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SECOND REGULAR AND SECOND SPECIAL SESSIONS

Final Report
of the

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

November 20, 1998

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Executive Summary

I. Legislative history and commission process

The 118th Maine Legislature established the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities in 1997 with the passage of Resolve of 1997, Chapter 81 and the amendment to it passed in Resolve of 1997, Chapter 129.

The duties of the commission include examination of the following issues concerning long-term care facilities:

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

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

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

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

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

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

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

8. Salaries, dividends and management fees in nursing facilities.

The commission met 15 times during its work over two interim sessions. Experts in the field of nursing facility quality of care and reimbursement met with the commission and participated in telephone conferences with commission members. Interested parties representing nursing facilities, regulators and consumer advocates attended meetings and provided information to the commission. The commission considered the following issues: nursing facility reimbursement by Medicare, Medicaid, insurance and private pay sources, the Medicaid Principles of Reimbursement, rate setting, rate equalization, the financial health of the nursing facility industry, employment issues, financial assistance from the Maine Health and Higher

Educational Facilities Authority, quality of nursing facility care, minimum staffing requirements, paperwork reduction initiatives and interaction with consumers and families.

II. Commission recommendations

The Commission believes that Maine residents should have access to high quality long-term care services in their homes and communities and in long-term care facilities close to their homes. To ensure that these services are available, long-term care facilities and agencies must be financially healthy and consumers must be able to plan for their care and to understand the services that are provided in the long-term care system. To these ends the commission makes the following recommendations:

1. Outcome-based incentives. The commission recommends that the Legislature direct the Department of Human Services to undertake pilot projects to reward high quality care in nursing facilities based on successful performance by the facilities. The commission suggests that successful performance be measured using quality indicators from the Minimum Data Set already in use and from consumer and family satisfaction surveys. The commission suggests that successful performance may be rewarded by means of financial rewards, favorable public information, decreased regulation by the State or in other ways. The commission cautions the department to preserve consumer choice in urban and rural settings to the extent practical, to avoid preserving with financial or other assistance facilities that perform poorly because of incompetence and to avoid inadvertently restricting access to care.

2. Reimbursement for nursing facility care through the Medicaid system. The commission is persuaded that reimbursement to nursing facilities through the Medicaid program may be inadequate to ensure high quality care to residents. The commission recognizes, however, that the need for more reimbursement for facilities needs to be balanced against the need to fund home and community based care. Therefore, the commission recommends that the Department of Human Services review the Principles of Reimbursement as well as information from facilities in order to identify the specific areas in which reimbursement is inadequate.

The commission recommends that the Legislature direct the Department of Human Services to develop new approaches to reimbursement targeted to specific problems, including the following, and report to the Legislature's Joint Standing Committee on Health and Human Services by February 1, 1999:

A) Examining operating costs to determine specific areas in which reimbursement may be inadequate. In doing so the department should consider the following options for reimbursement:
   - reimbursing facilities' costs for medical directors at a level reflecting the increased acuity of nursing facility residents;
   - merging the indirect and routine cost components;

- reimbursing for all aspects of direct care for residents, including medical supplies, in one cost category so that they may be adjusted by case mix;
- reviewing the most recent information from time studies being used for the Medicare prospective payment system and making a determination whether the time study presently in use reflects nursing costs in Maine's facilities and is appropriate for use; and
- studying employment markets, labor costs and turnover rates at facilities around the State and, for those facilities that are at or above direct care limits, developing methods for providing increased reimbursement. This study should be done in conjunction with the Department of Labor and should build upon the work already done by that department and by the Maine Health Care Association;

B) Re-basing reimbursement rates from 1993 to 1996 or the most recent complete audited year and adopting new medians and cost caps in order to keep up with the higher costs faced by facilities due to inflation, increased paperwork requirements, and higher resident acuity. In doing so the department should consider the following options for re-basing:
   - re-basing costs with an emphasis on those most directly impacting high quality resident care; and
   - re-basing cost components on a rolling schedule whether periodically or when a stated event occurs, such as when 50% of the facilities are over the cap;

C) Tying caps applicable to the different cost components to the size of the facility, placing higher caps on the smaller facilities, which are often in rural areas, in recognition of the higher costs faced by those facilities and the importance of maintaining access to nursing facility care in rural areas; and

D) Removing any reimbursement incentives that have unintended adverse impacts on resident care.

3. Minimum staffing requirements. The commission recommends that the Legislature direct the Department of Human Services to replace its current minimum staffing ratios with minimum staffing requirements that:

A) are tied to the acuity level of residents and to the other needs of residents that effect the quality of their lives; and
B) ensure that adequate numbers of direct care staff are available at all times to meet residents' needs.

The commission recommends that the Commissioner of Human Services present a proposal to implement and fund these new requirements to the Legislature's Joint Standing Committee on Health and Human Services by March 1, 1999.

4. Rate Setting. While some members of the commission support the concept of rate equalization, they recognize that legislation requiring nursing facilities to charge equal

rates to Medicaid residents and private payers could require additional legislative appropriations which would jeopardize needed funding for home and community based care. Accordingly, the commission does not recommend that equal rates be mandated at this time.

5. Paperwork reduction. The commission recommends that the Legislature direct the Commissioner of Human Services to report to the Joint Standing Committee on Health and Human Services by June 1, 1999 with a plan to reduce paperwork in nursing facilities which must include consideration of the opportunities presented by advancing technology and the feasibility of linking data between the Minimum Data Set (MDS 2.0) and Medical Eligibility Determination (MED'96) forms.

6. Interaction with consumers and families. The commission recommends that the Legislature take the following actions:

A) direct the Department of Human Services to improve the provision of information on long-term care services, costs and performance; and

B) strengthen and make more independent the Long-term Care Steering Committee by allocating more resources to it and changing its duties so that it advises the Commissioner and the Legislature.

7. Flex beds. The commission encourages the Department of Human Services and the Maine Health Care Association to continue their work on a proposal to allow the use of "flex beds," by which the commission means that beds licensed for long-term or residential care may be used to meet the changing needs of residents and may be reimbursed according to the level of care provided. The commission cautions that any proposal must not compromise the quality of life of a facility's residents.

8. Regulatory barriers to high quality care. The commission recommends that the Legislature direct the Commissioner of Human Services to study and identify regulatory barriers to high quality care and make recommendations for relief or modification of rules and report to the Joint Standing Committee on Health and Human Services by January 1, 2000.

9. Long-term care insurance information. The commission recommends that the Legislature direct the Bureau of Insurance to:

A) collect information on long-term care insurance and provide a report by March 1 each year to the Commissioner of Human Services, the Joint Standing Committee on Health and Human Services and the public. The information collected should include the number and types of policies purchased by consumers, the cost of premiums, daily benefit levels and the duration of benefits. Information should also be collected on policies paying benefits to or for consumers, including the types of policies, daily benefit levels and remaining duration of benefits; and

B) conduct a study of the use of individual income tax credits as incentives to encourage the purchase of long-term care insurance. The study should analyze the effectiveness of tax credits in encouraging the purchase of long-term care insurance in other states and the anticipated cost to the State from establishing a tax credit for all or part of the premium cost of qualifying long-term care policies. The Bureau should provide a report to the Joint Standing Committee on Health and Human Services by January 1, 2000.

10. Report on changes in long-term care. The commission recommends that the Legislature direct the Commissioner of Human Services to consult with the Long-term Care Steering Committee, study changes in the delivery and financing of long-term care and report to the Joint Standing Committee on Health and Human Services by March 1, 2000. The report should cover changes in the delivery of long-term care in facilities and by home and community-based providers, changes in reimbursement systems including, but not limited to the changes in the Medicare reimbursement system, the use of "flex beds," the quality of care provided to residents of Maine, the growth in home and community-based care and the availability of services and providers in all parts of the State.

11. Medicare reimbursement system. The commission recommends that the Legislature pass a legislative resolution opposing the change to the proposed prospective payment reimbursement system that has been instituted in the federal Medicare program for the reasons that it is flawed in its structure and that its application will cause financial hardship for Maine's long-term care facilities and will reduce the quality of care provided to Maine's residents. The commission is concerned that the new reimbursement system will lower reimbursement for care, cause the loss of skilled nursing facility beds available under the Medicare program and restrict access to care for residents who are eligible for Medicare. Maine was one of six states participating in a demonstration project under the Medicare program. Nursing facilities in all states that participated in the demonstration project are in jeopardy because the system omitted reimbursement for Part B pharmaceuticals for providers in states that participated in the demonstration project. Commission members fear that the new reimbursement system will lower reimbursement for staffing to a national average, which is below the staffing level provided in Maine facilities, and thus will lower the quality of care provided in Maine.

I. INTRODUCTION

The 118th Maine Legislature established the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities in 1997 with the passage of Resolves of 1997, Chapter 81. The resolve established the commission, charged the commission with duties and required a report to the 118th Legislature by December 15, 1997. See Appendix A.

The commission held meetings on November 3, 12 and 19 and December 3 and 17, 1997. Despite the intensive work and voluminous information considered in only two months, the commission was unable to complete its work by the December 15th deadline. The commission submitted a letter to the Legislative Council requesting an extension of its authority and a new reporting date. The Legislative Council approved the extension request on November 20, 1997.

On December 15, 1997 the commission provided an interim report to the 118th Legislature detailing the work that the commission had undertaken and their request for an extension into the next year. The interim report expressed the opinion of the commission that the issues posed by consideration of Maine's long-term care system were complex and interrelated and presented questions about overlapping areas of public policy and state budgeting, the relationships of different regulated industries, the impact of anticipated growth in managed health care, the operation of nursing facilities and nursing facility management. See Appendix B.

During the Second Regular and Second Special Sessions of the 118th Legislature representatives of the commission met with members of the Joint Standing Committee on Health and Human Services and presented their interim report. In addition, in February, 1998 four consumer representatives on the commission issued their own report to the committee. See Appendix C. The passage of Resolve of 1997, Chapter 129 extended the authority of the commission, added an additional member to represent consumers of nursing facility services, altered the commission's duties and provided a new deadline of November 20, 1998 for a report to the 118th Legislature.

As amended by the resolve in the Second Special Session, the duties of the commission include examination of the following issues concerning long-term care facilities:

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

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

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

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

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

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

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

8. Salaries, dividends and management fees in nursing facilities.

During its second term of work the commission met May 20, June 3 and 17, September 2 and 16, October 1, 14 and 28 and November 12, and November 16, 1998. Experts in the field of long-term care, quality of care and reimbursement issues met with the commission, both in person and by telephone conference call. Appendix D contains a list of members on the commission during the second season of its work. See Appendix E for Resolve of 1997, Chapter 129 which contains the appointment of the new member of the commission and the charge to the commission for its second season of work.

Commission members considered regulating the long-term care nursing facility industry in the manner in which public utilities are regulated and unanimously decided against the idea. With regard to salaries, dividends and management fees, the commission decided against making a recommendation.

II. REIMBURSEMENT OF NURSING FACILITIES

A. Overview

There were 8194 residents of nursing facilities, 93.3% of whom were over age 65, in Maine in 1996, the most recent year for which data were available to the commission. [1] They resided in 142 nursing facilities across the State, ranging in size from 17 residents in the facility to 280 residents.[2] Some of the nursing facilities are not-for-profit, some are for-profit; some are affiliated with hospitals; some are affiliated with independent living centers, assisted living or residential care facilities (formerly known as boarding homes), and some are not. Some are independent, and some are part of a larger corporate structure. All are licensed by the Maine State Department of Human Services and are subject to inspection by the department and by the federal Department of Health and Human Services Health Care Financing Administration (HCFA).

Residents of nursing facilities pay for their care, or have their care paid for, in several different ways. Some residents pay for their care themselves or another person or entity pays for

[1] Across the States, 1998, Profiles of Long-term Care Systems, The Public Policy Institute, pg. 90, 1998.
[2] Nursing Facility Occupancy by Payment Source, Appendix F.

them. The care for some residents is paid for by health, long-term care or converted disability insurance. For statistical purposes these sources, excluding Medicare and Medicaid payments, are grouped into a category called private pay. In 1997 the proportion of residents whose care was private pay was 17%. See Appendix F for the proportions of nursing facility residents by payment source. In September, 1998 the proportion of residents in the private pay category was 20%.[3]

Private pay rates in Maine are set by the contract between the nursing facility and the resident, without participation or regulation by the State or federal governments. In some facilities private pay rates are close to the Medicare and Medicaid rates. In others the disparity is wider. See Appendix G for a list of private pay rates. The commission studied the rates at the different facilities and members expressed concern that a large disparity between private pay and public pay rates leads private pay residents to spend their savings faster. This means that those with moderate savings and income deplete their resources faster, thereby arriving sooner at the point of needing assistance from the Medicaid program. See section II on rate setting.

B. Insurance

Some residents have their care paid for by insurance. Health care insurance, including health maintenance organization contracts, pays for a small proportion of long-term care, primarily post-illness or accident admissions that are for rehabilitation purposes. Disability insurance may also be converted to pay for nursing care. A breakdown of the private pay category into actual cash payments and insurance payments is not available. The commission did not consider in any depth issues related to insurance other than long-term care insurance.

The chart below provides information on long-term care insurance policies and the decisions to be made in choosing the correct policy for the individual. Different policies provide coverage for the individual beneficiary according to capacity to perform activities of daily living, which are defined in each policy and which include such skills as eating, dressing and personal hygiene, cognitive impairment, and medical necessity. The younger the individual is when initially purchasing the policy, the lower the premium. As the long-term care insurance policy is purchased a year at a time insurance carriers must offer to renew all policies each year. The individual may purchase inflation protection to protect against premium increases above a set percentage. Otherwise premiums may increase, although not based on the individual's health. In choosing a policy the individual must balance anticipated needs, preferences for long-term care and personal resources and assets. In choosing benefit levels the individual must decide upon the length for which benefits will be provided and the amount per day of benefit. The fewer the benefits purchased, the higher the risk accepted by the individual and, it follows, the lower the premium.

[3] Information obtained from Deborah Couture, Department of Human Services, Bureau of Medical Services, November 19, 1998.

Long-term Care Insurance Decision Points

Elimination period	**Daily benefit**	**Benefit duration**
Definition: the period of time an individual must pay for care from other sources before the insurance benefit commences.	Definition: the amount of insurance benefit, stated as a dollar amount per day. Any charges for care that exceed the daily benefit must be paid from other sources.	Definition: the maximum period of time for which insurance benefits will be paid. Benefits may be paid during one or more periods of care, which are then added together.
Consumer decision	**Consumer decision**	**Consumer decision**
The duration of the elimination period should be planned after considering other sources of payment for care during that period. It can run from 0 to 730 days. Longer elimination periods lower premium costs but require other resources to pay during the time that they run.	Selecting the daily benefit requires a look into the future. First the individual must choose the type of facility or service benefit to be purchased, including the option of home care. Then the maximum daily benefit must be chosen. It should be sufficient, with any other additional income to the individual, to pay for anticipated care needs for the person. Another choice in this category is inflation protection to increase the average daily benefit each year when the policy renews. Less generous benefits lower premiums but may require assets or income to provide needed care outside the benefits of the policy.	The individual may purchase as short as 2 years of benefits (which may be used in one or more periods of long-term care) or as long as a lifetime of benefits. An individual who is receiving benefits under the policy does not pay premiums while receiving benefits. Choosing a shorter benefit period decreases premiums.

The commission studied long-term care insurance in Maine, which must be offered for care in a nursing facility or at home and which may include respite care or assisted living care. It may not require a hospital or skilled nursing care stay as a precondition to receiving benefits, or require care in a facility setting prior to receiving home care.

The commission also reviewed the tax deduction available on the Maine individual income tax for long-term care insurance premiums for certified policies. The deduction is available regardless of whether the taxpayer itemizes or files the short form tax return.

Commission members reviewed a wide array of information on long-term care insurance from the Bureau of Insurance, the American Health Care Association, the National Association of Insurance Commissioners and a number of commercial insurers, as well as articles from leading consumer magazines. See Appendix H for information from the Bureau of Insurance on long-term care insurance.

The commission also studied long-term care insurance purchase incentive programs in place in other states, detailed in Appendix I. These programs, which exist only with the approval of HCFA, allow special treatment for the assets of a person who has purchased and fully utilized a qualifying long-term care insurance policy. Assets may be disregarded upon application for assistance to the Medicaid program or in the process called Medicaid estate recovery, in which repayment is collected for the state and federal governments after the death of the person whose care was paid by Medicaid. In the model referred to as the Dollar for Dollar model the disregard is in the amount paid by the insurance policy. In the Total State Assets model all assets are disregarded, no matter the extent. There is also a combination model that blends the two approaches and grants partial disregard of assets.

State programs to encourage the purchase of long-term care insurance through incentives based on asset disregards in the Medicaid program depend on approval from HCFA. The options available to states for obtaining HCFA approval were significantly narrowed with the enactment of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). Since the enactment of OBRA '93, no new states have enacted programs of the Total State Assets type. Missouri, North Dakota, Oregon and Rhode Island have not implemented insurance purchase incentive programs that they had enacted prior to OBRA'93. Colorado, Maryland and Michigan enacted programs but expressly made them conditional upon the repeal of the OBRA '93 provisions that restrict asset disregard. To date, the relevant provisions of OBRA '93 have not been repealed.

C. Medicare

Some residents have their care paid for by Medicare, the federal program for persons who are 65 years old or older or who are disabled and certain people with end stage renal disease. In 1997 these residents made up 11% of the residents in Maine's nursing facilities. In 1998 this percentage remained at 11%.[4] Medicare is not, however, a long-term care program, so it funds long-term care only after, and within 30 days of, a hospital stay of at least 3 days. Medicare long-term care benefits are limited to skilled nursing care for up to 100 days, with the first 20 days paid fully and the resident paying $95.50 per day for each of the remaining 80 days. Medicare funds are 100% federal funds.

Prior to July 1, 1998 Medicare paid for skilled nursing facility care on a cost reimbursement basis. Beginning July 1, 1998, Medicare began paying for nursing care through a prospective payment system that is based on the category of the resident's medical condition, determined according to Resource Utilization Groups-III (RUG-III). The new system will

[4] Information obtained from Deborah Couture, Department of Human Services, Bureau of Medical Services, November 19, 1998.

include for the first time payment for pharmaceuticals, medical supplies, some ambulance services, laboratory services and speech, occupational and physical therapy services. These services were previously billed separately, sometimes by a different provider, but are now part of the set rate paid to the nursing facility. Services that may be billed separately under the new system include services provided by physicians, physicians' assistants, nurse practitioners and clinical nurse specialists, psychologists and nurse anesthetists and charges for dialysis, hospice care and some ambulance services.[5]

Providers of nursing facility care are seriously concerned that the inclusion of the new category of charges in the set fee based on RUG-III will underpay the facilities. Providers of nursing facility care told the commission that the extent and fair reimbursement for the newly packaged services provided to the residents is of great concern. They feel that the costs of delivering these essential services are not adequately reflected in the new reimbursement formula since nursing facilities have not provided or monitored the costs of some included services, such as pharmaceuticals. The commission learned of the grave concerns of the nursing facility industry that the new prospective payment reimbursement system could underpay facilities, undermine their fiscal integrity and place patient care at risk.

D. Medicaid

The Medicaid program, established under Title XIX of the Social Security Act, provides reimbursement to nursing facilities for low-income persons with limited resources who qualify for inclusion in one of the Medicaid eligible categories. These categories include persons who are disabled or medically needy and certain Medicare beneficiaries. It is a joint federal-state program, funded in Maine with roughly 2/3 federal and 1/3 state money. In 1996 Medicaid long-term care expenditures in Maine totaled $342,667,000. Medicaid paid nursing facilities $213,614,000; home health care providers $13,677,000; and home and community-based services under Medicaid waivers $64,517,000. [6] The percentage of residents for whom care was paid by Medicaid decreased from 76% in 1993 to 72% in 1997.[7] By September, 1998 the percentage of Medicaid residents had decreased to 69%.[8]

Medicaid rates are calculated according to the Principles of Reimbursement for Nursing Facilities, a formula adopted by rulemaking within the Department of Human Services that is semi-prospective and is based on facility-specific base year allowable costs with limitations applicable to similar facilities that are referred to as peer group caps. The two peer groups are made up of hospital-based facilities and non-hospital-based facilities. A portion of the rate, the direct care component, is adjusted quarterly to reflect the facility's average case mix for Medicaid residents. This case mix is calculated based on assessments of the residents' needs for care using a method referred to as the Minimum Data Set (MDS 2.0). See Appendix J for a copy of the Principles of Reimbursement.

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[5] Stephanie Rice, CPA, Berry, Dunn, McNeil and Parker, in testimony before the commission, September 16, 1998.
[6] Across the States, supra, pg. 91.
[7] Nursing Facility Occupancy by Payment Source, Appendix F.
[8] Information obtained from Deborah Couture, Department of Human Services, Bureau of Medical Services, November 19, 1998.

The four cost components of Medicaid rates, listed in the first four rows of the chart below, are adjusted annually for inflation. They include direct care costs, indirect care costs, fixed costs and routine costs. Ancillary expenses, listed on the fifth row of the chart, include occupational, physical and speech therapy, medications and drugs and durable medical equipment. Ancillary expenses are separately and fully reimbursed on a fee-for-service basis. (Note the discussion above of these same ancillary expenses moving from a cost based reimbursement system to a prospective payment system under the federal Medicare program.)

Medicaid Rate Components

Category	Included costs	Limitations, application
Direct patient care	Nursing and ward clerk salaries and fringe benefits, excluding director of nursing. Activities personnel salaries and fringe benefits.	Quarterly case mix applied, based on MDS assessments. Facility costs are limited to median costs for all facilities plus 12%.
Fixed costs	Interest on long-term debt. Capital expenses. Depreciation on buildings and land. Rental expenses. Real estate and personal property taxes. Depreciation and amortization. Property, liability and malpractice insurance. Workers' compensation costs. Water and sewer connection charges. Return on equity (8%) for proprietary providers. Administrator in training salaries and fringe benefits, with prior approval.	This component is retrospective. Pass through at 100% reimbursement, except that adjustments are made for occupancy below certain levels: 90% for facilities with more than 60 beds and 85% for facilities with 60 or fewer beds.
Routine costs	All other operating expenses except ancillaries and those not included in the other 3 categories. Administrative expenses are capped. Management fees are not allowed.	This component is prospective. Facility costs are limited to median costs for all facilities plus 8%.
Ancillaries	Physical therapy. Occupational therapy. Speech therapy. Medications and drugs. Durable medical equipment.	This component is retrospective, fee-for-service.

Sanctions may be imposed and reimbursement reduced to nursing facilities with high error rates in the assessment of resident nursing needs (the MDS 2.0 assessment).[9] Quarterly sanctions are imposed for error rates above 35%, reducing reimbursement for direct care for a quarter by from 2% to 10%. Sanctions imposed under this provision have totaled $130,000, an amount considered by the Department of Human Services to be small in comparison to the avoided error rate and the consequent savings to the Medicaid program.[10] See Appendix K.

There is another area in which penalties may be applied to reimbursement from the Department of Human Services. If a facility completes the payment year with an occupancy rate below the standard applicable to facilities of its size, reimbursement for fixed costs is reduced to reflect an assumed occupancy rate.[11] For a facility with 60 or fewer beds, the occupancy rate is 85%. If a facility with 54 beds has a final occupancy rate of 82%, reimbursement for fixed costs is reduced from 100% of their total costs to 85% of their total costs. For a facility with more than 60 beds, the occupancy rate is 90%. If a facility with 154 beds has a final occupancy rate of 88%, reimbursement for fixed costs is reduced from 100% of their total costs to 90% of their total costs. The Department of Human Services considers this occupancy adjustment to be a money saver since without it fixed costs are allocated to a smaller number of residents, which would result in a higher per resident daily cost. The department also considers the occupancy adjustment to be a motivator to facilities to convert unused beds to other uses. The department estimates that the adjustment penalty saves the Medicaid program almost $3,000,000 per year.[12]

During its discussions commission members learned that Medicaid pays nursing facilities millions of dollars per year less than their actual allowable costs. Commission member Michael McNeil provided to the commission copies of a letter from himself to the Joint Standing Committee on Health and Human Services dated April 2, 1997 and accompanying information compiled by the accounting firm of Berry, Dunn, McNeil and Parker. He also provided to the commission copies of a letter from himself to Paula Valente, Executive Vice President of the Maine Health Care Association, dated July 24, 1998 and accompanying information. See Appendices L and M. In the letters Mr. McNeil informed the commission that Medicaid underpays nursing facilities because it caps allowable costs based on 1993 costs and because some real costs are not allowed by Medicaid at all, such as management fees.

The difference between Medicaid allowable costs and reimbursable costs amounted to $16,169,517 for 1996 for Maine's 142 nursing facilities. The Department of Human Services confirmed the shortfall figures in the $16,000,000 range and commission members agreed that the shortfall was caused in large part because of the 5-year old base year and in part because of the cap on allowable expenses. See Appendix N, Comparison of Reimbursable to Actual Costs from Michael McNeil, Berry, Dunn, McNeil and Parker, and Appendix O, Total Costs Schedule A versus G, from John Bouchard, Audit Division, Department of Human Services.

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[9] Principles of Reimbursement for Nursing Facilities, section 41.23.4, dated July 1, 1998.
[10] Medicaid Nursing Facility Reimbursement, pg. 8.
[11] Principles of Reimbursement for Nursing Facilities, section 44.10, dated July 1, 1998.
[12] Medicaid Nursing Facility Reimbursement, pg. 10.

III. RATE SETTING

A. Introduction

The commission was charged with examining the setting of rates for the different payers, the advisability of rate equalization between private and public payers and the case mix payment system for private paying patients. The commission studied the current methods used by Medicaid and Medicare for reimbursement of nursing facilities. See section II.

The commission reviewed presentations and submissions from a number of parties on rate setting and rate equalization. Information from Minnesota and North Dakota was informative on the subject and experts in the field were consulted to enable commission members to ask questions and obtain more information.

In reference to two bills before the Joint Standing Committee on Health and Human Services during the 118th Legislature, commission member Michael McNeil and the accounting firm of Berry, Dunn, McNeil and Parker suggest that there would be a need for a significant increase in the Medicaid budget if rate equalization were achieved via increasing the Medicaid rates to the same level as private pay rates. The exact amount of funding required would depend on the level at which rates were set.[13] See Appendix P. One estimate is that it would cost $18,340,000 per year to raise the Medicaid rate to the private pay rate.[14] The opposite method of reaching the equal rate goal would be to decrease the private pay rates, imposing the Medicaid rates as caps on private pay beds, thereby decreasing revenue to nursing facilities by the amount of the difference between Medicaid rates and private pay rates, multiplied by the numbers of residents in each category. There is no estimate for the option of increasing the Medicaid rates somewhat and decreasing the private pay rates somewhat, presumably because the point at which the two rates were to meet would determine the cost to all payers, both public and private.

B. Minnesota

Minnesota has had a rate equalization law since 1977, based on a cost-based reimbursement system, and is now beginning a new contract-based system. In Minnesota cost-based reimbursement is based on analysis of resident needs through a case-mix evaluation. Operating costs are included, excluding physician, therapy and drug costs. In general single bed rooms are considered a luxury and are not subject to rate equalization unless medically necessary. A reimbursement specialist with the Minnesota Department of Human Services, when asked about the effects of rate equalization, concluded that it had not had a measurable effect on the number of nursing facility beds per 1000 residents. High numbers of nursing facility beds per capita has been a concern to states because excess beds contribute to high costs in the system as a whole and are paid for in part by reimbursement for all occupied beds, including those paid for through the Medicaid program. Minnesota addressed the issue of excess bed capacity

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[13] Letter from Michael McNeil to Joint Standing Committee on Health and Human Services regarding LD 991 and 1291, dated April 2, 1997

[14] Letter from Michael McNeil to Joint Standing Committee on Health and Human Services regarding LD 991 and 1291, dated April 2, 1997

separately, and decreased the number of beds, via a moratorium on nursing facility beds certification in 1983 and a moratorium on nursing facility licensure in 1985.[15]

In 1995 Minnesota began work on a nursing home contract alternative payment project (hereinafter called the contract project). The Minnesota cost-based reimbursement system will switch to contract-based reimbursement over a 5-year period ending July 1, 2000. At present 218 of the 444 nursing facilities have enrolled in the contract project.[16] Contract rates are negotiated between the facility and the state Department of Human Services and depend in part on costs in the established base year of the facility. The contract rate is set at a base rate, adjusted annually for inflation. Other terms of the contract may include a lessening of state regulations and an exemption from rate equalization for short stay private pay residents. Plans now call for the use resident needs assessment through use of the Minimum Data Set (MDS) to track and evaluate resident clinical care. Eventually, standards are planned to allow measurement of quality of care and resident satisfaction. When the project is fully implemented, the nursing facility and the Department of Human Services will jointly set quality goals and the facility will be eligible for incentive payments of up to 5% of the contract amount for meeting the quality goals. On July 1, 2000 the old system of cost-based reimbursement will be replaced in full by the contract-based system. See section IV on quality of nursing facility care for a discussion of the measurement of quality of care and quality of life.

C. North Dakota

Rate equalization for nursing facility care became the law in North Dakota in 1990, using the same system design as in neighboring Minnesota. Rates are based on case-mix reimbursement. Single rooms are considered a luxury, unless medically necessary, and there are no limits on the charge for them. The system was instituted by raising the Medicaid rates to the level of private pay rates, at a significant cost to the state. Rate equalization has lowered profit margins to 3 to 5% and has not had a measurable effect of the ratio of beds per 1000 residents in North Dakota.[17]

D. Commission discussion

The commission spoke with experts around the country who are familiar with the reimbursement systems in place in Minnesota and North Dakota. Rate equalization appears to be on a different track from contract-based reimbursement, although the two systems could work together. Minnesota is moving away from rate equalization in its contract project by allowing an exception to rate equalization for short-term private pay residents. Commission members were told that public discussion of the Minnesota contract project had not included its effect on rate equalization.[18]

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[15] Conversation with Charles Osell, Reimbursement Specialist, Minnesota Department of Human Services, December 3, 1997.
[16] Conference call of commission with Patricia Cullen, Minnesota Health Care Providers, October 14, 1998.
[17] Telephone conversation with David Sack, Administrator of Institutional Reimbursement, North Dakota Department of Human Services, December 3, 1997.
[18] Conference call with Dr. Robert Kane, September 2, 1998.

Commission members listened with interest to a proposal by the Department of Human Services to begin work on performance-based reimbursement. Challenges to implementing a new system include the development of the performance standards, the most difficult of which will be the consumer and family satisfaction measurements, and the appropriation of funding with which to provide the financial rewards to high performing nursing facilities. See the recommendations in section VII.

IV. NURSING FACILITY FINANCIAL HEALTH

A. Introduction

Financial information about the condition of the nursing facility industry was provided to the commission from the Maine Health Care Association, commission member Michael McNeil, other commission members and the Department of Human Services. The information shows an industry that faces serious financial challenges. Some facilities are in serious financial difficulty and some are financially healthy. Significant change in reimbursement of nursing facilities began July 1, 1998 with the new Medicare reimbursement system and more change is coming.

Commission members are concerned that nursing facilities be adequately supported and reimbursed so that Maine residents have access to high quality long-term care services in their communities. These services should include facility-based and home and community-based services. A choice of the same high quality services should be available whether the resident qualifies for reimbursement through Medicare, Medicaid, another payer or pays privately. State regulation should adequately protect the public and be workable for the regulated providers. The long-term care system should serve as a model of cooperation among all interested parties. Reimbursement for publicly-paid care should be fair and prompt and should promote the public policy goals of the State. It should enable long-term care providers to deliver their services through well-trained and fairly paid staff whose work reflects the care, concern and respect due to recipients of that care. With these goals in mind the commission settled on the recommendations on financial health contained in section VII.

There are some commission members who felt that the financial health of the industry is dependent as much on the industry's willingness to adapt to the changing market and a changing regulatory environment. These commission members felt that this was just as important as state and federal reimbursement.

B. Medicare

In 1997, Medicare provided reimbursement for 11% of the residents in Maine's nursing facilities. This percentage has increased from 5% in 1993.[19] The Principles of Reimbursement require nursing facilities to certify for occupancy by persons whose care is reimbursed by Medicare different numbers of beds in different parts of the State, according to the numbers of

[19] Nursing Facility Occupancy by Payment Source, Appendix F.

Medicare recipients and patients in hospitals awaiting nursing facility admission and other relevant demographic information.[20] Access to nursing facility care reimbursed by Medicare is an important public policy goal in Maine, in part to maximize federal funds since Medicare funding is 100% federal funding and in part to assure Maine residents that the nursing facility care they need will be available to them as close to their home communities as possible.

The commission learned that the federal government has just changed the manner in which it reimburses for Medicare nursing facility care. The new prospective payment system is discussed in section II. All parties before the commission, and commission members themselves, concluded that the Medicare changes are significant and that the impact on Maine's long-term care facilities are expected to be negative, more specifically, less reimbursement for more comprehensive care undertaken by the facilities. This is of grave concern as it endangers the quality of care provided and access to nursing facility services across the State.

C. MED'94 and MED'96

In 1994 the Legislature undertook to decrease Maine's reliance on high cost institutional long-term care and to increase the number of choices for long-term care and the use of home and community-based care and services. To accomplish this the Legislature directed the Department of Human Services to revise its criteria for nursing facility admission reimbursed through the Medicaid program to focus on the individual's functional ability and medical and social needs.[21] The needs assessment was planned to achieve the purposes of the statutory charge, "to determine the most cost-effective and clinically appropriate level of long-term care services." The department undertook the revision and adopted a new assessment tool entitled the Medical Eligibility Determination, 1994, referred to as MED'94. This assessment tool was revised in 1996 to take into account Alzheimer's disease and other dementias, with the resulting assessment tool referred to as MED'96. Another change to the assessment process occurred when the Legislature required MED'96 assessments of all applicants for nursing facility care, not just those applying for Medicaid assistance or reasonably anticipated to make such an application within 180 days.[22]

Commission members learned that the average occupancy rate of nursing facilities decreased from 96% in 1993 to 84% in 1997.[23] During this time period the Department of Human Services adopted the MED'94/MED'96 assessment tool, shifted resources to home and community-based care and encouraged the development of other options for long-term care. The results were impressive. More than 500 new beds were created for residential and other specialized services during 1996 alone. By February, 1997 more than 20 nursing facilities "banked" more than 286 beds, taking them off-line for Medicaid reimbursement purposes while

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[20] 22 MRSA section 1812-H, subsection 2-A.
[21] 22 MRSA section 3174-I. See also Long-Term Care Reform, A Status Report, February, 1997, Department of Human Services, pgs. 1-4.
[22] 22 MRSA section 3174-I.
[23] Nursing Facility Occupancy by Payment Source, Appendix F.

retaining the right to an expedited certificate of need process if the facility decides to bring them back on-line.[24] By late 1998 the total of banked beds had reached 486.[25]

The shift in state policy regarding eligibility for nursing facility care, increased consumer choice and changes in state and federal regulations have been effective in more people receiving home and community-based care and have in part caused financial difficulties for the nursing facilities. As is most pertinent to the work of the commission, the number of nursing facility beds decreased from 10,139 in 1993 to 9,226 in 1997. See Appendix F. Nursing facility care as a proportion of the Maine's long-term care budget decreased from 85% in state fiscal year 1993-94 to 80% in state fiscal year 1995-96, while the percentage spent on boarding care increased from 5% to 7% and the percentage spent on home care increased from 10% to 13% in the same time period.[26] Since 1993 residential care level beds reimbursable through the Medicaid program grew by the following numbers:

• Alzheimer's care beds	301
• Geriatric care beds	1259
• Head injury care beds	12
• HIV-AIDS care beds	6
• Mental health care beds	89
• Total	1667[27]

D. Medicaid reimbursement

Reimbursement for nursing facility care through the Medicaid program has been discussed in section II. Commission members became convinced during the course of their work that the level of reimbursement provided by the Medicaid program does not adequately ensure quality care for nursing facility residents. Commission members concluded that the rates paid to nursing facilities are in danger of failing to meet the needs of residents and that recalculation of the base year rates used in the reimbursement formula is called for in accordance with the Principles of Reimbursement.[28] The commission discussed revising the Principles of Reimbursement and recommends a number of changes including re-basing, examining operating costs and tying caps for cost components to the size of the facility. The commission also recommends that the Department of Human Services study a number of reimbursement issues and undertake a pilot project to reimburse nursing facilities based on an outcome-based incentive system. See section VII.

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[24] Long-Term Care Reform, A Status Report, February, 1997, Department of Human Services, pg. 7.
[25] Information obtained from Catherine Cobb, Department of Human Services, Bureau of Elder and Adult Services, November 17, 1998.
[26] Long-Term Care Reform, A Status Report, February, 1997, Department of Human Services, pg. 4.
[27] Information obtained from Catherine Cobb, Department of Human Services, Bureau of Elder and Adult Services, November 17, 1998.

[28] Principles of Reimbursement, section 37.2, effective date July 1, 1998.

E. Employment issues

Information was presented to the commission connecting the recently healthy economy, near full employment and the relatively small size of Maine's nursing facilities to the financial stress they are experiencing. [29] Relatively small facilities, and Maine's rank 46th in size in the country, mean that facilities are not able to benefit from economies of scale. The cost of care in a home of under 50 beds runs 25% higher than the cost of care in a home with 200 and over beds.[30] Near full employment means that wages and benefits must be competitive with other employment or, as has been happening in Maine's nursing facilities, employees are harder to hire and harder to retain and staff turnover increases. The commission considered information showing that Maine's facilities have the 5th highest total compensation in the country and that employment costs represent 65% of the total operating expenses of the facilities.[31]

The current employment situation has a negative impact on patient care and staff morale and increases facility costs. The commission discussed ways to increase reimbursement to direct care workers in order to address this problem. See section VII for recommendations with regard to employment.

F. MHHEFA financing

Maine is a leader among the states in making affordable financing available to nursing facilities through the Maine Health and Higher Educational Facilities Authority (MHHEFA), as authorized in Title 22, Maine Revised Statutes, Chapter 413. Since its establishment in 1971 MHHEFA has made fixed rate, long term capital available to for-profit and not-for-profit higher educational and health care facilities. Two programs are available for nursing facilities: one operating in the national tax-exempt credit markets provides loans to not-for-profit nursing facilities and one operating in the national taxable credit market provides loans to proprietary nursing facilities.

On the tax-exempt financing side, through the pooling of borrowers and the moral obligation reserve fund credit enhancement, MHHEFA is able to purchase bond insurance and obtain interest rates based on a AAA credit rating, a rating which would not otherwise be available to some nursing facilities, if only because of their small size. The improved credit rating results in lower interest rates and savings for the facilities in repaying the loans. In addition, the pooling of borrowers allows the sharing of costs for common services such as printing, legal services, and credit rating service charges.

On the for-profit financing side, pooling borrowers has produced substantial savings because of the homogenizing effect of pooling, the moral obligation reserve fund credit enhancement and the sharing of common costs. Bond insurance has not been used in this portion of the business.

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[29] Attachment to letter Paula Valente dated July 24, 1998.
[30] Attachment to letter to Joint Standing Committee on Health and Human Services dated April 2, 1997.
[31] Attachment to letter to Paula Valente dated July 24, 1998.

Through the participation of the Maine Health and Higher Educational Facilities Authority nursing facilities have had access to loans for construction projects and refinancing of mortgages amounting to $155,392,811, of which $135,187,811 is currently outstanding. The amount of the outstanding balance, $135,187,811 at the time of the commission's final meeting, is the amount for which the moral obligation reserve fund is potentially liable. See Appendix P, MHHEFA, Taxable Reserve Fund Resolution, Outstanding Balances and Location and Appendix Q, Not for Profit Nursing Homes Outstanding Balances and Locations.

This financing mechanism results in loans to nursing facilities at lower interest rates than would otherwise be possible. Since most interest payments are reimbursable in full through the Medicaid program, the savings in interest translates into direct savings to the Medicaid budget. MHHEFA and commission member Michael McNeil provided financial information estimating that use of MHHEFA financing has saved the nursing facilities approximately $30,000,000 in interest expense over the lives of the loans and that this translates into a savings of approximately $23,000,000 for the Maine Medicaid program.[32] See Appendix R.

The Maine Health and Higher Educational Facilities Authority has assisted nursing facilities experiencing financial difficulties in meeting their financial obligations to MHHEFA. MHHEFA has done this by advancing funds under a forbearance agreement negotiated between MHHEFA and the institution, as shown on Appendix S, MHHEFA Taxable Nursing Home Advance and Payment History. MHHEFA presented information to the commission about its advance payments to nine nursing facilities, showing the repayments and balances due from each facility. MHHEFA foreclosed and ceased operations at one facility and is working on the sale of the property and licensed nursing beds. One facility is under contract for sale and the long-term plans include repayment of MHHEFA when the sale is concluded.

Some commission members questioned the wisdom of the State's providing moral obligation credit enhancement to for-profit institutions. These members are concerned that MHHEFA's involvement in the financing of long-term care facilities could lead to their having influence in policy questions properly reserved to the Legislature.

G. Overall financial health

Information on the overall financial status of Maine's nursing facilities came to the commission from commission member Michael McNeil and the accounting firm of Berry, Dunn, McNeil and Parker, based upon information from 117 non-hospital based nursing facilities. The letter and attachments in Appendix L show financial information and ratios for these 117 nursing facilities. This information shows an industry with current ratios of less than 1.0, declining total profit margins that hover below 1, and cumulative negative equity. In 1995 the total profit margin of Maine's nursing facilities was 1.80, which, compared to the national median of 3.79 placed Maine's facilities 37th in the nation.[33] Maine's facilities placed poorly once again in

[32] "Estimated savings from use of moral obligation reserve fund program vs. traditional financing," from MHHEFA and letter to Paula Valente dated July 24, 1998.
[33] Attachment to letter to Paula Valente dated July 24, 1998.

median debt service coverage ratio in 1995, where the median ratio was 2.22 and Maine's ratio was 1.08, ranking Maine 46th in the country.[34]

Commission members learned that nursing facilities are putting their resources into care for their residents. Although the data is taken from different years, the commission benefited from the picture presented in the letter to the Joint Standing Committee on Health and Human Services dated April 2, 1997 and the attachments, all of which are included in Appendix L:

- 1996 total costs $141.25 per day
- 1996 Medicaid allowable costs $112.81 per day
- 1995 total costs $130.91 per day
- 1995 Medicaid allowable costs $105.94 per day
- 1994 total operating cost $ 98.47 per day
- 1994 direct care expense $ 35.54 per day
- 1994 indirect care expense $ 13.83 per day
- 1994 administrative and general expense $ 16.18 per day[35]

Commission member Michael McNeil brought to the attention of the commission figures included in the letter of July 24, 1998 to Paula Valente and updated those figures with percentages at the meeting on October 1, 1998. The figures show the following:

Amounts and Percentages of Medicaid Reimbursement for Selected Actual Costs and Allowable Costs in the Medicaid Program, 1996

	Actual Costs		Allowable Costs	
	Dollar amount	Percentage of total costs	Dollar amount	Percentage of total costs
Salaries, wages and fringe benefits	$85.32	57.7%	$73.25	62.7%
Administrative compensation	$2.45	1.65%	$2.81	2.4%
Owners and officers compensation	$ .09	.06%	0	0
Central office	$1.34	.9%	$ .93	.79%
Management fees	$ .92	.62%	0	0
Total cost per patient day	$147.81		$116.77	
Average direct care hours per resident day equals 3.9 hours.				

[34] Attachment to letter to Paula Valente dated July 24, 1998.
[35] Attachment to letter to the Human Services Committee dated April 2, 1997.

Commission members discussed the financial situation of the state's nursing facilities and agreed upon a number of recommendations to bring about positive change. See the recommendations in section VII.

V. QUALITY OF NURSING FACILITY CARE

Commission members studied the quality of nursing facility care at almost every meeting. Questions about quality and how to encourage and ensure it arose with regard to all of the other issues considered by the commission. Commission members agreed that quality of care is closely tied to staffing. They also agreed that staffing at a level to provide high quality care requires adequate reimbursement to the nursing facilities.

Some commission members felt the quality of nursing facility care is difficult to readily define. Some define it as an attribute of excellence, a feeling that you get when you walk through the door. Others say it is the provision of services and an environment so that residents feel positive and maintain dignity, control and independence while either improving, achieving or maintaining their highest functional level or slowing their level of decline. High quality care is individualized care. It is critical to the success of a nursing facility stay. With it the individual resident may achieve a high quality of life. High quality care is the TLC in long-term care.

The commission reviewed articles on quality of care and reams of material on quality measures and quality indicators. Since 1990 the federal government, through the Health Care Financing Administration, has been working to develop and use quality indicators, a system to measure the quality of care delivered in nursing facilities. See Appendices T and U for examples of articles on quality indicators. The quality indicators take information gained from the MDS assessment tool and provide an overview of the residents and the care provided in the nursing facility.[36] The Maine Medicaid program and Maine nursing facilities have participated in a demonstration project since 1993. Over the years the project has used between 30 and 37 quality indicators. Recent changes in the quality indicators signal a shift in the focus from problem resolution to assurance of quality services. The quality indicators include items related to physical functioning and allow examination of a facility's clinical policies, prevention techniques and quality improvement efforts. The quality indicators cover the following:

- accidents;
- behavioral and emotional patterns;
- clinical management;
- cognitive functioning;
- elimination and continence;
- mobility;
- infection control;
- nutrition and eating;
- physical functioning;

[36] Nursing Home Quality Indicator Development, pg 1.

- psychotropic drug use;
- resident or family participation in assessment;
- maintenance of family relationships;
- quality of life (which, the commission notes with interest, is measured by prevalence of daily physical restraints and prevalence of little or no activity);
- sensory function;
- communication; and
- skin care.

The commission considered the information gathered from the HCFA quality indicators to be very valuable information about nursing facilities and residents, but only half the answer to judging quality of nursing facility care. This is because of their focus on problem areas and their inability to reflect how consumers feel about their living situations, their care and the quality of their lives.

The Minnesota contract project proposes to use performance-based reimbursement for which outcomes information will be required. See Appendices V and W on the contract project. Research is currently being done in Minnesota and Wisconsin on anticipated outcomes for residents of nursing facilities. This requires establishing resident status and then articulating measurable outcomes for the nursing facility population. This function is difficult in nursing facilities because of the mix of resident conditions and prognoses. Dr. Robert Kane identified five clusters of residents, as follows:

- those in active recuperation or rehabilitation;
- those with chronic physical disabilities, who are likely to decline gradually over time;
- those with cognitive disabilities, who are likely to decline over time and to reside in the facility for a very long time;
- those in persistent vegetative states; and
- those in terminal states whose needs are primarily for hospice and ameliorative care.[37]

Outcomes can include the presence of positive physical conditions and the absence of negative ones (for example, the ability to walk as against the occurrence of falls), clinical measurements such as blood pressure levels and calculations of cost and cost-effectiveness. They reflect perceived health status, ability to perform activities of daily living, cognitive performance, affect, social activity and satisfaction with care and living environment. Used in this way outcomes incorporate into the evaluative process the health status of the resident and the resident's feelings and level of satisfaction with the care provided. See Appendices X and Y, "Assessing the Outcomes of Nursing Home Care" and "Assuring Quality in Nursing Home Care" by Dr. Robert Kane and others.

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[37] Kane, "Assuring Quality in Nursing Home Care," pg 234.

In a research project described in "Assessing the Outcomes of Nursing-Home Patients" Dr. Kane and a group of partners worked with residents asking satisfaction related questions including questions about the following areas:

- whether the staff shows a personal interest;
- whether something is done about complaints;
- overall satisfaction;
- whether the nursing staff cares about the resident;
- whether help comes in a reasonable time;
- whether the facility is a cheerful place;
- whether the resident is able to keep personal possessions;
- whether life in the facility is boring;
- whether the food is good;
- whether the resident is able to see a physician when needed;
- whether the resident's room and surroundings are clean;
- whether the resident has enough privacy;
- whether the resident is able to choose his or her own bedtime;
- whether personal belongings have disappeared; and
- whether the amount of noise bothers the resident.

The researchers concluded that it is possible to measure value-based outcomes for nursing facility residents. In order to establish the outcomes information such as that listed above must be collected from residents, families of residents, providers of nursing facility care, regulators, legislators and the general public.

In separate research a group once again including Dr. Kane studied the prediction of outcomes for nursing facility residents. See Appendix Z, "Predicting the Outcomes of Nursing Home Patients." The study encountered varying degrees of success in predicting resident outcomes depending on the use of a scale score or the prediction of status changes. The study suggests proceeding with outcome-based reimbursement, compensating for actual costs in

nursing facilities and varying the outcome-based reward depending on the ability of the payer to pay. According to the authors a wealthy system that would like to encourage experimentation and place substantial risk on nursing facilities could place more funds in the outcome-based category. A more conservative system could augment the actual costs category and place just a small incentive payment in the outcome-based category. The study also suggests non-monetary rewards, such as positive publicity and decreased regulatory requirements, that are valuable to nursing facilities and should be considered.[38]

As discussed in section III, the Minnesota contract project has chosen two sets of measurements for outcomes and will use both in the determination of which nursing facilities are meeting their goals for delivering high quality care and therefore qualifying for the additional reward payment of up to 5% of their base contract amount. One of the two sets of measurements is based on a subset of quality indicators that are resident-level data chosen from the MDS assessment by the Center for Health Systems Research and Analysis at the University of Wisconsin-Madison. This set is slanted to the clinical side. The other set is quality of life measures which will be developed from resident surveys of satisfaction, refined into benchmarks for stated outcomes. Both sets of measurements are still under development.

Commission members supported a recommendation that provides mechanisms for input from residents and families on quality of care and directs the Department of Human Services to undertake pilot projects to reward high quality. They also support identifying regulatory barriers to high quality care and increasing the quality of care by addressing staffing issues. The issue of staffing needs and the challenges of a near full employment economy in some parts of the state are discussed in sections IV and VI.

VI. ADDITIONAL INFORMATION

During the course of its work the commission reviewed additional information that pertained to its duties and to the operation of nursing facilities, including recent reports on staffing ratios and paperwork reduction, an agreement between the Department of Human Services and the Maine Health Care Association and a petition presented at the November 12th meeting.

A. Minimum staffing ratios

Resolve of 1997, Chapter 34, established the Task Force on Minimum Staffing to review the minimum staffing required of nursing facilities, to consider increasing minimum staffing ratios and to make recommendations for changes in departmental rules concerning minimum staffing levels. The task force presented its report to the Joint Standing Committee on Health and Human Services August 19, 1997 and supplemented that with another report on March 2, 1998. See Appendix AA for a copies of the reports of the task force and the report of task force member Brenda Gallant. Its major findings included the following.

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[38] Kane, "Assuring Quality in Nursing Home Care," pg. 236.

- Direct care licensed nursing staff, as recognized by the Principles of Reimbursement, are performing non-direct care functions. The task force recommended that the commission look into this issue.

- The case mix assessment data could be used to collect information on empirical staffing criteria based on fluctuating resident acuity.

- Increased patient acuity indicates a need for acuity-based staffing.

- Increasing CNA staffing could result in decreasing licensed nursing staff available for direct care.

- A question was raised about incentives for nursing facilities to save on direct care costs.

- Minimum staffing is a safety threshold, not a prescription for daily staffing and not "best practice."

- Factors in achieving best practice include staffing levels, staffing recruitment, training and retention, facility leadership and reimbursement to match staffing.

- Staffing ratios are an inexact response to the challenge of providing quality nursing facility care.

The Task Force on Minimum Staffing made the following recommendations:

- Implement new staffing ratios of 1:6 on the day shift, 1:10 on the evening shift and 1:15 on the night shift;

- Examine the availability of certified nursing assistants throughout the state; and

- The Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities should examine the issue of reimbursement for certified nursing assistants, focusing on reimbursement for direct and indirect care as opposed to routine services.

In addition to the report of the Task Force on Minimum Staffing, the Joint Standing Committee on Health and Human Services received a separate memorandum from one member, Brenda Gallant, the State Long Term Care Ombudsman, a copy of which is included in Appendix AA. In the memorandum Brenda Gallant disagreed with the staffing ratios recommended by the task force and provided additional information. She made her own set of recommendations, which included:

- Replace the concept of minimum staffing with a requirement that facilities staff to meet the needs of residents as determined by case mix assessments and require the Department of Human Services to adopt rules requiring such staffing; and

- Structure increased nursing facility reimbursement to address the shortage of certified nursing assistants, planned for targeted labor shortage areas.

Members of the commission considered the recommendations of the Task Force on Minimum Staffing. They agreed upon recommendations that new minimum staffing requirements be adopted that are tied to acuity and needs level of the residents and that ensure that direct care staff are available to meet residents' needs and that the Commissioner of Human Services present a proposal to implement and fund these requirements to the Joint Standing Committee on Health and Human Services by March 1, 1999.

B. Paperwork reduction

The commission also had an opportunity to review the report of the Task Force on Paperwork Reduction in Nursing Facilities, attached as Appendix BB. Established by Resolve of 1997, Chapter 71, the task force reported on January 1, 1997, having studied the problem of paperwork required for patient assessment, care and reimbursement in nursing facilities, the needs of the patient and family, the nursing and professional staff of the facility, the Department of Human Services and any other interested party and having searched for methods of meeting the legitimate needs of all parties in the most efficient and efficacious manner.

The task force was fortunate in that it was able to bring about change almost at the time that it identified problems and suggested solutions. The following accomplishments highlight the work of the task force.

- Duplications in the requirements of Department of Human Services Licensing and Certification and Principles of Reimbursement were eliminated.

- An intermediate step was inserted into the process for submitting the minimum data set plus (MDSPlus) information, allowing errors to be caught early and without penalty.

- The schedule for completing the MDSPlus was revised to comport with other reporting requirements.

- Requirements for verification of information on the MDSPlus were lessened.

- It was clarified that there is no standardized form required for response to a resident assessment protocol.

- The Department of Human Services Licensing and Certification agreed to accept facility staffing schedules instead of requiring transfer onto a state specified form.

- The task force developed a format for care plans that is being tested in a pilot project.

Members of the commission were interested in the issues posed by the Task Force on Paperwork Reduction in Nursing Facilities. They agreed on a recommendation that the Department of Human Services present to the Joint Standing Committee on Health and Human Services a plan to reduce paperwork in nursing facilities which will include consideration of the opportunities presented by advancing technology and the feasibility of linking data between the Minimum Data Set and Medical Eligibility Determination forms.

C. Department of Human Services agreement with the Maine Health Care Association

The commission also reviewed the agreement between Commissioner Kevin W. Concannon, of the Department of Human Services, and John C. Orestis, President of the Maine Health Care Association, dated January 30, 1998. See Appendix CC. In this agreement the department and the association agreed to work together to:

- develop management capacity in the nursing home industry to enable it to promote alternatives to traditional nursing homes and address human resource needs to improve the supply, availability and career development of health care workers;

- extend the initial medical assessment classification period from 30 to at least 90 days, with exceptions;

- revise, simplify and make consistent licensing rules for long-term care in different settings;

- seek amendment to restrictions on nursing facilities' providing home health care;

- design a demonstration project on flex beds; and

- modify requirements on depreciation, occupancy and acquisition cost to ease the reduction of nursing facility beds.

Commission members were interested in the agreement between the Department of Human Services and the Maine Health Care Association to work together on a project involving "flex beds" and endorse the proposal in their recommendations.

D. Petition to the Commission

At the November 12th meeting the commission received a petition asking for immediate improvements in four major areas of nursing facility care. The petition is included at Appendix DD. The four areas of concern are:

1. Staffing. Too few and often with too little training and supervision.
2. Lack of staff means there is no time to provide tender loving care, almost as important as physical attention.

3. Food. Little or no attention to individual preferences.
4. Lack of security and care for safety and well-being of residents in Alzheimer's units.

The petitions were accompanied by 2 letters to the commission and one letter to a nursing facility administrator which are included together as Appendix EE.

VII. RECOMMENDATIONS

The Commission believes that Maine residents should have access to high quality long-term care services in their homes and communities and in long-term care facilities close to their homes. To ensure that these services are available, long-term care facilities must be financially healthy and consumers must be able to plan for their care and to understand the services that are provided in the long-term care system. To these ends the commission makes the following recommendations:

1. Outcome-based incentives. The commission recommends that the Legislature direct the Department of Human Services to undertake pilot projects to reward high quality care in nursing facilities based on successful performance by the facilities. The commission suggests that successful performance be measured using quality indicators from the Minimum Data Set already in use and from consumer and family satisfaction surveys. The commission suggests that successful performance may be rewarded by means of financial rewards, favorable public information, decreased regulation by the State or in other ways. The commission cautions the department to preserve consumer choice in urban and rural settings to the extent practical, to avoid preserving, with financial or other assistance, facilities that perform poorly because of incompetence and to avoid inadvertently restricting access to care.

2. Reimbursement for nursing facility care through the Medicaid system. The commission is persuaded that reimbursement to nursing facilities through the Medicaid program may be inadequate to ensure high quality care to residents. The commission recognizes, however, that the need for more reimbursement for facilities needs to be balanced against the need to fund home and community based care. Therefore, the commission recommends that the Department of Human Services review the Principles of Reimbursement as well as information from facilities in order to identify the specific areas in which reimbursement is inadequate.

The commission recommends that the Legislature direct the Department of Human Services to develop new approaches to reimbursement targeted to specific problems, including the following, and report to the Legislature's Joint Standing Committee on Health and Human Services by February 1, 1999:

A) Examining operating costs to determine specific areas in which reimbursement may be inadequate. In doing so the department should consider the following options for reimbursement:

- reimbursing facilities' costs for medical directors at a level reflecting the increased acuity of nursing facility residents;
- merging the indirect and routine cost components;
- reimbursing for all aspects of direct care for residents, including medical supplies, in one cost category so that they may be adjusted by case mix;
- reviewing the most recent information from time studies being used for the Medicare prospective payment system and making a determination whether the time study presently in use reflects nursing costs in Maine's facilities and is appropriate for use; and
- studying employment markets, labor costs and turnover rates at facilities around the State and, for those facilities that are at or above direct care limits, developing methods for providing increased reimbursement. This study should be done in conjunction with the Department of Labor and should build upon the work already done by that department and by the Maine Health Care Association;

B) Re-basing reimbursement rates from 1993 to 1996 or the most recent complete audited year and adopting new medians and cost caps in order to keep up with the higher costs faced by facilities due to inflation, increased paperwork requirements, and higher resident acuity. In doing so the department should consider the following options for re-basing:
   - re-basing costs with an emphasis on those most directly impacting high quality resident care; and
   - re-basing cost components on a rolling schedule whether periodically or when a stated event occurs, such as when 50% of the facilities are over the cap;

C) Tying caps applicable to the different cost components to the size of the facility, placing higher caps on the smaller facilities, which are often in rural areas, in recognition of the higher costs faced by those facilities and the importance of maintaining access to nursing facility care in rural areas; and

D) Removing any reimbursement incentives that have unintended adverse impacts on resident care.

3. Minimum staffing requirements. The commission recommends that the Legislature direct the Department of Human Services to replace its current minimum staffing ratios with minimum staffing requirements that:

A) are tied to the acuity level of residents and to the other needs of residents that effect the quality of their lives; and

B) ensure that adequate numbers of direct care staff are available at all times to meet residents' needs.

The commission recommends that the Commissioner of Human Services present a proposal to implement and fund these new requirements to the Legislature's Joint Standing Committee on Health and Human Services by March 1, 1999.

4. Rate Setting. While some members of the commission support the concept of rate equalization, they recognize that legislation requiring nursing facilities to charge equal

rates to Medicaid residents and private payers could require additional legislative appropriations which would jeopardize needed funding for home and community based care. Accordingly, the commission does not recommend that equal rates be mandated at this time.

5. Paperwork reduction. The commission recommends that the Legislature direct the Commissioner of Human Services to report to the Joint Standing Committee on Health and Human Services by June 1, 1999 with a plan to reduce paperwork in nursing facilities which must include consideration of the opportunities presented by advancing technology and the feasibility of linking data between the Minimum Data Set (MDS 2.0) and Medical Eligibility Determination (MED'96) forms.

6. Interaction with consumers and families. The commission recommends that the Legislature take the following actions:

A) direct the Department of Human Services to improve the provision of information on long-term care services, costs and performance; and

B) strengthen and make more independent the Long-term Care Steering Committee by allocating more resources to it and changing its duties so that it advises the Commissioner and the Legislature.

7. Flex beds. The commission encourages the Department of Human Services and the Maine Health Care Association to continue their work on a proposal to allow the use of "flex beds," by which the commission means that beds licensed for long-term or residential care may be used to meet the changing needs of residents and may be reimbursed according to the level of care provided. The commission cautions that any proposal must not compromise the quality of life of a facility's residents.

8. Regulatory barriers to high quality care. The commission recommends that the Legislature direct the Commissioner of Human Services to study and identify regulatory barriers to high quality care and make recommendations for relief or modification of rules and report to the Joint Standing Committee on Health and Human Services by January 1, 2000.

9. Long-term care insurance information. The commission recommends that the Legislature direct the Bureau of Insurance to:

A) collect information on long-term care insurance and provide a report by March 1 each year to the Commissioner of Human Services, the Joint Standing Committee on Health and Human Services and the public. The information collected should include the number and types of policies purchased by consumers, the cost of premiums, daily benefit levels and the duration of benefits. Information should also be collected on policies paying benefits to or for consumers, including the types of policies, daily benefit levels and remaining duration of benefits; and

B) conduct a study of the use of individual income tax credits as incentives to encourage the purchase of long-term care insurance. The study should analyze

the effectiveness of tax credits in encouraging the purchase of long-term care insurance in other states and the anticipated cost to the State from establishing a tax credit for all or part of the premium cost of qualifying long-term care policies. The Bureau should provide a report to the Joint Standing Committee on Health and Human Services by January 1, 2000.

10. Report on changes in long-term care. The commission recommends that the Legislature direct the Commissioner of Human Services to consult with the Long-term Care Steering Committee, study changes in the delivery and financing of long-term care and report to the Joint Standing Committee on Health and Human Services by March 1, 2000. The report should cover changes in the delivery of long-term care in facilities and by home and community-based providers, changes in reimbursement systems including, but not limited to the changes in the Medicare reimbursement system, the use of "flex beds," the quality of care provided to residents of Maine, the growth in home and community-based care and the availability of services and providers in all parts of the State.

11. Medicare reimbursement system. The commission recommends that the Legislature pass a legislative resolution opposing the change to the proposed prospective payment reimbursement system that has been instituted in the federal Medicare program for the reasons that it is flawed in its structure and that its application will cause financial hardship for Maine's long-term care facilities and will reduce the quality of care provided to Maine's residents. The commission is concerned that the new reimbursement system will lower reimbursement for care, cause the loss of skilled nursing facility beds available under the Medicare program and restrict access to care for residents who are eligible for Medicare. Maine was one of six states participating in a demonstration project under the Medicare program. Nursing facilities in all states that participated in the demonstration project are in jeopardy because the system omitted reimbursement for Part B pharmaceuticals for providers in states that participated in the demonstration project. Commission members fear that the new reimbursement system will lower reimbursement for staffing to a national average, which is below the staffing level provided in Maine facilities, and thus will lower the quality of care provided in Maine.

VIII. IMPLEMENTING LEGISLATION

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

Whereas, the quality of care for residents in nursing facilities is threatened by high staff turnover, the burdens of excessive paperwork, and the current rates and methods of reimbursement used in the Medicare and Medicaid programs; 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 by the People of the State of Maine as follows:

Sec. 1. Pilot projects on performance contracts in the nursing facility field. The Department of Human Services shall undertake pilot projects to reward high quality care in nursing facilities based on successful performance by the facilities. Successful performance must be measured using quality indicators from the Minimum Data Set already in use and from consumer and family satisfaction surveys. Successful performance may be rewarded by means of financial rewards, favorable public information, decreased regulation by the State or in other ways. The department shall be cautious to avoid inadvertently restricting access to care, to act in order to preserve consumer choice in urban and rural settings to the extent practical and to avoid preserving with financial or other assistance facilities that perform poorly because of incompetence.

Sec. 2. Report regarding Principles of Reimbursement. The Department of Human Services shall develop new approaches to reimbursement of nursing facilities under the Medicaid program targeted to specific problems, including the following, and shall report to the Legislature's Joint Standing Committee on Health and Human Services by February 1, 1999:

1) Examining operating costs to determine specific areas in which reimbursement may be inadequate. In doing so the department should consider the following options for reimbursement:
   - reimbursing facilities' costs for medical directors at a level reflecting the increased acuity of nursing facility residents;
   - merging the indirect and routine cost components;
   - reimbursing for all aspects of direct care for residents, including medical supplies, in one cost category so that they may be adjusted by case mix;
   - reviewing the most recent information from time studies being used for the Medicare prospective payment system and making a determination whether the time study presently in use reflects nursing costs in Maine's facilities and is appropriate for use; and
   - studying employment markets, labor costs and turnover rates at facilities around the State and, for those facilities that are at or above direct care limits, developing methods for providing increased reimbursement. This study should be done in conjunction with the Department of Labor and should build upon the work already done by that department and by the Maine Health Care Association;

2) Re-basing reimbursement rates from 1993 to 1996 or the most recent complete audited year and adopting new medians and new cost caps in order to keep up with the higher costs faced by facilities due to inflation, increased paperwork requirements, and higher resident acuity. In doing so the department shall consider the following options for re-basing:

- re-basing costs with an emphasis on those most directly impacting high quality resident care; and
- re-basing cost components on a rolling schedule whether periodically or when a stated event occurs, such as when 50% of the facilities are over the cap;

3) Tying caps applicable to the different cost components to the size of the facility, placing higher caps on the smaller facilities, which are often in rural areas, in recognition of the higher costs faced by those facilities and the importance of maintaining access to nursing facility care in rural areas; and

4) Removing any reimbursement incentives that have unintended adverse impacts on resident care.

Sec. 3. Minimum staffing requirements. The Department of Human Services shall replace its current minimum staffing ratios with minimum staffing requirements that:

- are tied to the acuity level of residents and to the other needs of residents that effect the quality of their lives; and
- ensure that adequate numbers of direct care staff are available at all times to meet residents' needs.

The Commissioner of Human Services shall present a proposal to implement and fund these new requirements to the Legislature's Joint Standing Committee on Health and Human Services by May 1, 1999.

Sec. 4. Report on paperwork reduction. The Commissioner of Human Services shall report to the Joint Standing Committee on Health and Human Services by June 1, 1999 with a plan to reduce paperwork in nursing facilities which must include consideration of the opportunities presented by advancing technology and the feasibility of linking data between the Minimum Data Set (MDS 2.0) and Medical Eligibility Determination (MED'96) forms.

Sec. 5. Initiatives to make the Medicaid program more consumer friendly. The Department of Human Services shall take action to improve the provision of information on long-term care services, costs and performance and to strengthen and make more independent the Long-term Care Steering Committee by allocating more resources to it.

Sec. 6. Report on regulatory barriers to high quality care. The Commissioner of Human Services shall study and identify regulatory barriers to high quality care and make recommendations for relief or modification of departmental rules and shall report to the Joint Standing Committee on Health and Human Services by January 1, 2000.

Sec. 7. Annual report. Beginning March 1, 2000 and annually thereafter and report due January 1, 2000. The Bureau of Insurance shall collect information on long-term care insurance and provide a report by March 1 each year to the Commissioner of Human Services, the Joint Standing Committee on Health and Human Services and the public. The information collected must include the number and types of policies purchased by consumers, the

cost of premiums, daily benefit levels and the duration of benefits. Information must also be collected on policies paying benefits to or for consumers, including the types of policies, daily benefit levels and remaining duration of benefit. The Bureau shall also conduct a study of the use of individual income tax credits as incentives to encourage the purchase of long-term care insurance. The study must analyze the effectiveness of tax credits in encouraging the purchase of long-term care insurance in other states and the anticipated cost to the State from establishing a tax credit for all or part of the premium cost of qualifying long-term care policies. The Bureau shall provide a report to the Joint Standing Committee on Health and Human by January 1, 2000.

Sec. 8. Report on changes in long-term care. The Commissioner of Human Services shall consult with the Long-term Care Steering Committee, study changes in the delivery and financing of long-term care and report to the Joint Standing Committee on Health and Human Services by March 1, 2000. The report must cover changes in the delivery of long-term care in facilities and by home and community-based providers, changes in reimbursement systems including, but not limited to the changes in the Medicare reimbursement system, the use of "flex beds," the quality of care provided to residents of Maine, the growth in home and community-based care and the availability of services and providers in all parts of the State.

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

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