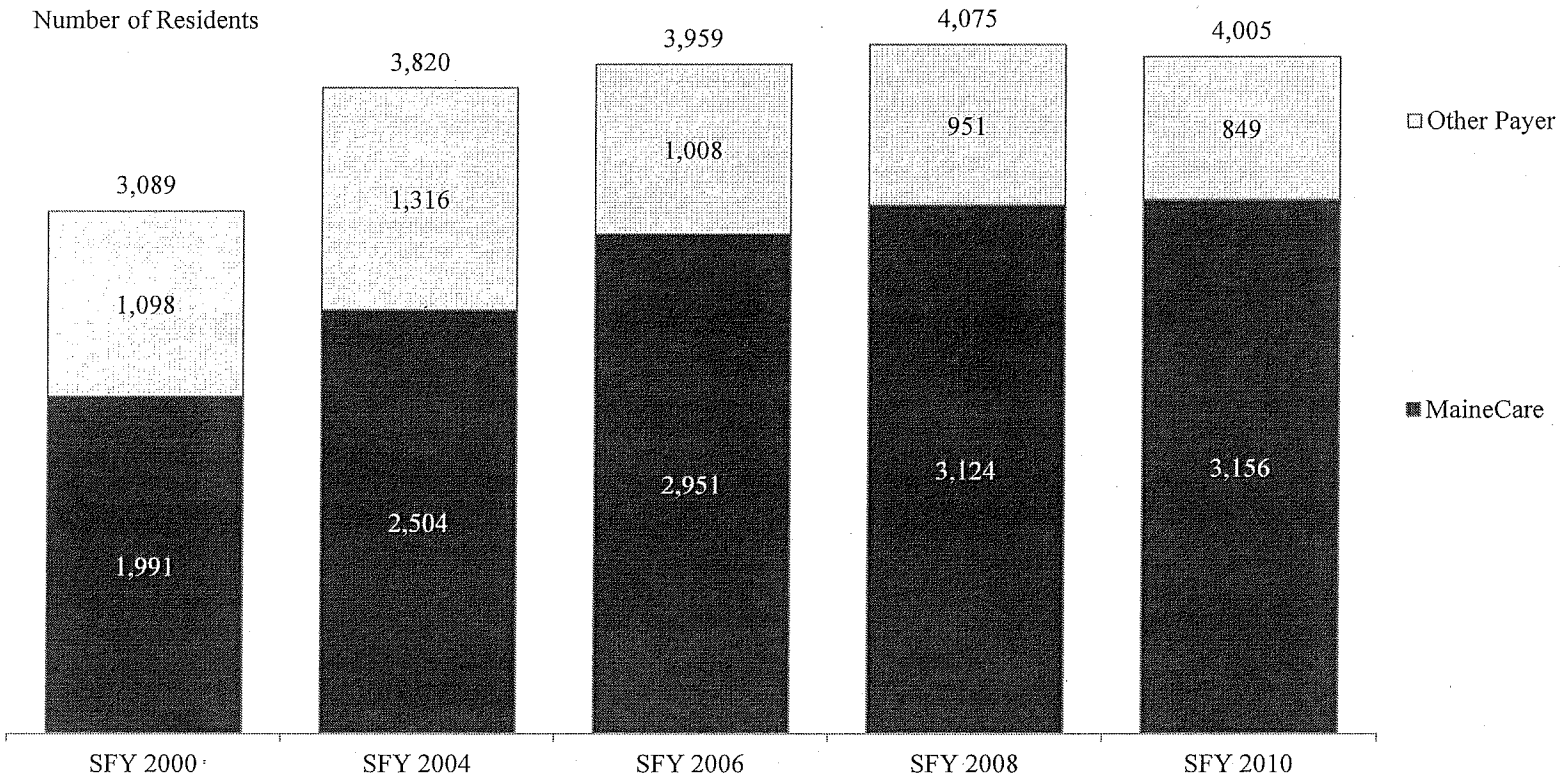
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Percent of population age 85 and above who resided in nursing facilities in 2010



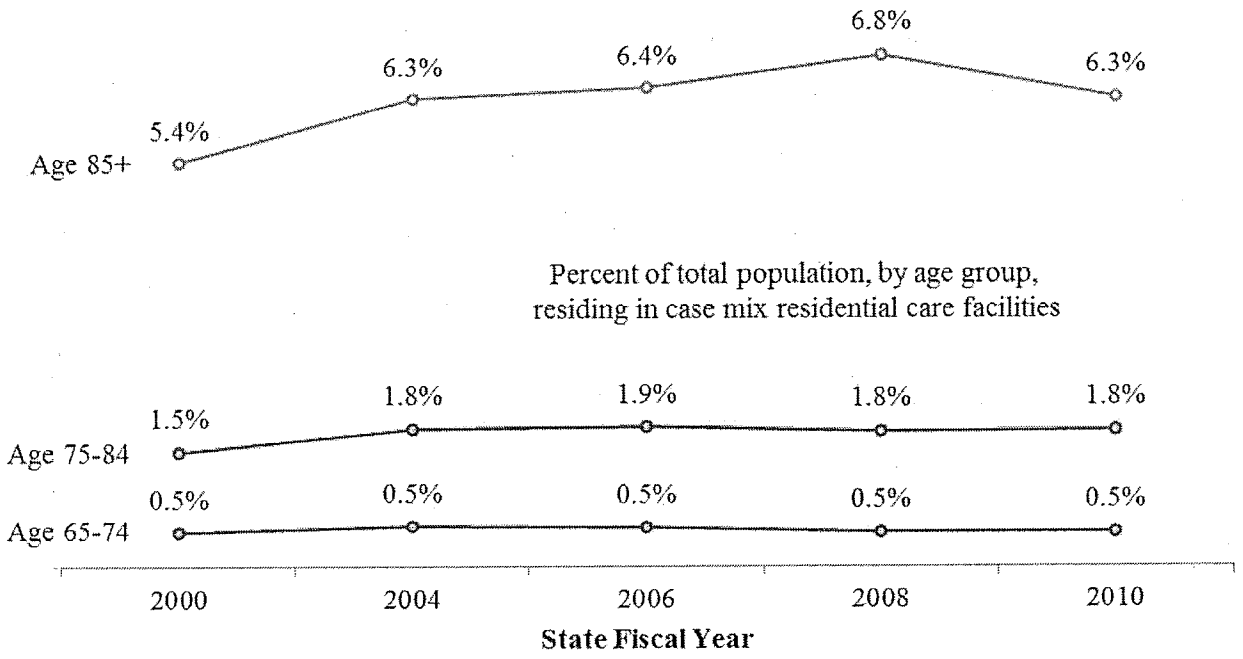
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Average number of residential care residents grew 30% between SFY 2000 and SFY 2010



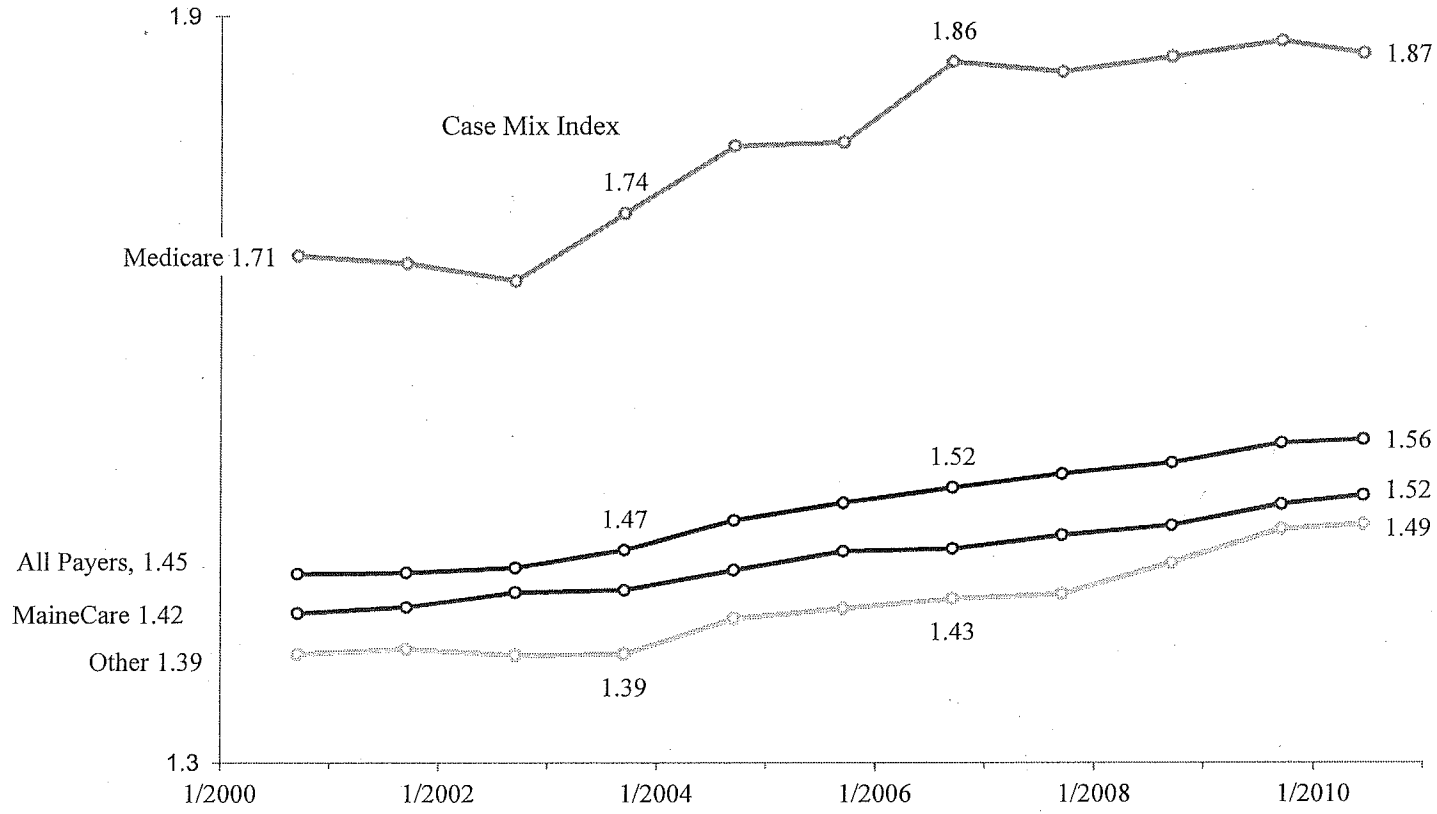
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The percent of Maine's population residing in residential care facilities by age group, 2000 to 2012



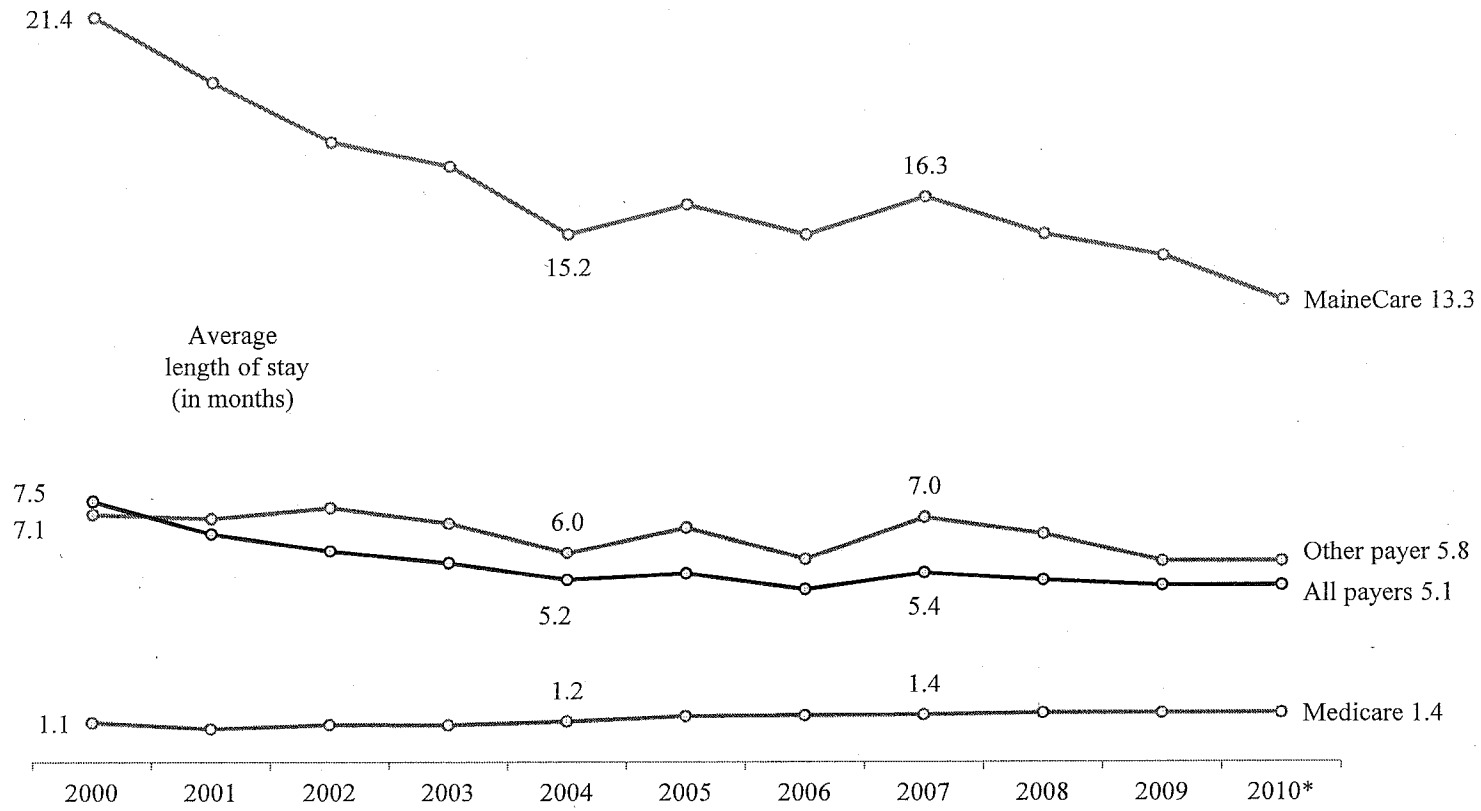
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The case mix (acuity) of nursing home residents increased from 2000 to 2010



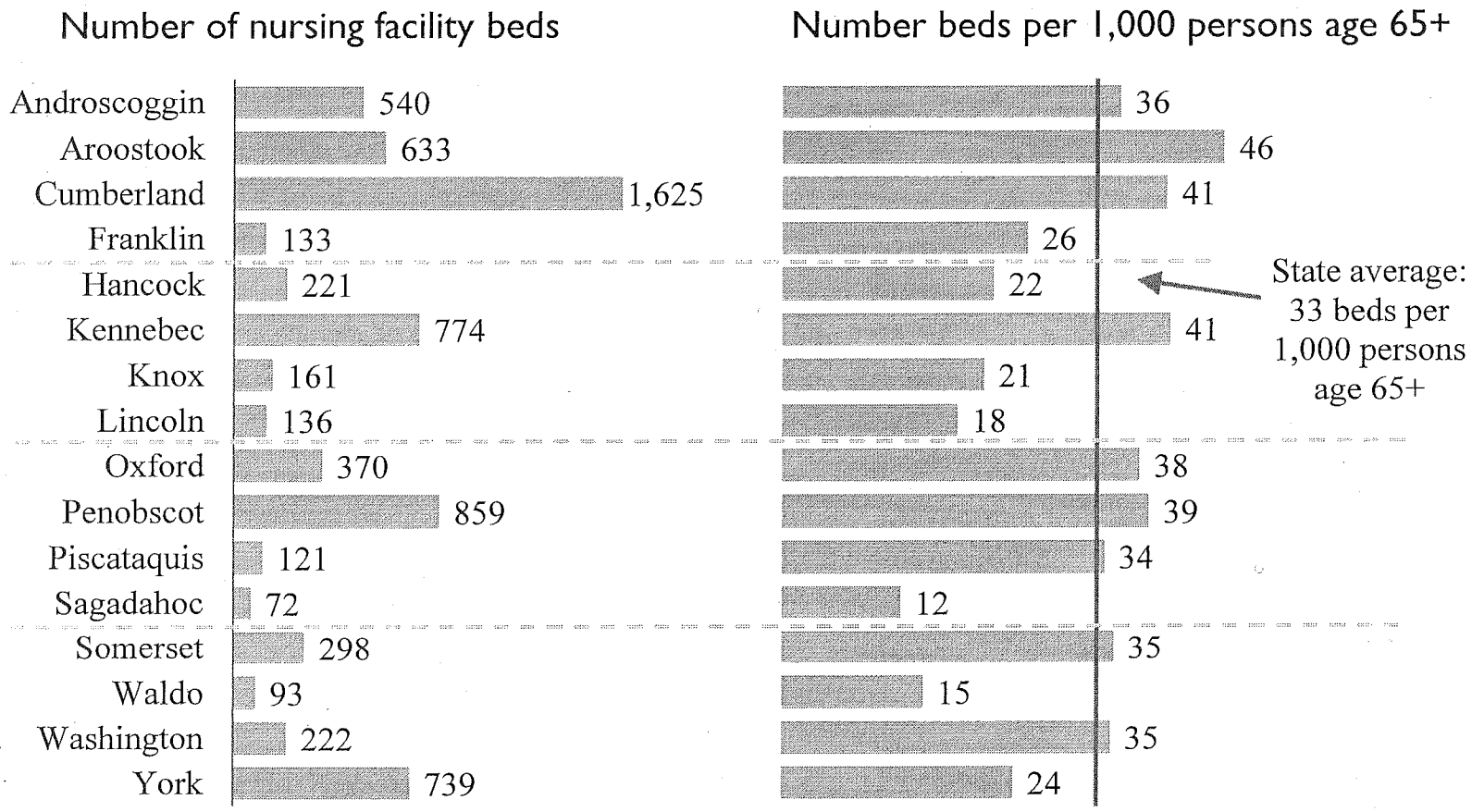
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Average length of stay in nursing facilities for MaineCare residents declined from 2000 to 2014



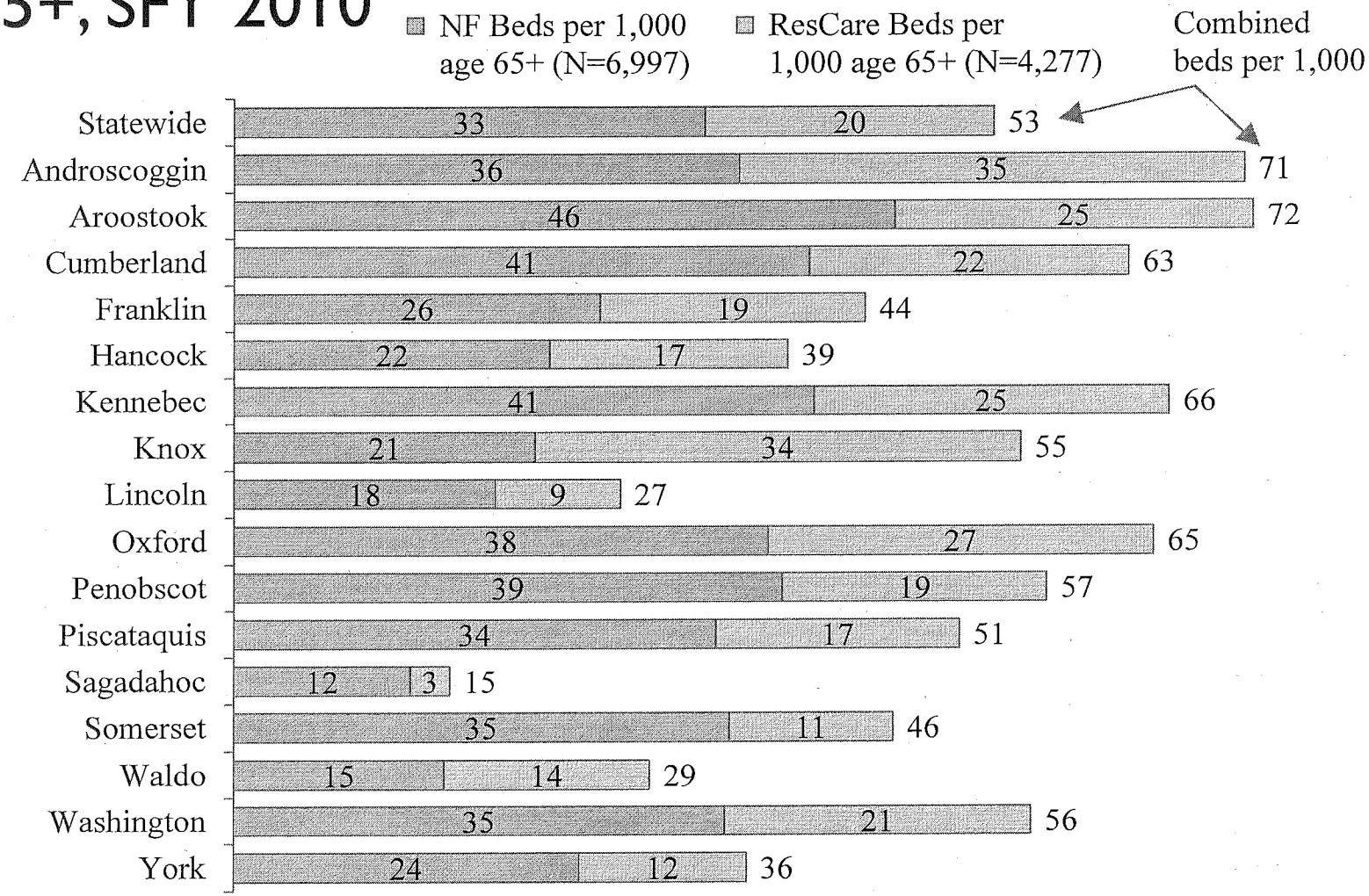
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The distribution of nursing facility beds by Maine County and number of beds per 1,000 persons, age 65-or-above, SFY 2010



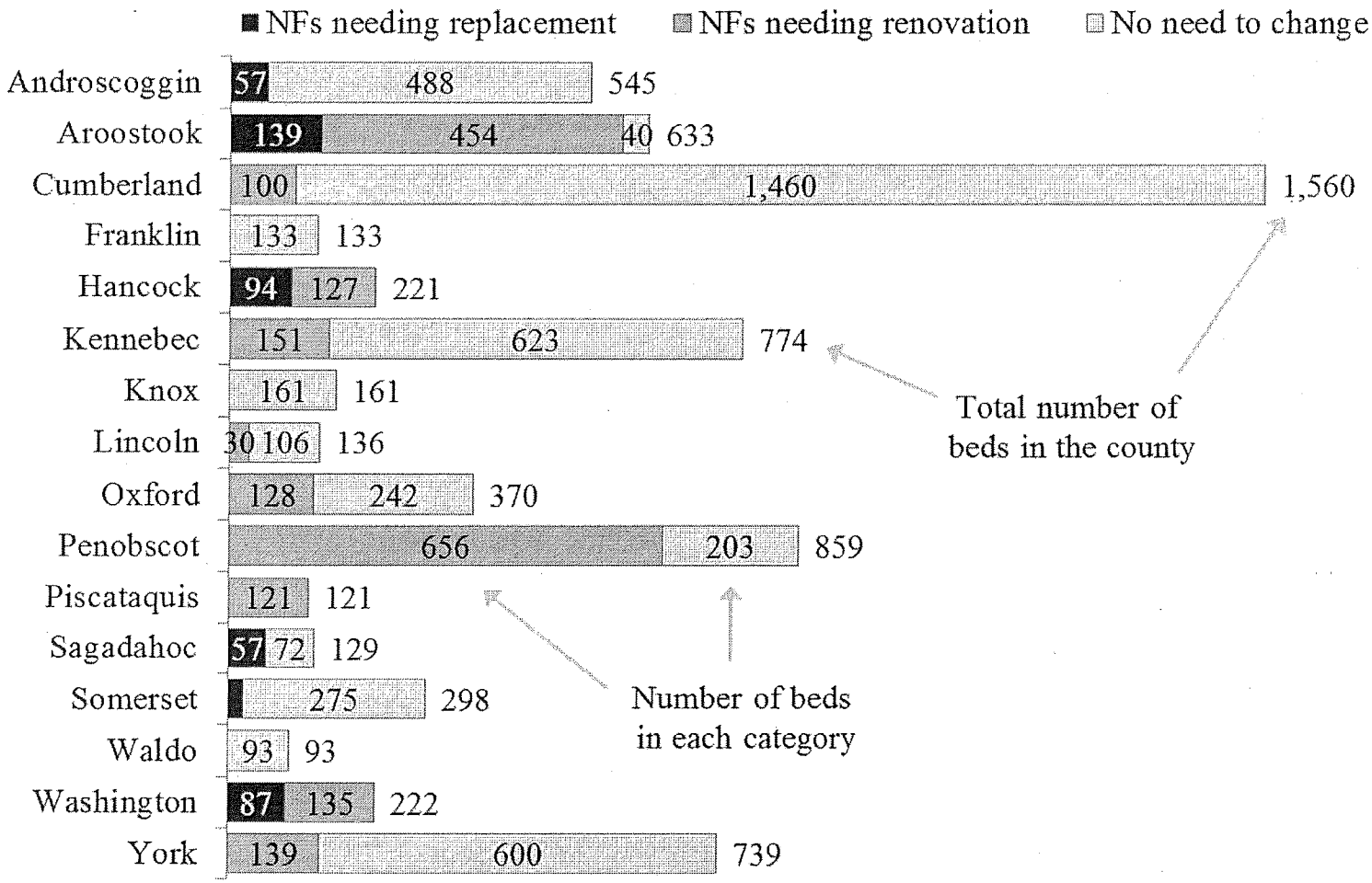
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The number of nursing facility and case-mix residential care beds per 1,000 persons age 65+, SFY 2010



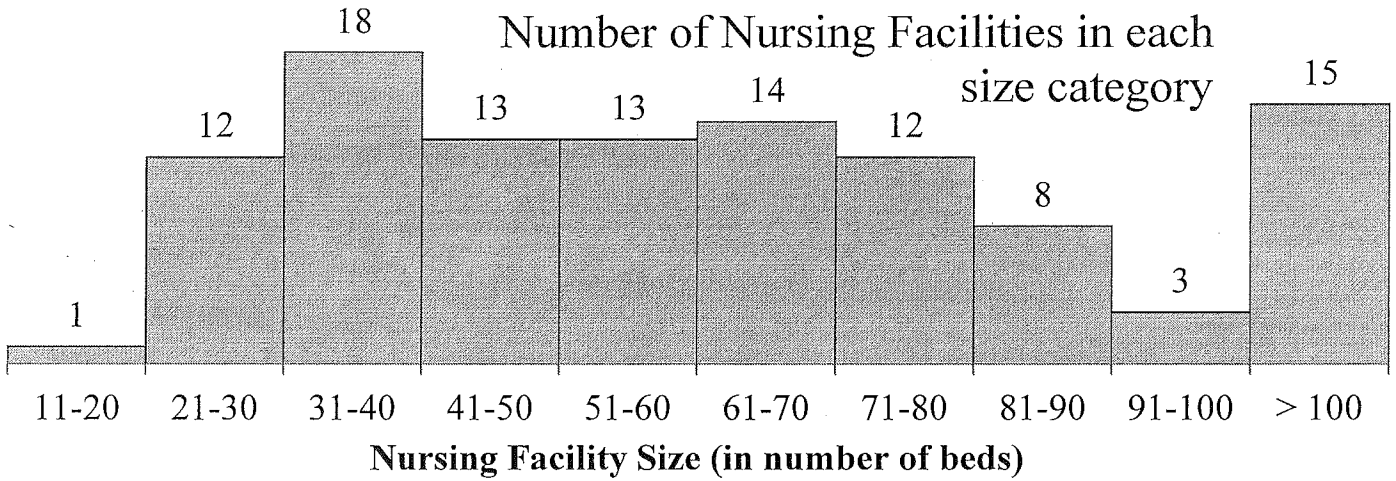
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

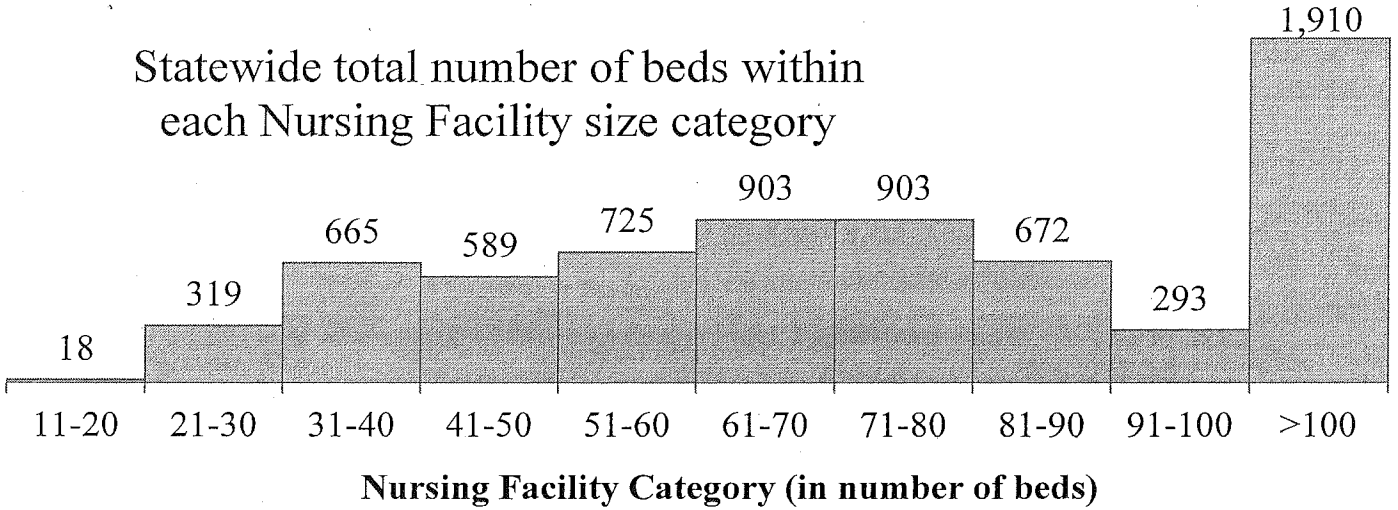
In 2009, nearly 3-out-of-10 Maine Nursing Facility beds were in buildings needing renovation and 7% of beds were in buildings in need of replacement.



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

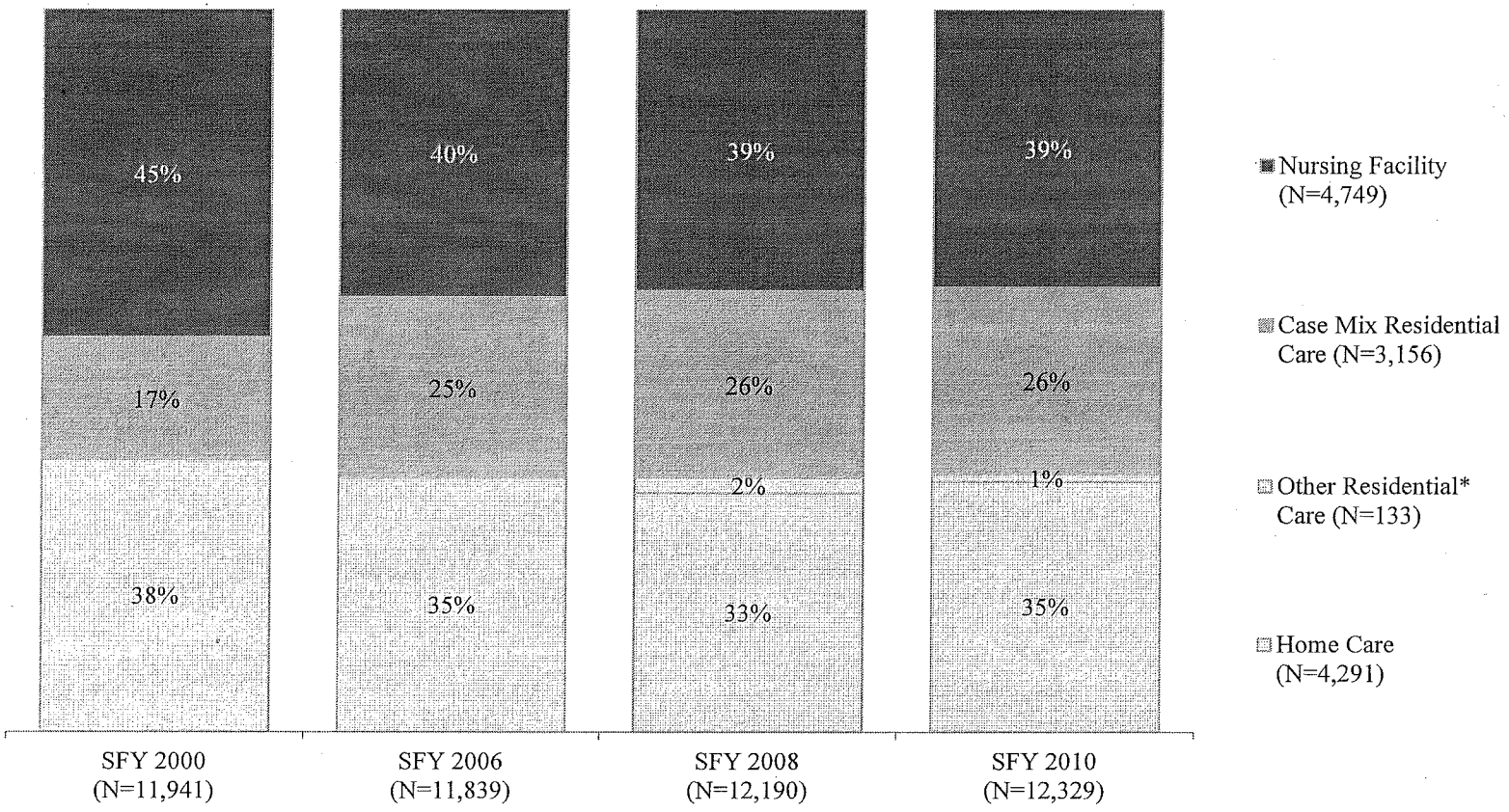
In 2010, nearly half of Maine's nursing facilities (48%) were larger than 60 beds (N=109)





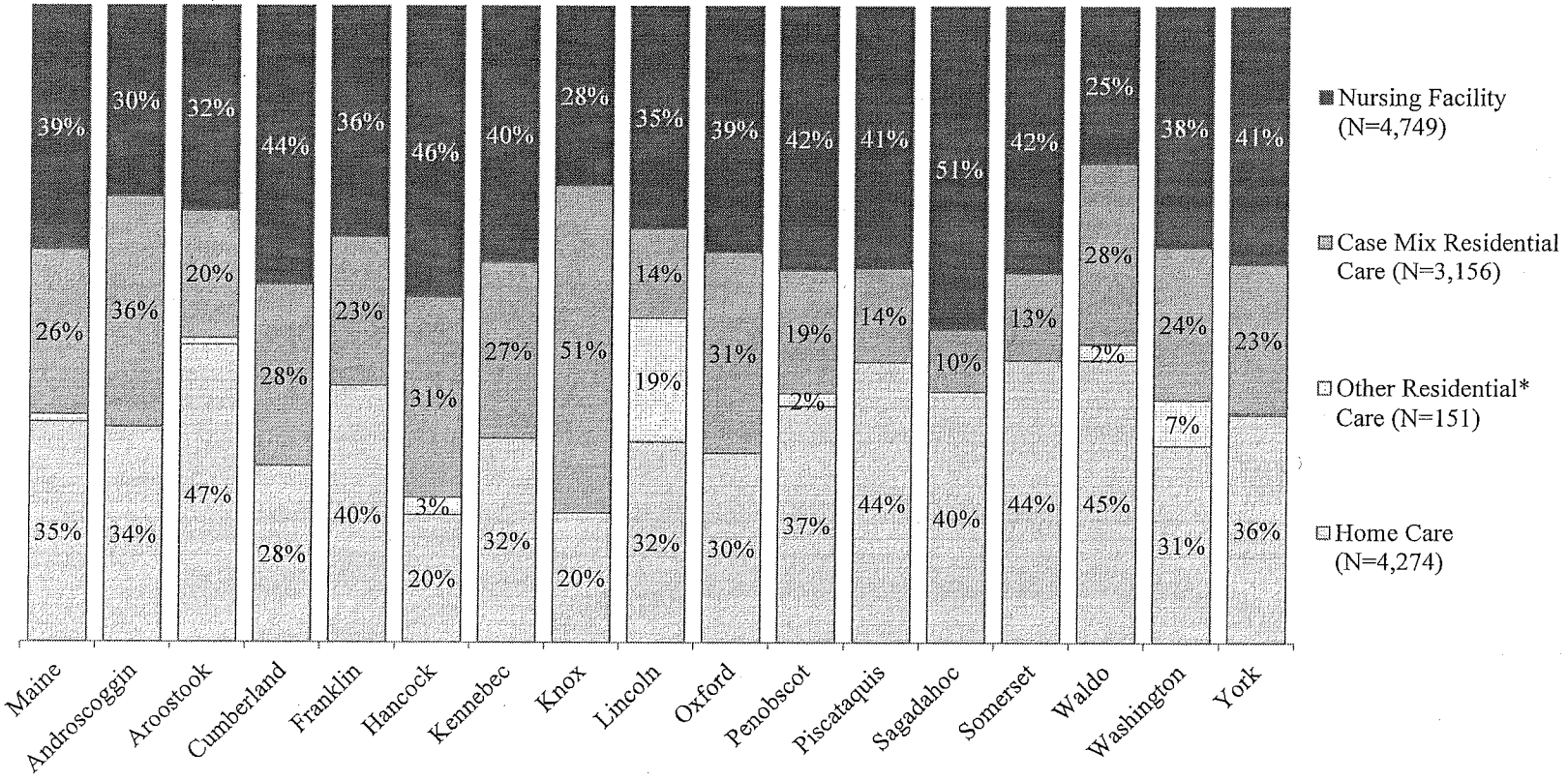
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Distribution of average monthly MaineCare LTC users by setting



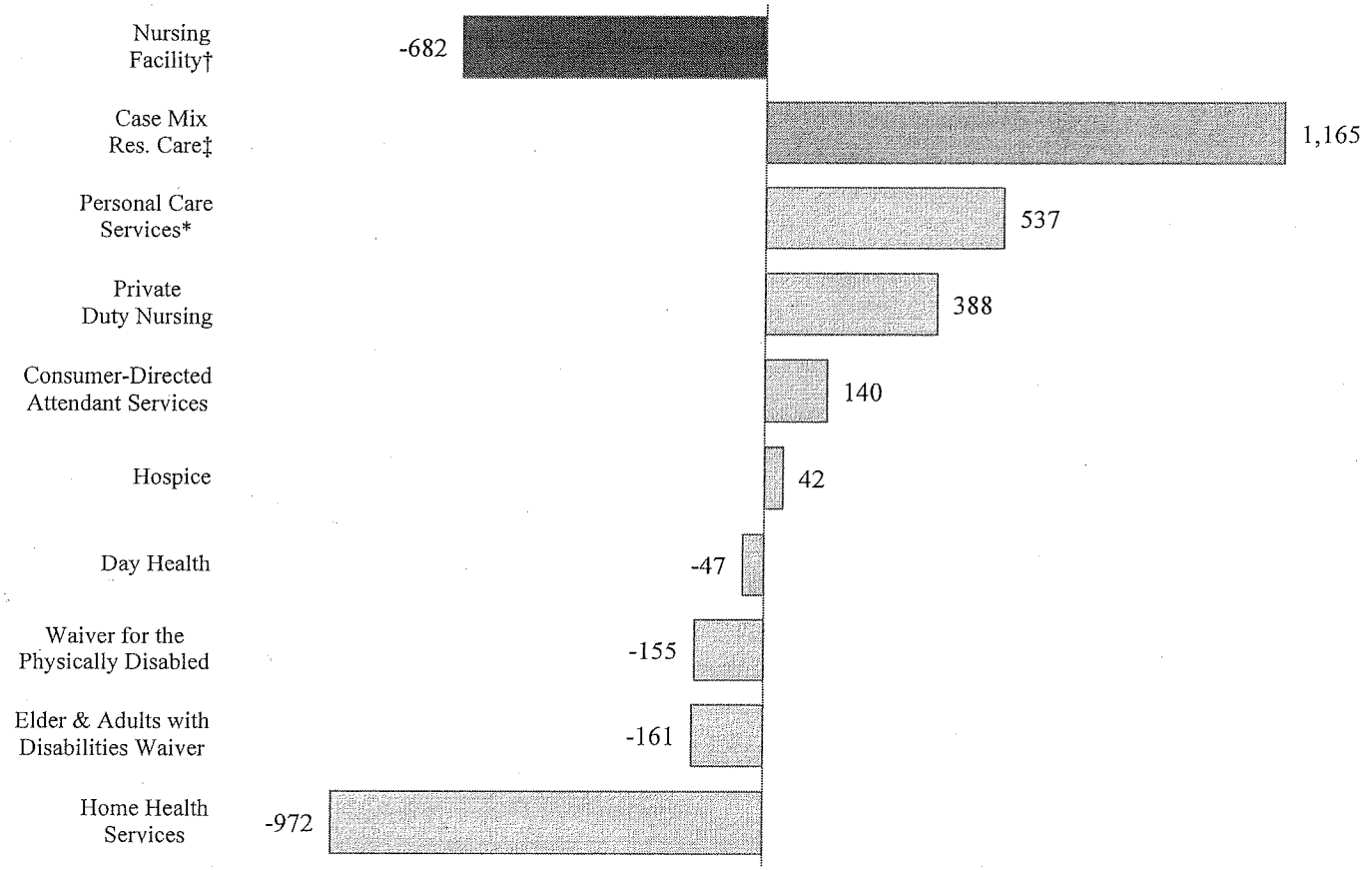
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Distribution of average monthly number of MaineCare LTC users by setting by county



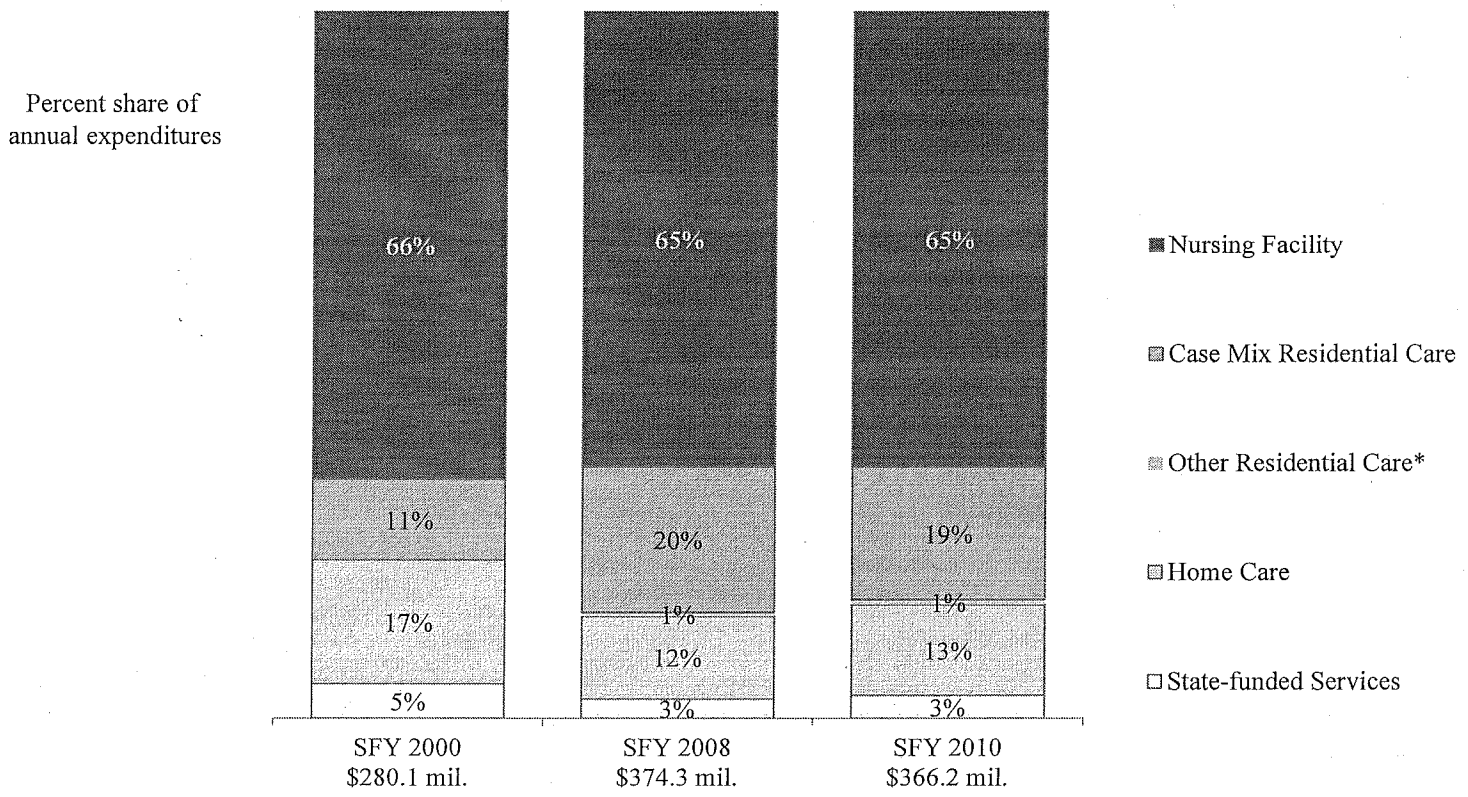
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Change in average monthly number of MaineCare members using MaineCare LTSS, 2000-2010



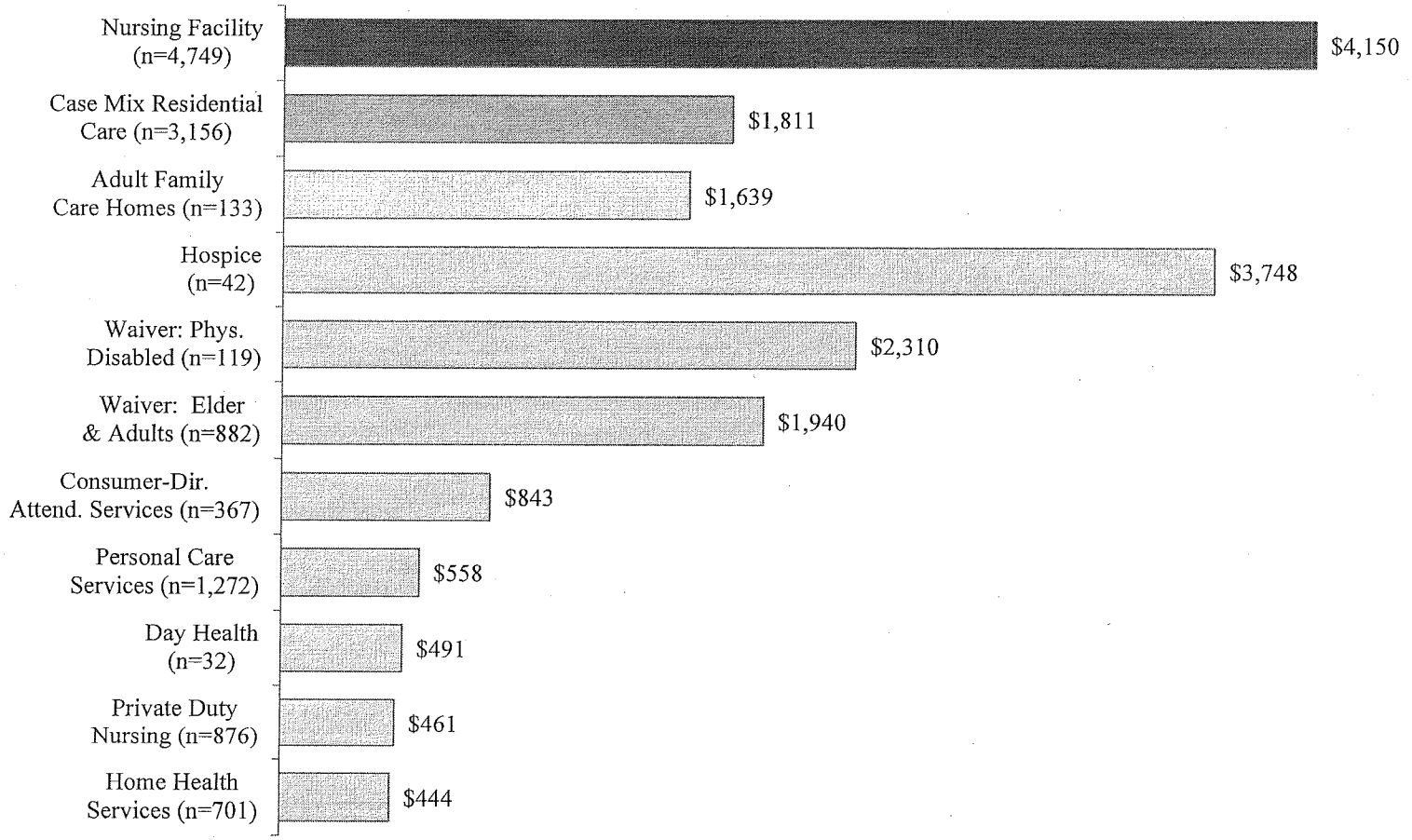
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Annual MaineCare LTC expenditures by setting, SFY 2010



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Average MaineCare LTSS expenditures per service user per month, SFY 2010



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Nursing Home Pay for Performance Systems

Types of Quality Measures

- Staffing
- Consumer satisfaction
- Inspection performance
- Clinical quality indicators
- Person-centered/quality of life
- Efficiency
- Access
- Employee satisfaction
- Quality improvement

Performance Methods

- Benchmarks
- Percentile ranking
- Year to year improvements
- Structure versus process
- Risk adjustments

(Source: Performance in 5 states: Lessons for the Nursing Home Sector. States included Iowa, Minnesota, Oklahoma, Utah and Vermont)

Nursing Home Pay for Performance Systems (cont)

Administration

- Complex versus Simple
- Relies on existing data and/or additional data (e.g. consumer surveys)
- Composite index versus simple approach

Payment method

- Added to per diem
- Funds allocated competitively

Findings

Need to incentivize engagement

- Secure funding
- Design systems that are perceived as fair and workable
- Minimize administrative burden on facilities
- Address different aspects of quality
- Encourage improvement among low-middle tier performers

- Slow Phase-in
- Availability of funding
- Provider participation is key
- Flexibility

Results

- Indiana study found that nursing home quality improved in 3 areas (falls, quality of life and rehospitalizations)
- Study of 8 states (2001 to 2009) found 3 quality measures improved (people in restraints, with pain, with pressure sores); other measures did not change or worsened
- Study in Minnesota found that facilities that participated in the program had greater gains in targeted areas of improvement and overall quality.

Other Nursing Home Incentives

Access Incentives

- Add-ons for serving people with certain conditions (e.g. ventilator dependent; brain injury; dementia); for serving Medicaid recipients; encourage higher occupancy

Efficiency Incentives

- Facility paid a state-wide rate; median; or peer group rate
- Facility receive bonuses for keeping costs below a ceiling

Other LTSS Initiatives

- Money Follows the Person
- Health Homes/Medical Homes and Nursing Homes
- Long Term Care Managed Care
- Rebalancing Services

Money Follows the Person

- Provides opportunities for people living in nursing homes to return to the community
- Maine participates in this program

Health Homes/Medical Homes

- People with hi costs/multiple chronic conditions assigned to "health home" to coordinate care and identify gaps in care
- Some states implementing health homes with nursing home and residential care residents
- Maine has a Health Home initiative for people with multiple chronic conditions and behavioral health conditions

Managed Long Term Care

- Managed long term care increasing

- States are including home and community based services and nursing facility services within managed long term care

Rebalancing Programs

- Focus on increasing access to home and community based services
- Less reliance on nursing home services

Conclusions

- Demographics will drive economic and other policy decisions in next 10 years
- It is helpful to look at long term care system as a whole – to develop a balanced system
- Pay for performance provides opportunity to implement value based purchasing within the long term care system

Other Resources

- Chartbook: Older Adults and Adults with Physical Disabilities – Population and Service Use Trends in Maine. http://muskie.usm.maine.edu/Publications/DA/Adults-Disabilities-Maine-Service-Use-Trends-chartbook-2012.pdf
- AARP Across the States Profiles of Long-Term Services and Supports 2012 http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html

APPENDIX E

Testimony from direct care workers

ROY G. GEDAT

111 Main Street, Norway, Maine 04268 • 207 890 1609 • 207 743 9080 • royggedat@gmail.com

October 25, 2013

Statement of Concern to the Long term Care Commission to Study Nursing Facilities

Please do not dilute the staffing standards in nursing homes.

I am Roy Gedat from Norway Maine and I am here today as a volunteer to make this plea.

For 7 years I worked for advocacy organizations focused on improving the jobs of direct care staff. Those are the people who change the bedpans, give the baths, provide personal care and do much of the actual staffing of patients in residential facilities and homes. This advocacy usually focused on improving pay and health benefits as well as strengthening professional standards and insuring that the workforce is granted the respect and status they earn every day. This work put me in regular contact with direct care workers in Maine and across the country. I have also worked as a direct care worker. Currently I run a private duty "non-medical" home care business and serve as the elected Treasurer of Oxford County.

Never have I heard a direct care staff person request more flexibility and less staffing in a residential facility. In fact, people who work in those positions report quite the opposite!

Inadequate staffing puts personal care workers in unsafe and stressful positions every day resulting in compromised care to the patients and residents they are there to assist. Low wages coupled with difficult (at best) working conditions result in a discouraged workforce, difficult retention and high turnover. I can report that providing high quality care without enough staffing is simply not possible!

Maine's current staffing ratios really only set a low bar to insure quality care. While our state is better than many in this regard there is no doubt we could AND SHOULD do better. Many

experts advocate for a staffing ratio minimum of better than 4.5 hours per resident day, the national average is 4.1 (hprd) and Maine only requires 3.49.

Don't we owe it to the frail and compromised residents of our nursing homes to keep that in mind?

Finally, let me remind you why these standards exist in the first place. We have a sad and well documented history of NOT caring for human beings in nursing homes and other institutions. It took years of shocking stories of abuse, indifferent care and cover-ups for the government to step in and insure a level of quality care. In some states this is still going on. Now we have standards, inspections, a state ombudsman to field complaints and movements to empower self-advocacy. Even with those measures in place we still have to be vigilant to insure that we don't slip back too those dark days in the name of saving money or granting administrative flexibility.

Maine's network of residential care facilities are a vital and important part of our safety net. They are also an important economic driver proving important and needed jobs.

Yes, changes to need to be made to our long term care system. We need to make sure we have a quality workforce. We need to provide more staffing and better quality care. There is simply no reason to lower staffing requirements in nursing homes and every reason to increase the staffing standards.

Thank you for your attention.

My name is Michele Heath. I am a Certified Nursing Assistant who works in a local nursing facility. I have worked as a CNA since the summer of 2010 in two different nursing facilities.

I got into direct care because I enjoy helping people. The first facility I worked per diem at $10 an hour, but had left because I needed a job with a set amount of hours a week and health insurance. I currently work at another facility with a guaranteed 32 hours a week, health insurance and make $9.97 an hour.

I work the evening shift, 3 in the afternoon until 11 at night, where the minimum staffing ratio is one 'direct care provider' for every 10 residents. I realize that 'direct care providers' include nurses, med-techs and CNAs on the floor, however, when using the minimum staffing ratio where I work I can have up to 13 residents to take care. This includes transfers (which may take two people), assisting them with ambulation, dressing, bathing and toileting. Passing meals, feeding, changing soiled bedding, turning residents who stay in bed every two hours to prevent pressure ulcers (bedsores), and charting on everything that takes place on my shift. Some of my residents are total assists, which means that I must do everything listed above for them. Almost all of my residents are two assists, meaning it takes two people to help them and take two CNAs off the floor until we have completed the task.

I try and get to my residents as soon as I can to provide the care they need but there are times that they do have to wait and they do know when we are working short because it takes a while before we can get to them to help them into bed. The facility I work for strives for quality, patient centered care and so do I. However, I ask myself "how can I deliver that when I got thirteen people to take care of?" The answer is that I can't do it. No matter how hard I try to

provide quality care for a resident when I am helping them, all I have is time to provide the basics and move on to the next resident.

The stress of working at the state minimum is frustrating for both the residents and myself. I have had residents ring there call bells during the busiest part of the evening, getting everyone into bed, and ask for something to drink and then apologize to me for taking me away from whatever it was I was doing or going to do because they know how busy the other aids and I are. These facilities are their homes and they shouldn't have to feel like they are taking us away from other people to ask for a simple request like something to drink. I will admit that this upsets me and makes me wonder 'how many of my residents need or want something but don't tell the other aids or me because we always appear to be busy with something?'

I know that I am a good CNA. My residents are constantly thanking me for everything I do for them, telling me that I am patient with them and a hard worker. I appreciate hearing this from my residents because it lets me know that I am doing a good job and that they appreciate everything I do for them. This is my reason why I got into this type of work because I enjoy helping people and want to see them stay as healthy as they can.

With the state considering changing the hours form 3.49 hours in a 24 hour period to 3 hours in a 24 hour period that is time being taking away from these residents for their care, and to allow nursing facilities to staff according to need is not going to help anymore. I do not see how the changes the state is considering to the hours of direct care is any benefit for these residents or even the workers. I believe that the staffing ratios need to remain in place, even be enhanced so that there is more staff for a lower number of residents and consider taking the med-techs and nurses out of the ratio because even though they help they have their meds to pass and their own work to do.

Greetings members of this committee considering staffing changes in Maine's nursing homes:

I am Helen Hanson. I am a Certified Nurse Aide who works in a local nursing facility. I have done this type of work for ten years now, in the home and in a nursing facility.

I got my start in home care as a homemaker and then a Personal Support Specialist. I helped and supported many elders and those with physical disabilities in their homes with everything from grocery shopping and housekeeping to assistance with bathing, dressing, toileting, catheter care, eating, and changing batteries in a motorized wheelchair. Let me tell you, those batteries are like those found in a car and just has heavy.

I left home care because the hours of work are not stable, there is no guarantee of working the number of hours you need to make a living and pay your bills, and just as important, there is no access to employer-sponsored health insurance. When I left my home care job, I made $10.01 per hour.

I obtained my Nurse Aide certificate in 2009 because at that time, I worked with a quadriplegic in her home. She had many health issues beyond her physical disability and by becoming a CNA, it was a way for me to be better able to support her and understand her medical needs. I was also better able to communicate with her visiting nurse and take instruction and direction from this nurse.

I enjoy people and helping them, and this is why I got into direct care. I prefer to work in the home, one-to-one with the person I am caring for, and taking a little time to get to know them and what their preferences for care are, but because of the reasons mentioned above, I had to leave it. I now work per diem in a nursing facility, after working there full time for quite some time.

Working in a nursing facility offers a set amount of hours to work and access to health insurance. It does not offer a better, livable wage. My base pay is currently $10.05 per hour, just four cents more than I made working in home care. Yes, when I worked a regular schedule I had a guaranteed amount of hours and yes I had access to health insurance, but at what cost to me?

I work second shift, the evening shift, where the minimum staffing ratio is one "direct-care provider" for every 10 residents. When we use the minimum staffing ratio where I work, it equals one CNA being responsible for 12 or 13 residents on my shift. I understand that "direct-care provider" includes the nurses, med-techs, and CNAs on the floor, but the nurses and med-techs are responsible for their medication passes, and the nurses are responsible for bandage changes, tube feedings, IV medication administration, monitoring blood sugars, admissions and documentation, to name just a few of what it is they do. That leaves little time for the nurses and med-techs to jump in and help the CNAs with all that we need to do: transferring residents from chair to bed or bed to chair, most times with a mechanical lift that takes two aides off the floor for a bit; assist with ambulation; assist with toileting; dressing; passing meal

trays; feeding; monitoring and emptying foleys and ostomies; taking and recording weights and vital signs; changing soiled bed linen; turning bed-bound residents every two hours to prevent bed sores (this can take two aides off the floor if the bed-bound person is big and heavy and has limited bed mobility); bathing a resident in the shower or whirlpool tub; charting everything that occurred during the shift; unclogging toilets when they plug up; and taking the trash out. CNAs also handle their portion of an admission; we inventory a new resident's cloths and belongings, orientate them to their room and the bathroom, explain the meal services and times, and get their weight and vital signs as a baseline.

We are supposed to be providing quality, resident-centered care, based upon their preferences, but how can quality, resident-centered care be delivered when there is one CNA to 12 or 13 people? I cannot provide it. Being responsible for that many people allows me to provide the basics at a rushed rate. They all demand something at the same time and it is impossible to meet all their needs. It is hard to not get frustrated when you have 12 or 13 people demanding something of you all at the same time. Some of these 12 or 13 people need more assistance than others. The term is that they are a two-assist, meaning it takes two aides to help them ambulate or to transfer them. I try to assist all of them as quickly as I can, but inevitably, some have to wait. They do not like having to wait and are very vocal about it. I try to apologize when this happens. They ask me if we are working short. They know because it takes so long for someone to answer their call bell or help them get ready for bed.

The stress level and frustration from working at the state minimums is incredible. While at work I find myself saying "I'm doing all this for just $10 an hour!" I honestly do not see it getting better for CNAs working in nursing facilities and more importantly I do not see it getting better for the residents in these facilities.

I am a good CNA. I get feedback from my residents, telling me how compassionate and caring I am; how gentle I am. I try to be because I do not want to cause anyone more pain than what they are in. They tell me how patient I am. I have to be; most of these people cannot easily move on their own. The feedback I get from the people in my care means a lot. It lets me know I am doing a good job and that these folks are comfortable with me. I like that. This is why I got into direct care; I like people, I like helping them, and I want them to stay as healthy as possible.

With the State considering changing the hours of direct care from 3.49 hours in a 24-hour period to 3 hours in a 24-hour period and allowing the nursing homes themselves to staff according to need, without minimum staffing ratios, the changes recommended are NOT a good thing. Not good for the residents and not good for the already over-worked and extremely stressed staff. If anything, staffing ratios need to stay in place and need to be enhanced. A reasonable level is 1 CNA to 4 residents during the day, 1 CNA to six residents for the evening, and 1 CNA to 10 people overnight. Taking the RNs and med-techs out of the ratio equation should be considered too.

I am getting out of direct care. I struggle with my finances; not being able to set aside money for those emergencies that come up. I struggle with the frustration and stress of the job. I am tired of it. I am making a change and am in school at Husson University. I do not mind working hard, but I cannot continue to work so hard for so little and survive financially and mentally. I do not like the negativity I feel because of my job.

Good CNAs like me leave the profession. The turnover of nursing staff at my facility is extremely high. All the nurses that started when I did have moved on to other positions. Most of the CNAs I started working with have moved on to other jobs. The recurring theme is the stress and frustration we all deal with. What does this say about working in a nursing home? Who wants to do this work when there are not enough hands on the floor, when the pay barely allows you to pay your bills? Not me. The profession is losing one good CNA, one of many that leave to find work that is not so stressful and frustrating for $10 an hour.