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

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Executive Summary

The Commission to Continue the Study of Long-term Care Facilities was established by Public Law 2013, chapter 594, section 6. The Commission continued the work of the Commission to Study Long-term Care Facilities that was formed pursuant to Resolve 2013, chapter 78 and met during the interim of 2013. The duties established in Public Law 2013, chapter 594, section 6, subsection 4 were to study the following issues in the long-term care system:

- Funding for long-term care facilities, payment methods and the development of a pay-for-performance program to encourage and reward strong performance by nursing facilities;
- Regulatory requirements other than staffing requirements and ratios;
- Collaborative agreements with critical access hospitals for the purpose of sharing resources;
- The viability of privately owned facilities in rural communities;
- The impact on rural populations of nursing home closures; and
- Access to nursing facility services statewide.

The Commission is required to submit a report, with findings and recommendations, including suggested legislation, to the Health and Human Services (HHS) Committee by November 14, 2014. The Commission established a technical subcommittee on reimbursement issues that met twice. The full Commission met four times and developed the following specific recommendations.

1. Convene a technical work group to examine rate-setting. Recommend that the HHS Committee send a letter to the Department of Health and Human Services (DHHS) requesting that the department convene a technical work group of stakeholders to examine the following components of rate-setting in order to develop a logical proposal:

1. The wage index for direct care;
2. The development of a wage index for routine care;
3. The suitability of the current four labor regions;
4. Extraordinary circumstances; and
5. Acuity.

The technical work group must report its findings to the HHS Committee no later than January 1, 2016. The work group must retain the values surrounding access, adequate reimbursement for direct care and quality. Vote: 10 in favor; 1 absent.

2. Develop a policy for complex-needs patients. Recommend that the technical work group also include discussions and policies to include eligibility and reimbursement for complex-needs patients currently in out-of-state facilities or in hospitals. Vote: 10 in favor; 1 absent.

3. Convene a work group to develop pay-for-performance models with new money. Recommend that the HHS Committee send a letter to DHHS requesting that the department

convene a work group of a broad range of stakeholders to develop appropriate pay-for-performance models to be applied to the industry with new money. Stakeholders must include DHHS, nursing facilities, the Ombudsman program and organizations devoted to quality such as the Culture Change Coalition, Health Centric Advisors and Local Areas Networks of Excellence. When the work group has completed its work, it must meet with the technical work group to determine financing specifics. The work group recommendations and financing specifics must be included in the report to the HHS Committee no later than January 1, 2016. Vote: 10 in favor; 1 absent.

4. Provide a financial picture of the nursing facility industry. Recommend that the HHS Committee send a letter to DHHS requesting the department require facilities to provide a balance sheet and income statement with "vital signs" data including measures of financial condition (liquidity, debt, capital structure including age of the facility), provider subsidies and state shortfalls for direct care and routine cost funding, charity care, bad debt, investment earnings, donations and any other federal or state funding. DHHS would de-identify the facilities and aggregate the data into a publicly accessible financial picture of the industry. Vote: 9 in favor; 1 against; 1 absent. (The Commission member who voted against the motion supports the substance of the recommendation but opposes the request by letter, preferring legislation.)

5. Provide a history of the combination of the health care provider tax and General Fund contributions to MaineCare seed funding. Recommend that, in addition to the financial information in the recommendation above, the letter to DHHS requests that the department makes available to the Legislature and interested parties a history of the combination of health care provider tax collection and General Fund contributions to MaineCare seed funding. (This vote was combined with the vote above on financial information.)

6. Seek assistance to improve options for pursuing unpaid cost of care. Recommend that the HHS Committee write a letter to the Office of the Attorney General requesting assistance in considering available options for pursuing unpaid cost of care from families, guardians and powers of attorney and developing new strategies that may require legislative action to increase accountability. The Commission recognizes that the cost of legal fees for the collection of bad debt is currently an unreimbursed burden for long-term care facilities. In addition, the Commission believes allowing organizations, agencies and facilities to claim court costs as reimbursable costs for unpaid MaineCare debt should be considered. Vote: 10 in favor; 1 absent.

7. Restore crossover payments to nursing facilities. Recommend the restoration of crossover payments to nursing facilities for Qualified Medicare Beneficiaries that were cut in Public Law 2013, chapter 368. Vote: 10 in favor; 1 abstention.

8. Include continuing education for direct care staff in direct care costs. Recommend that the cost of continuing education for direct care staff be included in direct care costs rather than routine costs. Vote: 10 in favor; 1 absent.

9. Lower the threshold for occupancy adjustments. Recommend that the Principles of Reimbursement for Nursing Facilities, chapter 101 of the MaineCare Benefits Manual, Chapter III, Section 67, be amended so that the requirement for occupancy adjustments (penalties) is dropped to 80% of bed capacity for nursing facilities with more than 60 beds and to 75% for facilities with 60 beds or less. Vote: 9 in favor; 2 absent.

10. Initiate a Maine-focused time study to reflect staff time with patients with dementia. Recommend that DHHS initiate a process that would result in a time study for Maine long-term care facilities reflecting the amount of time to support quality care for patients with dementia. Vote: 10 in favor; 1 absent.

11. Develop a critical access nursing facility designation. Recommend that DHHS develop a critical access nursing facility designation using criteria that is sensitive to the unique remote access challenges in Maine and is an allowable exception to MaineCare budget neutrality, and implement the program by April 15, 2015. Vote: 11 in favor.

12. Develop a procedure when bed rights are relocated. Recommend that the HHS Committee send a letter to DHHS requesting that the department develop and implement a procedure for considering when a nursing facility wants to close or reduce active nursing facility capacity due to the sale or transfer of bed rights; relocate beds to another facility under common ownership; or convert nursing facility beds to residential care beds. The report must include how the procedure could relate to the Certificate of Need process. The report is due to the HHS Committee no later than April 15, 2015. As part of the approval process, analysis will include:

1. The population aged over 65 and over 85;
2. Acuity average in the facility;
3. The number of nursing facility beds in the county;
4. Out-migration and in-migration trends;
5. Travel distance to the nearest nursing facility;
6. Occupancy data including the percentage of MaineCare occupancy;
7. Quality date (federal Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare);
8. Workforce availability;
9. Travel distance to other community resources such as residential care, assisted living facilities, independent housing with services, adult family care homes, and home and community based care.
10. Economic impact on the county; and
11. Other factors affecting access to nursing facility beds or home based care.

Vote: 11 in favor.

13. Review recommendations in the Center for Long-term Care Reform. Recommend that the HHS Committee send a letter to DHHS requesting that the department review and take into consideration the findings and recommendations in the Center for Long-term Care Reform reports, including, but not limited to, enhancing MaineCare's estate recovery program, reviewing eligibility requirements for MaineCare's long-term care programs, and initiating public awareness about financial planning for long-term care. The Commission further recommends

that, in the letter, the HHS Committee ask the department to report back during the 127th Maine Legislature with an update on efforts relating to financial eligibility for MaineCare's long-term care program. Vote: 11 in favor.

14. Support the Maine Aging Initiative. Recommend sending a letter to Speaker Eves expressing the Commission members' support for the Maine Aging Initiative and its efforts to address issues surrounding Maine's aging population, including long-term care challenges. Vote: 11 in favor.

15. Support DHHS's comprehensive planning for the continuum of care. Recommend that DHHS continue on its course of comprehensive planning for the continuum of care, recognize and seek to address current gaps and shortcomings in those plans and also acknowledge that other entities, such as housing for the elderly and/or disabled, play a part and should be considered in the statewide plan. The Commission also recommends that that the HHS Committee send a letter to DHHS requesting that the department consult and work in partnership with the Maine Aging Initiative in this regard and report back to the HHS Committee no later than February 15, 2015, with an update on the State of Maine's continuum of care planning efforts. Vote: 11 in favor.

16. Increase the personal needs allowance. Recommend the personal needs allowance for persons residing in nursing facilities increase from the current $40 per month to $50 per month and for persons residing in residential care from $70 per month to $90. Vote: 9 in favor; 2 absent.

I. INTRODUCTION

During the first interim of the 126th Maine Legislature, the Commission to Study Long-term Care Facilities, referred to as the "2013 Commission" in this report, began to address issues related to reimbursement, staffing and access to nursing facilities. The 2013 Commission was established by Resolve 2013, chapter 78. It held four meetings in 2013 and a final report was issued in December of 2013. Most of the recommendations of the 2013 Commission were enacted in Public Law 2013, chapter 594, including a recommendation to continue the study process. Section 6 of the law established the Commission to Continue the Study of Long-term Care Facilities, referred to in this report as the "Commission." Four meetings were held during the second interim of the 126th Maine Legislature. Membership of the Commission includes the members of the 2013 Commission with the exception of the DHHS appointee. James Martin, Director of the Office of Aging and Disabilities Services, serves on the new Commission (replacing Kenneth J. Albert, Director of the Division of Licensing and Regulatory Services). The full list of Commission members is contained in Appendix A.

The duties of the Commission are set forth in Public Law 2013, chapter 594, section 6, subsection 4. The Commission is charged with studying the following issues in the long-term care system:

- Funding for long-term care facilities, payment methods and the development of a pay-for-performance program to encourage and reward strong performance by nursing facilities;
- Regulatory requirements other than staffing requirements and ratios;
- Collaborative agreements with critical access hospitals for the purpose of sharing resources;
- The viability of privately owned facilities in rural communities;
- The impact on rural populations of nursing home closures; and
- Access to nursing facility services statewide.

The Commission is required to submit a report, with findings and recommendations, including suggested legislation, to the HHS Committee by November 14, 2014.[1]

The Commission held four meetings on the following dates: September 2, September 23, October 14 and October 28, 2014. All meetings were open to the public and were broadcast by audio transmission over the Internet. Agendas of Commission meetings and other information relating to the Commission can be found online at http://www.maine.gov/legis/opla/ltcstudycontinuation.htm.

In addition, the Commission designated a subcommittee to discuss technical issues relative to reimbursement of nursing facilities. The following Commission members served on the reimbursement subcommittee: Diane Barnes, town manager of Lisbon; Phil Cyr, administrator of the Caribou Rehab and Nursing Center; Rick Erb, chief executive officer at the Maine Health Care Association (MCHA); John Watson, chief financial officer at The Cedars in Portland; and

[1] Public Law 2013, chapter 594, section 6 included a deadline for the report of October 15, 2014. This deadline was extended by the Legislative Council to November 14, 2014.

Brenda Gallant, executive director of the Maine Long-term Care Ombudsman Program. The subcommittee met twice – October 2 and October 9, 2014, and presented their recommendations at the third meeting of the Commission on October 14, 2014.

II. BACKGROUND

The 2013 Commission created by Resolve 2013, chapter 78, made 14 recommendations in its report to the Joint Standing Committee on Health and Human Services. Twelve of the recommendations were included in the suggested legislation included in the 2013 report. The HHS Committee reported out LD 1776, An Act To Implement the Recommendations of the Commission to Study Long-term Care Facilities, based on the suggested legislation in the 2013 Commission's final report with only clarifying amendments but no substantive changes. The bill was further amended by the Legislative Council on the study table to remove a provision that would have created a Blue Ribbon Commission on Long-term Care across the long-term care spectrum that included funding for contracted staffing. The bill was again amended by the Appropriations and Financial Affairs (AFA) Committee, including the removal of another provision related to health insurance costs for nursing facility personnel.[2] LD 1776 became law without the Governor's signature, as Public Law 2013, chapter 594. The full text of the law is included as Appendix B.

In summary, Public Law 2013, chapter 594 does the following:

1. Establishes a new base year for nursing facilities that is the fiscal year of each nursing facility ending in calendar year 2011; the base year is to be updated every two years;
2. Increases the peer group upper limit to 110% of the median for routine costs and for direct care costs;
3. Eliminates the administration and management expense ceiling (although these costs are still subject to allowability standards);
4. Allows for a cost of living adjustment to be included in the budget request (using the Consumer Price Index (CPI) for Medical Care Services – Nursing Home and Adult Day Care Services for routine costs and using the CPI, Historical CPI for Urban Wage Earners and Clerical Workers – Nursing Home and Adult Day services for direct care costs);
5. Establishes a payment to nursing facilities that have a MaineCare utilization that is greater than 70% of MaineCare days of care; this payment is cost settled;
6. Includes hold harmless provisions that apply to both direct care and routine costs;
7. Applies new provisions retroactively to July 1, 2014, so that nursing facilities are paid new rates from that date;
8. Requires the collection of cost of care overpayments, uses some of that recoupment to pay for increases in reimbursement and requires DHHS's contractor to correct the overpayment issue; and
9. Establishes a Commission to Continue the Study of Long-term Care Facilities based on the Commission to Study Long-term Care Facilities with the same membership criteria and similar duties.

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[2] The Commission had recommended by a vote of 6 to 3 to direct the Department of Health and Human Services to amend the Principles of Reimbursement to move health insurance costs for nursing facility personnel in subsection 41.1.7(3) from the direct care cost component and in subsection 43.4.1(16)(c) from the routine cost component to the fixed cost component in subsection 44.

In order for MaineCare nursing facility reimbursement changes required by Public Law 2013, chapter 594 to be implemented, DHHS had to amend its MaineCare rules. The department adopted an emergency rule on August 15, 2014, with a retroactive application date of July 1, 2014, for the changes. The department then followed the regular rulemaking process in order to make the changes permanent. At the time of writing this report, the public hearing and public comment process were over but the rulemaking process was not yet complete.

Among the provisions relating to nursing facility reimbursement in Public Law 2013, chapter 594, one specific provision directed DHHS to amend its department rules under the MaineCare Benefits Manual, Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities in subsection 80.3.2 to increase the specific resident classification group case mix weight attributable to a resident with dementia. However, the proposed rule implementing the Commission's recommendations does not make any changes to the existing rule based on dementia. The rulemaking fact sheet notice states that group case mix weight methodology is "function or level-of-service based" and is not based on diagnosis, and that "the rule's case mix methodology already provides that a dementia patient whose condition worsens and needs a higher level of care is put in a case mix with a greater weight."

The authorizing legislation for the Commission includes duties from the previous year with the exception of those completed (i.e., staffing) and a reporting date of October 15, 2014. Originally, the Commission was to report to both the HHS Committee and the Blue Ribbon Commission on Long-term Care. With the removal of the Blue Ribbon Commission from the legislation, the early reporting date was no longer necessary and the Commission requested and was granted an extension to November 14, 2014, from the Legislative Council.

It is worth noting that two recommendations made by the 2013 Commission had no statutory requirements. First, the 2013 Commission recommended no changes to staffing ratios and requirements for licensed staff coverage adopted in Chapter 110, Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities, Chapter 9, subsection 9.A.3 and 9.A.4. The duties of the 2013 Commission included studying the development of minimum staffing requirements based on a 24-hour time period. The 2013 Commission determined that existing staffing ratios should remain unaltered, and consequently the duties for the Commission do not include an examination of staffing. Secondly, the 2013 Commission expressed support for LD 1092, An Act to Increase the Use of Long-term Care Insurance, a bill that had been carried over in the Insurance and Financial Services (IFS) Committee. The bill related to individuals with life insurance policies entering into a life settlement contract with a life care benefits company to use the proceeds for long-term care expenses. LD 1092 was reported out unanimously "Ought Not to Pass" by the IFS Committee.

III. REIMBURSEMENT

A. Labor costs and acuity

The 2013 Commission recommended the continuation of the study commission process because members felt that there was still considerable unfinished work in terms of completing the duties established in Resolve 2013, chapter 78. There were a number of recommendations amending

DHHS's Principles of Reimbursement for Nursing Facilities, Chapter 101, MaineCare Benefits Manual, Chapter III, Section 67, incorporated into Public Law 2013, chapter 594, but some Commission members believed there had been insufficient time in 2013 to delve into details of the components of rate-setting.

The Commission appointed a reimbursement subcommittee that met twice and then made a number of recommendations to the full Commission at the third meeting on October 14, 2014. The Subcommittee determined that the current rate-setting process does not serve the needs and realities of nursing facilities in the State but that it required technical expertise beyond the Commission. The full Commission agreed.

The subcommittee argued that the labor costs in nursing facilities are not sufficiently or equitably accounted for in rate-setting, and rate-setting is not structured to meet external forces that influence labor costs in a timely manner. There were concerns that rate-setting for direct care costs establishes upper payment limits that are not appropriately or adequately tied to acuity or hours of care. There were concerns that the method for establishing upper payment limits for routine costs not only groups labor and non-labor costs together but they are grouped without regard to the diversity of service delivery models or geographic labor markets or acuity. In addition, there is not a wage index for routine care. There was also concern that the system of indexing four labor regions does not necessarily reflect true variances in costs of direct care labor in different parts of the state.

In addition, external influences on labor costs are not covered until there is a rebasing two years later and then only to a level that favors providers that are close to peer group medians. A move in Portland to increase the minimum wage would likely result in wage creep in Portland facilities creating short and long-term consequences; providers would have no means to recover the additional labor costs and would be only partially reimbursed under a rebasing two years later. The Principles of Reimbursement include an allowance for a prospective rate increase for extraordinary circumstances – unforeseen and uncontrollable expenses that increase costs. Extraordinary circumstances include natural disasters or fires, changes in licensure requirements and unforeseen increases in minimum wage, Social Security or other employee retirement contributions. However, subcommittee members were unclear whether a local minimum wage increase would trigger the provision.

The Commission recommends that the HHS Committee send a letter to DHHS requesting that the department convene a technical work group of stakeholders to examine the following components of rate-setting in order to develop a logical proposal:

1. **The wage index for direct care;**
2. **The development of a wage index for routine care;**
3. **The suitability of the current four labor regions;**
4. **Extraordinary circumstances; and**
5. **Acuity.**

The technical work group must report its findings to the HHS Committee no later than January 1, 2016. The work group must retain the values surrounding access, adequate reimbursement for direct care and quality. Vote: 10 in favor; 1 absent.

B. Complex needs patients

The Commission heard from Lisa Harvey-McPherson, Eastern Maine Healthcare Systems Vice President, Continuum of Care and Chief Advocacy Officer, regarding geriatric patients with complex needs that are either living in a hospital despite being medically stable or living with family and experiencing multiple emergency room visits. These patients include those on ventilators, bariatric patients and those requiring complex behavior management. Commission members heard that there are gaps in the continuum of care resulting in a lack of facilities with the equipment and expertise to care for these complex patients. A formal process and increased awareness among nursing facilities may encourage nursing facilities to consider accepting complex-case patients who are currently residing in out of state facilities or in hospitals and to invest in specialty units. Lisa Harvey-McPherson's letter is included as Appendix C.

The Commission recommends that the technical work group (recommended above) include discussions and policies to include eligibility and reimbursement for complex-needs patients currently in out of state facilities or in hospitals. Vote: 10 in favor; 1 absent.

C. Pay-for-performance incentives

Pay-for-performance programs in healthcare give financial incentives to clinicians and facilities for improved quality. A primary objective of pay-for-performance programs is to provide incentives to low and middle-level performers while also rewarding high-level performers. The ultimate goal is providing the highest quality of care for residents in long-term care facilities. Some states have pay-for-performance Medicaid nursing programs, usually funded with additional money. There are several different measures that can be used such as clinical measures, staffing levels or retention, client satisfaction or greater efficiency (e.g., administrative). See the memo prepared by Kristin Brawn of the Office of Policy and Legal Analysis (OPLA) in Appendix D for examples. Commission members recommend further study of the pay-for-performance issue by the department with clinical stakeholders and organizations devoted to quality such as the Culture Change Coalition, Health Centric Advisors and Local Areas Networks of Excellence.

The Commission recommends that the HHS Committee send a letter to DHHS requesting that the department convene a work group of a broad range of stakeholders to develop appropriate pay-for-performance models to be applied to the industry with new money. Stakeholders must include DHHS, nursing facilities, the Ombudsman program and organizations devoted to quality such as the Culture Change Coalition, Health Centric Advisors, and Local Areas Networks of Excellence. When the work group has completed its work, it must meet with the technical work group to determine financing specifics. The work group recommendations and financing specifics must be included in the report to the HHS Committee no later than January 1, 2016. Vote: 10 in favor; 1 absent.

D. Financial information on the industry

Stephanie Rice from Berry, Dunn, McNeil and Parker, briefed the 2013 Commission on the MaineCare nursing facility shortfall showing a shortfall of over $29 million between allowable costs per day and reimbursement per day in 2011 based in 2011 "as-filed" cost reports. DHHS

provided similar data. 2013 Commission members noted that the underfunding amount was further understated because of internal caps in the routine cost components. However, Commission members felt that more specific requests for financial information were unmet because important information on nursing facilities is either not collected or not shared.

Nursing facilities submit a great deal of financial information but it is not compiled into an industry-wide profile. Commission members thought it would be helpful to policymakers as well as to the department, the industry and the public for the department to de-identify facilities and aggregate the financial data from all facilities. This would provide an overall picture of the financial health of the industry.

The Commission recommends that the HHS Committee send a letter to DHHS requesting the department to require facilities to provide a balance sheet and income statement with "vital signs" data including measures of financial condition (liquidity, debt, capital structure including age of the facility), provider subsidies and state shortfalls for direct care and routine cost funding, charity care, bad debt, investment earnings, donations and any other federal or state funding. DHHS would de-identify the facilities and aggregate the data into a publicly accessible financial picture of the industry. Vote: 9 in favor; 1 against; 1 absent. (The Commission member who voted against the motion supports the substance of the recommendation but opposes the request by letter, preferring legislation.)

E. Health care provider tax

The health care provider tax is imposed annually against each nursing facility located in Maine at 6% of its annual net operating revenue and against each residential treatment facility (defined as an intermediate care facility for persons with intellectual disabilities and not including a private nonmedical institution) at 6% of its annual gross patient services revenue. The current Health Care Provider Tax was enacted in Public Law 2001, chapter 714, Part CC at a 6% tax rate. The rate was decreased to 5.5% in Public Law 2007, chapter 539, Part X and increased back to 6% in Public Law 2011, chapter 411 effective October 1, 2011, consistent with federal law.[3] More than 40 states levy a health care provider tax.[4]

Tax revenues accrue as dedicated revenue to DHHS. The nursing home tax is dedicated to support nursing facility and other long-term care programs and the residential treatment facilities tax is dedicated for developmental services. In both cases, a part of the proceeds of the taxes replace reductions in General Fund appropriations for these purposes. The Commission finds that overall State MaineCare seed funding should remain consistent over time, and the health care provider tax should not be used to supplant General Funds.

The Commission recommends that, in addition to the financial information in the recommendation above, the letter to DHHS requests that the department makes available

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[3] Office of Fiscal and Program Review, Compendium of State Fiscal Information through Fiscal Year Ending June 30, 2013:
http://www.maine.gov/legis/ofpr/compendium/compend/COMPEND_files/2013Compendium/SECTION%20II.pdf

[4] National Conference on State Legislatures, "Health Provider and Industry Taxes and Fees":
www.ncsl.org/research/health/health-provider-and-industry-state-taxes-and-fees.aspx

to the Legislature and interested parties a history of the combination of health care provider tax collection and General Fund contributions to MaineCare seed funding. (This vote was combined with the vote above on financial information.)

F. Bad debt

Nursing facilities write off over a million dollars in bad debt every year for several reasons. Bad debt is not considered a reimbursable cost under MaineCare although it is under Medicare. According to Commission members operating nursing facilities, most bad debt comes from MaineCare clients not paying their cost of care portion. Nursing facilities can only charge the resident for payment and cannot hold other family members responsible. In addition, a nursing facility cannot discharge a resident for failing to pay their cost of care unless there is a safe place for the resident to go, so discharge is rarely a practical option. Nursing facilities do, at times, pursue claims for misuse of funds in civil court but the legal costs are often outweighed by the funds gained. Commission members believe there should be more accountability for families, guardians and powers of attorney that are granted the responsibility and trust for dealing with the financial resources of a person who is a resident of a nursing facility.

Bad debt can also come from changes to financial eligibility generated by changes in medical eligibility. Commission members were told that Oceanview Nursing Home & Residential Care in Lubec (which had to close) was negatively impacted by residents who medically qualified for nursing facility level care after being in residential care at the facility. It can take many months for DHHS to make decisions on MaineCare financial eligibility and the facility is paying for the resident until eligibility is determined. If the resident is determined to be eligible, the nursing facility is paid retroactively; however if the resident is not determined eligible, the nursing facility receives nothing. Similarly, if crossover payments for dually eligible individuals are not restored, nursing facilities expect these lost payments to be written off as bad debt.

The Commission recommends that the HHS Committee write a letter to the Office of the Attorney General requesting assistance in considering available options for pursuing unpaid cost of care from families, guardians and powers of attorney and developing new strategies that may require legislative action to increase accountability. The Commission recognizes that the cost of legal fees for the collection of bad debt is currently an unreimbursed burden for long-term care facilities. In addition, the Commission believes allowing organizations, agencies and facilities to claim court costs as reimbursable costs for unpaid MaineCare debt should be considered. Vote: 10 in favor; 1 absent.

G. Crossover payments for certain Qualified Medicare Beneficiaries (QMBs)

Cuts to crossover payments for certain QMBs to nursing facilities and hospitals were made in the state 2014-15 biennial budget, Public Law 2013, chapter 368. During a Medicare Part A covered stay, any co-pay due from a dual or QMB eligible resident is billed by Medicare directly to MaineCare as a crossover billing. Prior to the budget, crossover payments from MaineCare were routinely paid as billed but the budget eliminated certain crossover payments for certain income levels of QMBs. For a Medicare Part A stay, Medicare pays the first 20 days and the co-pay begins on day 21 at $152 a day. One week of lost co-pays erases the average Medicare margin obtained in the first three weeks of a QMB resident's stay. For a Medicare Part C (Medicare

Advantage) stay, the co-pay can start as early as seven days and can be 40% ($180 or more a day). Although unpaid co-pays can be partially recovered as a bad debt expense on a Medicare cost report, they are only paid at 65% and may take up to 18 months for the facility to receive partial payment.

The crossover payments cut in the budget applies to both nursing facilities and hospitals so specific data for impacts on nursing facilities alone is not yet available. Commission member, Rick Erb from the MHCA, did an informal survey of facilities to get an indication of the impact. He stated that the average loss on an annualized basis was $17,000 per facility, with an approximate $1.7 million total for the industry; the lowest impact was $300 a year with other facilities being impacted by closer to $50,000 a year. The impact is greatest on large facilities with a high volume of Medicare residents.

Commission members are concerned that access may become an issue as a result of the elimination of the crossover payments for QMBs. Nursing facilities may evaluate potential Medicare clients without private resources on their potential length of stay and consider not taking those who appear to need care for over 20 days. Loss of MaineCare payments will also likely increase the burden on private payers who already pay over cost to make up for MaineCare payments that are below cost.

The Commission recommends the restoration of crossover payments to nursing facilities for QMBs that were cut in Public Law 2013, chapter 368. Vote: 10 in favor; 1 abstention.

H. Continuing education for direct care staff

Currently all continuing education for staff is included under routine costs regardless of whether the employee is categorized as direct care (e.g., RNs, LPNs, CNAs) or routine (e.g., administrative, custodians). Routine costs include operating expenses not included in direct care or fixed costs (e.g., heating). According to Commission members who manage nursing facilities, reimbursement on the routine costs component is insufficient to allow for staff continuing education. Continuing education for direct care employees keeps skills current and may impact quality. Continuing education for employees in the routine care category should remain there. Funding for continuing education should not be used to reduce available funds for staffing.

The commission recommends that the cost of continuing education for direct care staff be included in direct care costs rather than routine costs. Vote: 10 in favor; 1 absent.

I. Occupancy penalties

Facilities incur penalties for occupancy rates that fall below 90% of bed capacity or below 85% for facilities with 60 beds or less. On average, Maine nursing facilities were 91% full in state fiscal year 2014 although there is some variance around the state ranging from 85.9% in Washington County to 95.6% in Androscoggin County. Ninety-five percent capacity is generally considered full.[5] Commission members felt nursing facilities that are already

[5] "Maine's Continuum of Care for Aging and Long Term Care Services and Supports", DHHS Office of Aging and Disability Services presentation to the Commission, 28 October 2014. This presentation is available at: http://www.maine.gov/legis/opla/LTCContinuumofCare102014.pdf

struggling in rural areas are in an unnecessarily worse situation if they incur occupancy penalties. Fixed costs (interest, depreciation, property taxes, insurance, workers compensation etc.) are normally paid as a 100% pass through and do not change if a nursing facility is not fully occupied. According to MCHA, in August 2014, 22 facilities fell below the occupancy requirements.

The Commission recommends that the Principles of Reimbursement for Nursing Facilities, chapter 101 of the MaineCare Benefits Manual, Chapter III, Section 67, be amended so that the requirement for occupancy adjustments (penalties) is dropped to 80% of bed capacity for nursing facilities with more than 60 beds and to 75% for facilities with 60 beds or less. Vote: 9 in favor; 2 absent.

IV. REIMBURSEMENT FOR RESIDENTS WITH DEMENTIA

Maine's population is the oldest in the nation. In fact, the number of Maine residents over 65 years of age is expected to double between 2010 and 2030.[6] Increasing age is a significant risk factor for dementia and as Maine's population ages, the number of residents with dementia will continue to grow.[7] The University of Southern Maine (USM), Muskie School of Public Service prepared a 2013 report, titled "Dementia in Maine – Characteristics, Care and Cost Across Settings," for the DHHS Office of Aging and Disability Services that provides a picture of dementia trends in Maine and its potential impact on Maine's long-term care system.

The 2013 Muskie School report states:

> *As the oldest state in the nation, Maine faces the impending impact of dementia on its social systems, community resources and its health and long term care systems. While remaining at home is the overwhelming preference for people needing long term services and supports, the increasing need for supervision and support with incontinence care, transfer, locomotion and eating makes living at home increasingly difficult particularly for those with dementia who live alone and/or who don't have a family caregiver.*

According to the 2013 Muskie School report, two-thirds of the people in nursing homes have a diagnosis of dementia. The Commission discussed at length the amount of time and resources required to provide supervision and support services to residents with dementia in long-term care facilities.

In its final report, the 2013 Commission recommended that DHHS amend its department rules under the MaineCare Benefits Manual, Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities in subsection 80.3.2 to increase the specific resident classification group case mix weight that is attributable to a resident who is diagnosed with dementia. On August 15, 2014, the department adopted an emergency rule which implemented many of the recommendations of the 2013 Commission as presented in Public Law 2013, chapter 594. The emergency rule had a retroactive application date of July 1, 2014, for the provisionally adopted

[6] http://muskie.usm.maine.edu/Publications/DA/Dementia-Maine-Chartbook-2013.pdf
[7] Ibid.

changes. In September 2014, DHHS provided notice of the proposed rule, which seeks to make permanent those changes to nursing facility reimbursement made in the emergency rule.

DHHS did not increase the "weight" for residents with dementia and provided the following explanation in their rulemaking notice:

> *[PL 2013], ch. 594's requirement that the rule be amended to increase the specific resident classification group case mix weight that is attributable to a nursing home resident who is diagnosed with dementia is not directly applicable to the case mix methodology which is set forth in the rule, which is function or level-of-service based, and not based on diagnosis. The rule's case mix methodology already provides that a dementia patient whose condition worsens, and needs a higher level of care, is put in a case mix with a greater weight. The Department carefully reviewed this issue, but is not proposing to make any changes for this rulemaking.*

However, the Commission continues to have concerns about reimbursement rates relative to patients diagnosed with dementia.

The Principles of Reimbursement for Nursing Facilities rule adopted by DHHS in its MaineCare Benefits Manual is an acuity-based system using the federally required Resident Assessment Instrument (RAI). Upon admission to a nursing facility, all residents must have an RAI, which is an interdisciplinary, individualized assessment. The Minimum Data Set (MDS) is a standardized primary screening and assessment tool of health status, and is a component of the RAI. The MDS contains items that measure physical, psychological and psychosocial functioning.[8] The MDS is the foundation of the comprehensive assessment for all residents in a Medicare and/or Medicaid-certified long-term care facility.[9] Nursing home residents are then categorized into Resource Utilization Groups (RUGs) based on residents' characteristics as identified in the MDS. RUGs determine reimbursement to nursing facilities under this "prospective payment system." MaineCare currently uses the RUG-III classification model with 45 nursing facility resident categories.

Beginning in 2006, the federal Centers for Medicare & Medicaid Services (CMS) conducted a time study to recalibrate the RUG-III case mix weights. The Staff Time and Resource Intensity Verification (STRIVE) study was a national staff time measurement study conducted June 2006 through February 2007 that provided data to update the Medicare Skilled Nursing Facility Prospective Payment System. The study was sponsored by CMS and conducted by the Iowa Foundation for Medical Care. The purpose of the study was to determine the amount of time that nursing home staff spend caring for residents, as well as other elements of resident care. This was the first national nursing home study undertaken in the U.S. since 1997.

The STRIVE study resulted in the RUG-IV classification system, with 66 resident categories. At the third meeting of the Commission, Catherine McGuire, Karen Mauney and Julie Fralich from the USM's Muskie School of Public Service presented information relating to case mix and dementia in Maine nursing facilities. According to the Muskie School, the RUG-IV case mix

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[8] http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/IdentifiableDataFiles/LongTermCareMinimumDataSetMDS.html

[9] Ibid.

weights for dementia patients are not significantly different than those under RUG-III. Under RUG-III, 60% of dementia patients fall under the Physical RUG category and, under RUG-IV, 56%.[10] Furthermore, the majority of Maine nursing facility residents are in the Physical RUG group. Assisting residents with Activities of Daily Living (ADL) is the primary driver of care needs in the Physical RUG category.[11] ADLs are basic, routine tasks, such as bathing, dressing, eating and using the toilet.[12]

As described above, DHHS has not increased the specific resident classification group case mix weight attributable to a resident diagnosed with dementia nor is the classification system used to establish staffing needs. The use of the RUG-III case mix weights in the state's reimbursement system is a cost-based tool for allocating direct care reimbursement. The Commission believes the current case mix classification system, as applied, is not meeting the needs of residents, particularly those with dementia.

The Commission recommends that DHHS initiate a process that would result in a time study for Maine long-term care facilities reflecting the amount of time to support quality care for patients with dementia. Vote: 10 in favor; 1 absent.

V. ACCESS

The 2013 Commission and the current Commission both had several duties related to access to facilities in rural areas and statewide. Commission members are particularly concerned that access to services across the state not be impaired. Several facilities in rural areas of the state closed recently. In 2012, the 52-bed Atlantic Rehabilitation and Nursing Center in Calais closed and the company moved the beds to Ellsworth. Three other nursing facilities closed in the summer of 2014: Oceanview Nursing Home & Residential Care in Lubec, a 31-bed facility; Pittsfield Rehab & Nursing, a 57-bed facility; and Penobscot Nursing Home, a 54-bed facility. The Oceanview beds were purchased by Woodlands Assisted Living, and the Pittsfield beds were purchased by Maine Veteran Homes. It is unclear at the time of writing where the Oceanview and Pittsfield beds will be located. The residents of Penobscot Nursing Home were relocated after the facility lost its certification; an assisted living facility at the same site was unaffected. The status and ownership of the Penobscot beds is, as yet, unknown. Brenda Gallant, Long Term Care Ombudsman and Commission member, briefed the Commission on September 23rd regarding the relocation of the residents from the three homes this summer. Ms. Gallant indicated that there were good coordination of staff and good outcomes for the residents although it was a difficult summer.

A number of challenges for the nursing facilities that have recently closed in Maine have been cited. In particular, rural homes often have high MaineCare populations and are often located in areas away from hospitals releasing residents into skilled nursing care reimbursed by Medicare.

[10] http://www.maine.gov/legis/opla/ltc2014mtgmtrls.htm
[11] Ibid.
[12] http://www.seniorhomes.com/p/activities-of-daily-living/

A. Critical access nursing facility designation

The idea of developing a "critical access nursing facility" designation is modeled on critical access hospitals and the remote island nursing facility. The critical access hospital program was created by Congress in 1997, after a number of rural hospital closures, to ensure that individuals in isolated areas would continue to have access to health care.[13] In order to qualify as a critical access hospital, a hospital must meet a number of criteria including being located more than a 35-mile drive from any other hospital (or 15 miles in mountainous area), have no more than 25 beds for acute inpatient care, and provide inpatient care for a period no more than 96 hours per patient per year.[14]

Remote island nursing facilities is a category, subject to CMS approval, of nursing facilities that must: be located on an island; have less than 30 licensed nursing facility beds; not be physically located within a hospital; not have any licensed residential care beds; and maintain a MaineCare utilization of 95% or greater. Only one nursing facility in the state is designated as a remote island nursing facility, Eastport Memorial Home. Unlike other nursing facilities, it is reimbursed at cost without being subject to caps as long as the costs are still "reasonable."

Commission members believe that there are other communities in Maine that are remote and in which nursing facilities are struggling to stay open. The twin concepts of critical access hospitals and remote island nursing facilities could provide a tool for retaining access to nursing facilities in all areas of the state, including rural and isolated ones. At the first Commission meeting, Nick Adolphsen and Herb Downs from DHHS stated that CMS would allow a critical access nursing facility designation. They also stated that the department is currently reviewing the eligibility criteria used by other states with such a designation and developing criteria that would be used to develop a Maine-specific critical access nursing facility program model. The department expects that this new category would require new funding from the Legislature and CMS approval.

The Commission recommends that DHHS develop a critical access nursing facility designation using criteria that is sensitive to the unique remote access challenges in Maine and is an allowable exception to MaineCare budget neutrality, and implement the program by April 15, 2015. Vote: 11 in favor.

B. Closures of nursing facilities and Certificate of Need (CON)

Nursing facilities are private businesses (profit and nonprofit). Owners make entrepreneurial decisions on how to operate the business. When a nursing facility fails, the bed rights may be the only value left that the owner can sell.[15] However, the nursing facility industry also operates within the public finance realm, receiving MaineCare and Medicare funding for many residents, and within the regulatory framework of the Certificate of Need (CON) process that recognizes the role of the State as a major payer and planner of long-term care services.

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[13] "When 'Critical Access' Hospitals Are Not so Critical", Jenny Gold, Kaiser Health News, December 8, 2011. Accessed October 23, 2014 at http://kaiserhealthnews.org/news.medicare-critical-access-rural-hospitals/

[14] 22 MRSA §7932, sub-§10

[15] Within the industry, the focus is on the "bed" but the Commission acknowledges that this is actually the authority to serve a resident.

A CON approval from DHHS is needed for new nursing facility services; relocation of bed from one nursing facility to another; replacement nursing facilities; changes in ownership and control of nursing facilities; and building modifications and capital expenditures by nursing facilities. Criteria for the CON application are established in 22 MRSA §335, sub-§§1 and 7 as well as in department rule. The CON process and criteria focus only on the need in the area where the new beds are being proposed to be placed but does not consider whether there is still need in the area where the beds were previously located. In order to increase the overall number of beds, the nursing facility MaineCare funding pool would have to be increased.

Commission members believe there should be a process to take account of the community where the beds are being moved from when there is a proposal to do so. An analytical process regarding the area where the beds previously existed, focusing on the aging population, availability and proximity of beds, and access to other services should be developed as well as how the process might interplay with the CON application process.

The Commission recommends that the HHS Committee send a letter to DHHS requesting that the department develop and implement a procedure for considering when a nursing facility wants to close or reduce active nursing facility capacity due to the sale or transfer of bed rights; relocate beds to another facility under common ownership, or convert nursing facility beds to residential care beds. The report must include how the procedure could relate to the CON process in a meaningful way. The report is due to the HHS Committee no later than April 15, 2015. As part of the approval process, analysis will include:

1. **The population aged over 65 and over 85;**
2. **Acuity average in the facility;**
3. **The number of nursing facility beds in the county;**
4. **Out-migration and in-migration trends;**
5. **Travel distance to the nearest nursing facility;**
6. **Occupancy data including MaineCare % occupancy;**
7. **Quality date (CMS Nursing Home Compare);**
8. **Workforce availability;**
9. **Travel distance to other community resources such as residential care, assisted living facilities, independent housing with services, adult family care homes, and home and community based care.**
10. **Economic impact on the county; and**
11. **Other factors affecting access to nursing facility beds or home based care.**

Vote: 11 in favor.

VI. FINANCIAL ELIGIBILITY – ASSETS AND INCOME

MaineCare requires a person to be both financially and medically eligible to qualify for nursing home care and in-home services. Medical eligibility is determined through the DHHS Office of Elder Services and financial eligibility is determined by the DHHS Office of Family Independence. A person must submit an application for financial assistance for nursing facility, residential care or in-home nursing care. An applicant must list all income and assets, including

those of his or her spouse, including, but not limited to, Social Security income (retirement or disability), checking and savings accounts, retirement accounts, real estate and motor vehicles. A copy of the "Application for Financial Assistance for Facility Costs" application can be found in Appendix E.

The Commission discussed at length two reports commissioned by the Maine Health Care Association (MHCA), which is a trade and professional organization for long-term care providers. The MHCA contracted with the Center for Long-term Care Reform (CLTCR), a private institute dedicated to long-term care policy, to conduct a study of Medicaid and long-term care financing in Maine. The CLTCR published two reports: *The Maine Thing About Long-Term Care: Is That Federal Rules Preclude a High-Quality, Cost-Effective Safety Net* (dated November 2, 2012 and sponsored by MHCA) and *Maximizing Non Tax Revenue from MaineCare Estate Recoveries* (dated May 15, 2013 sponsored by MHCA and the Maine Heritage Policy Center). Both reports can be found at the following link: http://www.centerltc.com/pubs/Maine.pdf.

Generally, the Commission supports the findings and recommendations of these two reports authored by Stephen A. Moses, president of the CLTCR. The Commission understands that there are fiscal constraints on MaineCare's long-term care program and that the program should be preserved for those most in need.

The Commission recommends that the HHS Committee send a letter to DHHS requesting that the department review and take into consideration the findings and recommendations in the CLTCR reports, including, but not limited to, enhancing MaineCare's estate recovery program, reviewing eligibility requirements for MaineCare's long-term care programs, and initiating public awareness about financial planning for long-term care. The Commission further recommends that, in the letter, the HHS Committee ask the department to report back during the 127th Maine Legislature with an update on efforts relating to financial eligibility for MaineCare's LTC program. Vote: 11 in favor.

VII. CONTINUUM OF CARE

The 2013 Commission voted unanimously in favor of the establishment of a Blue Ribbon Commission (BRC) on Long-term Care to review the State's plan for long-term care and the provision of services in the community and in nursing and residential care facilities. The 2013 Commission recommended broad representation on the BRC and the duty to draft a plan for long-term care for presentation to the Legislature and DHHS. However, at the end of the legislative session, this provision was removed from LD 1776, An Act to Implement the Recommendations of the Commission to Study Long-term Care Facilities.

Although the BRC recommendation was not implemented, the Commission continues to have particular interest in planning for long-term care along a continuum of services. The continuum of care for aging and long-term care services and supports ranges from in-home and community-based care services to residential care, assisted living facilities and nursing homes to hospitals. Throughout its deliberations, the Commission stressed the importance of looking at the full continuum of care. Services at the home and community-based end of the spectrum are considerably less expensive than those at the nursing facility end. Commission members

recognize that home and community-based services play a critical role in allowing individuals to age in place and in delaying entry into nursing facilities.

A. Maine Aging Initiative

Beginning in late 2013, the 126th Maine Legislature's Speaker of the House, Mark Eves, and the Maine Council on Aging (MCOA) convened a series of Roundtables on Aging and, in January of 2014, convened a Maine Summit on Aging bringing together community and business leaders as well as health and economic experts to discuss the challenges and opportunities associated with Maine's aging population. As a result, Maine leaders on aging issues released a "Blueprint for Action on Aging" with strategies to address the needs of this growing segment of the population in the areas of housing, transportation, workforce, health and public safety.

Subsequently, MCOA and the Speaker officially launched the Maine Aging Initiative with the intention of supporting the recommendations of the Blueprint report. Speaker Eves convened five work groups in the following policy areas: building aging friendly communities; workforce and employment; higher education; public and private safety; and health and well-being of older adults. During the 127th Maine Legislature, the Speaker also plans to convene a bipartisan Aging Issues Legislative Caucus with legislators from both the House and the Senate to meet regularly over the course of the next legislative session. Speaker Eves presented information about the Maine Aging Initiative at the second meeting of the Commission on September 23, 2014, and invited legislative members of the Commission to serve as the founding members of the caucus. The report and other information about the initiative may be found on MCOA's website at the following link: http://www.mainecouncilonaging.org/aginginitiative.php.

The Commission recommends sending a letter to Speaker Eves expressing the Commission members' support for the Maine Aging Initiative and its efforts to address issues surrounding Maine's aging population – including long-term care challenges. Vote: 11 in favor. (A copy of the letter is included as Appendix F.)

B. DHHS's Continuum of Care for Aging and Long-term Care Services and Community Supports

The Commission invited Jim Martin, Commission member and Director of the Office of Aging and Disability Services (OADS) within DHHS and Phyllis Powell, Associate Director for Finance and Community Partnerships at OADS, to present at the Commission's fourth meeting the department's comprehensive plans relating to Maine's continuum of care for aging and long-term care services and community supports. According to OADS, the percentage of Maine residents over 65 years of age has increased 15% from 2000 to 2010 while at the same time the percentage of those over age 65 utilizing a nursing home declined 26%. From 2010 to 2014, the percentage of residents over age 65 continued to rise another 16% while the percentage of the same population using a nursing home continued to fall.[16] The decline in Maine follows a national trend; for those over 65 years of age, from 2000 to 2010, nursing home use declined 30%.[17] Commission members cited the following as contributing factors for the decline in

[16] http://www.maine.gov/legis/opla/LTCContinuumofCare102014.pdf
[17] Ibid.

nursing facility use in Maine: more stringent eligibility requirements for nursing facility admissions; higher acuity residents and related turnover that creates shorter lengths of stay; expansion of home and community-based care; increased use of residential care facilities; and the fixed number of nursing home beds in Maine pursuant to State policy.

The continuum of care system in Maine is evolving and there are several components to the OADS strategic plan, including, but not limited to, the State Plan on Aging, State Plan for Alzheimer's Disease and Related Dementia in Maine and OADS Strategic Housing Plan. The Commission supports the department's comprehensive planning efforts. The Commission also recognizes that other entities, such as housing for the elderly and/or disabled, play an integral part in addressing Maine's long-term care needs.

At the second meeting, Lisa Harvey-McPherson, EMHS, Vice President, Continuum of Care and Chief Advocacy Officer, spoke to the Commission about challenges specific to hospitals. Ms. Harvey-McPherson explained that extended hospitalizations of complex cases, such as geriatric patients with psychiatric diagnoses and corresponding challenging behavior, currently occur more than desired due to the lack of options for care in the community. These complex cases are beyond the capacity of a typical nursing facility's level of care. Additionally, the Commission heard about nursing homes being challenged to care for patients who historically would not receive care in their facilities, such as relatively young adults with substance abuse problems or spinal cord injuries. For a copy of Ms. Harvey-McPherson's memo, see Appendix C. As mentioned earlier in this report, the Commission understands that DHHS is working on establishing a process to adequately address these complex cases.

The Commission recommends that DHHS continue on its course of comprehensive planning for the continuum of care, recognize and seek to address current gaps and shortcomings in those plans, and also acknowledge that other entities, such as housing for the elderly and/or disabled, play a part and should be considered in the statewide plan.

The Commission also recommends that that the HHS Committee send a letter to DHHS requesting that the department consult and work in partnership with the Maine Aging Initiative in this regard and report back to the HHS Committee no later than February 15, 2015, with an update on the State of Maine's continuum of care planning efforts. Vote: 11 in favor.

VIII. PERSONAL NEEDS ALLOWANCE

"Cost of care" is determined for all residents in nursing facilities or residential care facilities (also known as private non-medical institutions). The cost of care is the monthly amount the resident is expected to contribute toward the cost of his or her care in the facility. However, the MaineCare Eligibility Manual (DHHS rule) provides that a resident of a nursing facility or residential care facility who receives MaineCare may retain a monthly personal needs allowance (PNA) from his or her personal income. Any income above the PNA is applied toward the cost of care.

The PNA is typically used for personal care items and services such as television cable and telephone service, clothing, grooming and newspaper subscriptions. Currently, the PNA for a

resident in a nursing facility is $40 per month and for a resident in a residential care facility, $70 per month. These amounts were last increased approximately 30 years ago. Although, the PNA is not directly related to the Commission's charge, as long-term care facilities and the families of residents are financially pressured to do more with less, the Commission feels strongly that an increase in the monthly PNA is long overdue.

The Commission recommends the personal needs allowance for persons residing in nursing facilities increase from the current $40 per month to $50 per month and for persons residing in residential care from $70 per month to $90. Vote: 9 in favor; 2 absent.

IX. DRAFT LEGISLATION

A. Draft Legislation relating to the Principles of Reimbursement for Nursing Facilities

Resolve, To Implement the Recommendations of the Commission to Continue the Study of Long-term Care Facilities

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

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

Whereas, the recent closure of nursing facilities in particularly rural and underserved areas of the state has had a significant negative impact on those Maine families and communities;

Whereas, in order to provide high quality care to Maine's elderly and disabled persons and to maintain access to services across the state action is needed to continue a thoughtful and thorough planning process: and

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

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

1. Occupancy adjustment. The Principles of Reimbursement must be amended to decrease the occupancy percentage threshold required for a nursing facility with more than 60 beds from 90% to 80% and for a nursing facility with 60 beds or less, from 85% to 75%.

2. Continuing education for direct care staff. The Principles of Reimbursement must be amended so that the cost of continuing education for direct care staff is included as a direct care cost component in subsection 80.3 rather than a routine cost component in subsection 80.4.

3. Crossover payments. The Principles of Reimbursement must be amended to restore the crossover payments to nursing facilities related to nondual persons who are Qualified Medicare Beneficiaries in the Medicare Savings Program who are not dually eligible and for whom coverage has eliminated in Public Law 2013, chapter 368.

4. Critical access nursing facility designation. The Principles of Reimbursement must be amended to create a critical access nursing facility designation using criteria that are sensitive to the unique access challenges in remote areas of Maine. The rules must also be amended to provide that a critical access nursing facility designation qualifies as an allowable exception to MaineCare budget neutrality. The department shall seek the approval of the federal Department of Health and Human Services Centers for Medicare and Medicaid Services for the new designation and implement it by April 15, 2015.

SUMMARY

This resolve directs the Department of Health and Human Services to amend the Principles of Reimbursement for Nursing Facilities in the MaineCare Benefits Manual as follows:

1. Decrease the occupancy percentage threshold required for a nursing facility with more than 60 beds from 90% to 80% and for a nursing facility with 60 beds or less, from 85% to 75%;

2. Provide that the cost of continuing education for direct care staff is included as a direct care cost component rather than a routine cost component;

3. Restore crossover payments to nursing facilities related to the nondual Qualified Medicare Beneficiary program population of the Medicare Savings Program for whom coverage was eliminated in Public Law 2013, chapter 368; and

4. Create a new critical access nursing facility designation using criteria that are sensitive to the unique remote access challenges in Maine. The rules must provide that a critical access nursing facility designation is an allowable exception to MaineCare budget neutrality. The department shall seek the approval of the federal Department of Health and Human Services Centers for Medicare and Medicaid Services for the new designation and implement it by April 15, 2015.

B. Draft Legislation relating to Personal Needs Allowance

Resolve, To Ensure Appropriate Personal Needs Allowances for Persons Residing in Long-term Care Facilities

Sec. 1. Personal needs allowance for residents of nursing facilities. Resolved: That by October 1, 2015, the Department of Health and Human Services shall amend the rules of reimbursement for the MaineCare program to increase the personal needs allowance for persons residing in nursing facilities. The rules must provide for an increase in the personal needs allowance from $40 per month to $50 per month. Rules adopted pursuant to this section are routine technical rules as defined in Maine Revised Statutes, Title 5, chapter 375, subchapter 2-A; and be it further

Sec. 2. Personal needs allowance for residents of residential care facilities. Resolved: That by October 1, 2015, the Department of Health and Human Services shall amend the rules of reimbursement for the MaineCare program to increase the personal needs allowance for persons residing in residential care facilities. The rules must provide for an increase in the personal needs allowance from $70 per month to $90 per month. Rules adopted pursuant to this section are routine technical rules as defined in Maine Revised Statutes, Title 5, chapter 375, subchapter 2-A.

SUMMARY

This resolve directs the Department of Health and Human Services to amend its rules to provide for increases in the personal needs allowances of residents in nursing facilities and residential care facilities. The rules are designated as routine technical rules.

APPENDIX A

Commission to Continue the Study of Long-term Care Facilities
Membership List

Commission to Continue the Study of Long-term Care Facilities

Public Law 2013, Ch. 594

Appointment(s) by the Governor

James Martin DHHS	Representative of Governor's Office
Diane M. Barnes	Town Manager, Lisbon
Philip A. Cyr	Nursing facility director, owner, or administrator
Richard A. Erb	Director of a statewide association representing long-term care facilities
Brenda Gallant	Director of a long-term care ombudsman program
S. John Watson Jr.	Representative of a statewide association of long-term care facility owners

Appointment(s) by the President

Sen. Margaret M. Craven - Chair	Senate Member
Sen. David C. Burns	Senate Member

Appointment(s) by the Speaker

Rep. Peter C. Stuckey - Chair	House Member
Rep. Richard R. Farnsworth	House Member
Rep. Beth P. Turner	House Member

Staff:
Anna Broome
Karen Nadeau-Drillen

APPENDIX B

Authorizing Legislation, Public Law 2013, Chapter 594

LAW WITHOUT GOVERNOR'S SIGNATURE

MAY 1, 2014

CHAPTER

594

PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND FOURTEEN

S.P. 704 - L.D. 1776

An Act To Implement the Recommendations of the Commission To Study Long-term Care Facilities

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

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

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

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

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §1708, sub-§3, as corrected by RR 2001, c. 2, Pt. A, §33 and amended by PL 2003, c. 689, Pt. B, §6, is further amended to read:

3. Compensation for nursing homes. A nursing home, as defined under section 1812-A, or any portion of a hospital or institution operated as a nursing home, when the State is liable for payment for care, must be reimbursed at a rate established by the Department of Health and Human Services pursuant to this subsection. The department may not establish a so-called "flat rate." This subsection applies to all funds, including federal funds, paid by any agency of the State to a nursing home for patient care. The department shall establish rules concerning reimbursement that:

A. Take into account the costs of providing care and services in conformity with applicable state and federal laws, rules, regulations and quality and safety standards;

B. Are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities;

C. Are consistent with federal requirements relative to limits on reimbursement under the federal Social Security Act, Title XIX;

D. Ensure that any calculation of an occupancy percentage or other basis for adjusting the rate of reimbursement for nursing facility services to reduce the amount paid in response to a decrease in the number of residents in the facility or the percentage of the facility's occupied beds excludes all beds that the facility has removed from service for all or part of the relevant fiscal period in accordance with section 333. If the excluded beds are converted to residential care beds or another program for which the department provides reimbursement, nothing in this paragraph precludes the department from including those beds for purposes of any occupancy standard applicable to the residential care or other program pursuant to duly adopted rules of the department; ~~and~~

E. Contain an annual inflation adjustment that:

(1) Recognizes regional variations in labor costs and the rates of increase in labor costs determined pursuant to the principles of reimbursement and establishes at least 4 regions for purposes of annual inflation adjustments; and

(2) Uses the applicable regional inflation factor as established by a national economic research organization selected by the department to adjust costs other than labor costs or fixed costs~~.~~; and

~~Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.~~

F. Establish a nursing facility's base year every 2 years and increase the rate of reimbursement beginning July 1, 2014 and every year thereafter.

Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 2. 22 MRSA §1714-A, sub-§9 is enacted to read:

9. Cost-of-care overpayments. On or before June 30, 2015, the department shall collect the total amount of debt arising from cost-of-care overpayments that exceeds by $4,000,000 the amount of that debt that had been budgeted for fiscal year 2014-15 as of April 15, 2014. To the extent necessary to meet this requirement, the department may establish payment terms, modify as otherwise permitted by law existing payment agreements to accelerate payment terms and offset current payments in accordance with subsection 5. If 7 days' notice and opportunity to comment are provided, the department may adopt rules on an emergency basis to modify its implementation of subsection 5 on an emergency basis for purposes of collecting cost-of-care overpayments without making the emergency findings otherwise required by Title 5, section 8054, subsection 2.

Sec. 3. Amendment of Principles of Reimbursement for Nursing Facilities. The Department of Health and Human Services shall amend Rule Chapter

101, MaineCare Benefits Manual, Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities as follows.

1. The rule must be amended in order to establish a nursing facility's base year every 2 years and to increase the rate of reimbursement beginning July 1, 2014 and every year thereafter as follows:

A. In the direct care cost component in Section 80.3 and all other applicable divisions of Section 80.3 in which case mix data, regional wage indices or data required for rebasing calculations are referenced by date, the rule must be amended to establish a nursing facility's base year by reference to the facility's 2011 audited cost report or, if the 2011 audited cost report is not available, by reference to the facility's 2011 as-filed cost report; to refer to other required rebasing data no older than 2011 data; and to update a nursing facility's base year every 2 years thereafter; and

B. In the routine cost component in Section 80.4 and all other applicable divisions of Section 80.4 in which case mix data, regional wage indices or data required for rebasing calculations are referenced by date, the rule must be amended to establish a nursing facility's base year by reference to the facility's 2011 audited cost report or, if the 2011 audited cost report is not available, by reference to the facility's 2011 as-filed cost report; to refer to other required rebasing data no older than 2011 data; and to update a nursing facility's base year every 2 years thereafter.

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

A. In the direct care cost component in Section 80.3.3(4)(b), the peer group upper limit must be increased to 110% of the median; and

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

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

4. The rule must be amended in Sections 91 and 91.1 to provide for ongoing, annual rate changes beginning July 1, 2014 to adjust for inflation and to set the inflation adjustment cost-of-living percentage change in nursing facility reimbursement each year in accordance with the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index.

5. The rule must be amended to provide, beginning July 1, 2014, a supplemental payment, subject to cost settlement, to a nursing facility whose MaineCare residents constitute more than 70% of the nursing facility's total number of residents. The supplemental payment must provide an additional reimbursement of 40¢ per resident per day for each 1% this percentage of MaineCare residents is above 70%, except that the total supplemental payment must be calculated to avoid to the extent possible paying an

amount in excess of allowable costs that would be an overpayment upon settlement of the facility's cost report.

6. The rule must be amended in Section 80.3.2 to increase the specific resident classification group case mix weight that is attributable to a nursing facility resident who is diagnosed with dementia.

The rate of reimbursement for nursing facilities that results from amending the rules to reflect rebasing the nursing facility's base year pursuant to this section may not result for any nursing facility in a rate of reimbursement that is lower than the rate in effect on April 1, 2014. The department may implement this section by adopting emergency rules. If the department provides at least 7 days' notice and opportunity to comment before adopting these rules, it is not required to make the findings otherwise required by the Maine Revised Statutes, Title 5, section 8054, subsection 2.

Sec. 4. Savings arising from recoveries in excess of projections; transitional cap on rate increases.

1. The Department of Health and Human Services shall continue its best efforts to collect all remaining cost-of-care overpayments to nursing facilities and private nonmedical institutions that were paid when the department's computer systems, when providing reimbursement owed by the department, failed to take into account the financial contributions paid by residents in the nursing facilities and private nonmedical institutions and miscalculated the amounts payable under the MaineCare program. Cost-of-care overpayments collected in excess of amounts projected in developing and reporting budget information to the Legislature or the Governor must be used to fund the implementation of section 3 to the extent of funding provided in this Act.

2. If the total amount of debt arising from cost-of-care overpayments that the department collects in fiscal year 2014-15 exceeds $13,000,000, the excess must be carried over to fiscal year 2015-16 to be expended to provide additional funding for implementation of section 3. In fiscal years 2014-15, 2015-16 and 2016-17, the Department of Health and Human Services, subject to state plan approval by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, shall limit the actual rate increase provided to the total amount available as a result of the state funds appropriated for nursing home rate increases, including without limitation the dollar amount specified in any appropriation provision plus any net amount available as a result of increased nursing facility provider tax revenue and available federal funds, minus the amount necessary to fund the supplemental payment provided in section 3, subsection 5. In establishing this limit in any year in which it applies, the department first shall calculate and publish the rate increases that would result from increasing rates pursuant to all of section 3 except for subsection 5 and then grant to all facilities a pro rata portion of that increase that does not exceed the limit established in this subsection and also grant supplemental payments pursuant to section 3, subsection 5. The pro rata methodology must be applied uniformly to all facilities so that each facility receives the same percentage of the initially published rate increases, plus the supplemental payment if applicable.

Sec. 5. Cost-of-care overpayment correction. The Department of Health and Human Services shall immediately require that the department's contractor Molina Medicaid Solutions make adjustments to the Maine Integrated Health Management Solution computer system to correct and discontinue overpayments in the calculation and deduction of cost of care in the payment of nursing facilities and private nonmedical institutions.

Sec. 6. Commission To Continue the Study of Long-term Care Facilities. Notwithstanding Joint Rule 353, the Commission To Continue the Study of Long-term Care Facilities, referred to in this section as "the commission," is established. The membership, duties and functioning of the commission are subject to the following requirements.

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

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

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

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

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

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

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

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

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

2. The first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission. The chairs of the commission are authorized to establish subcommittees to work on the duties listed in subsection 4 and to assist the commission. The subcommittees must be composed of members of the commission and interested persons who are not members of the commission and who volunteer to serve on the subcommittees without reimbursement. Interested persons may include individuals with expertise in acuity-based reimbursement systems, a representative of an agency that provides services to the elderly and any other persons with experience in nursing facility care.

3. All appointments must be made no later than 30 days following the effective date of this Act. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all

members and after adjournment of the Second Regular Session of the 126th Legislature, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this Act a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

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

A. Funding for long-term care facilities, payment methods and the development of a pay-for-performance program to encourage and reward strong performance by nursing facilities;

B. Regulatory requirements other than staffing requirements and ratios;

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

D. The viability of privately owned facilities in rural communities;

E. The impact on rural populations of nursing home closures; and

F. Access to nursing facility services statewide.

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

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

7. No later than October 15, 2014, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health and Human Services. The joint standing committee of the Legislature having jurisdiction over health and human services matters may report out a bill regarding the subject matter of the report to the First Regular Session of the 127th Legislature.

Sec. 7. Bimonthly report. Beginning in July 2014 and ending in June 2016, the Department of Health and Human Services shall report bimonthly to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs on the department's efforts to establish and collect the debt arising from cost-of-care overpayments pursuant to the Maine Revised Statutes, Title 22, section 1714-A, subsection 9.

Sec. 8. Appropriations and allocations. The following appropriations and allocations are made.

HEALTH AND HUMAN SERVICES, DEPARTMENT OF (FORMERLY DHS)

Medical Care - Payments to Providers 0147

Initiative: Deappropriates funds for recovery of overpayments to providers that are in excess of the amounts currently budgeted for in the MaineCare program for fiscal year 2014-15.

GENERAL FUND	2013-14	2014-15
All Other	$0	($4,000,000)
GENERAL FUND TOTAL	$0	($4,000,000)

Nursing Facilities 0148

Initiative: Provides one-time funding for increased reimbursements under the MaineCare program for nursing facilities.

GENERAL FUND	2013-14	2014-15
All Other	$0	$4,520,000
GENERAL FUND TOTAL	$0	$4,520,000

FEDERAL EXPENDITURES FUND	2013-14	2014-15
All Other	$0	$7,311,686
FEDERAL EXPENDITURES FUND TOTAL	$0	$7,311,686

Nursing Facilities 0148

Initiative: Provides one-time funds for increased nursing home costs.

GENERAL FUND	2013-14	2014-15
All Other	$0	$189,840
GENERAL FUND TOTAL	$0	$189,840

FEDERAL EXPENDITURES FUND	2013-14	2014-15
All Other	$0	$307,091
FEDERAL EXPENDITURES FUND TOTAL	$0	$307,091

Nursing Facilities 0148

Initiative: Adjusts funds to reflect additional nursing home provider tax revenue.

GENERAL FUND	2013-14	2014-15
All Other	$0	($709,901)
GENERAL FUND TOTAL	$0	($709,901)

OTHER SPECIAL REVENUE FUNDS	2013-14	2014-15
All Other	$0	$709,901
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$709,901

HEALTH AND HUMAN SERVICES, DEPARTMENT OF (FORMERLY DHS) DEPARTMENT TOTALS	2013-14	2014-15
GENERAL FUND	**$0**	**($61)**
FEDERAL EXPENDITURES FUND	**$0**	**$7,618,777**
OTHER SPECIAL REVENUE FUNDS	**$0**	**$709,901**
DEPARTMENT TOTAL - ALL FUNDS	**$0**	**$8,328,617**

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

APPENDIX C

Letter from Lisa Harvey-McPherson, Eastern Maine Healthcare Systems Vice President, Continuum of Care and Chief Advocacy Officer

EMHS
Access to Quality Healthcare SM

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EMHS MEMBERS
Acadia Hospital
Affiliated Healthcare Systems
Beacon Health
Blue Hill Memorial Hospital
Charles A. Dean Memorial Hospital
Dirigo Pines Retirement Community
Eastern Maine HomeCare
Eastern Maine Medical Center
EMHS Foundation
Inland Hospital
Rosscare
Sebasticook Valley Health
TAMC

MEMO

To: Members of the Commission to Study Long-term Care Facilities

From: Lisa Harvey-McPherson, EMHS Vice President Continuum of Care & Chief Advocacy Officer

Subject: Continuum of Care Placement Challenges

Date: September 17, 2014

I want to thank you for a thoughtful and informative discussion during your September 2nd commission meeting. The importance of looking at the full continuum of care was noted multiple times during the day. With this in mind I want to bring to your attention challenges that hospitals experience as they care for patients with extended hospitalizations due to lack of community options and long term care facilities caring for relatively young adults in their facilities. The challenges are not unique to EMHS members and highlight a gap in service capacity within Maine's healthcare delivery infrastructure.

In preparation for this correspondence I queried EMHS member hospitals and nursing facilities for information to highlight the challenges we experience. The following scenarios represent typical challenges our providers and patients experience.

Multiple hospitals have geriatric patients with psychiatric diagnoses and challenging behaviors that represent clinical and behavior management complexity beyond the capacity of nursing facility level of care. Despite being medically stable, these patients have been "living" at our hospitals for over 6 months due to lack of community care settings that can manage the complex behavioral health challenges. Maine currently has two secure geriatric psychiatric units, one in Waterville and one in Southern Maine. No secure facility exists in Northern or Eastern Maine and with extensive wait lists for this scarce resource these patients "live in hospitals" for extended periods awaiting placement.

Conversely the same type of patient can be found living at home with family experiencing multiple emergency room visits until they clinically decompensate and are admitted to a hospital only to experience barriers to discharge as nursing facilities in the community cannot meet their needs.

Other hospital discharge challenges include patients with severe brain injury needing facility based care, often providers in Massachusetts are the only option for discharge. We recently cared for a brain injured patient for over 400 days awaiting DHHS MaineCare approval for placement out of state. Bariatric patients generally have no community placement option due to the special equipment, environment requirements and clinical intensity of services. One of our hospitals recently had a 600 lb. patient for over 200 days as no home or facility based option was available. This patient is now at another hospital in Maine experiencing the same challenges. Long term ventilator patients also experience challenges when return to home is not an option and in general nursing facilities do not have ventilator care specialty units.

Over the past few years nursing homes have been challenged to care for patients who historically would not receive care in nursing facilities. Current examples include young adults with substance abuse challenges receiving extended intravenous therapy due to infections resulting from unclean needles, young adults with spinal cord injuries, patients in their 40's living in nursing facilities post stroke, young homeless mother needing tube feedings pending surgery, middle aged paraplegic male who is a former convict assaulted another resident shortly after admission.

Our goal in highlighting these challenges is to engage the Commission in a discussion and analysis of the gaps in Maine's care continuum and develop policy solutions supporting the care delivery infrastructure needed to serve Maine citizens.

Thank you for the opportunity to present this challenge.

APPENDIX D

Office of Policy and Legal Analysis,
Memo pay-for-performance program, Kristen Brawn

OPLA RESEARCH REQUEST MEMO

To: Jane Orbeton, Senior Legislative Analyst
From: Kristin Brawn, Legislative Researcher
Date: December 2, 2013
RE: State Medicaid Pay-for-Performance Programs in Long-Term Care

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Hi Jane,

You asked me to research Medicaid pay-for-performance programs in nursing homes for other states, in particular, the reimbursement mechanism for those programs. I contacted NCSL to see if they had any information, and they are currently researching the information, as they didn't have anything readily available. My contact at NCSL sent me a few articles regarding pay-for-performance programs in nursing homes, which I have summarized below. I am also attaching a comparison table of state Medicaid pay-for-performance programs in nursing homes, which I compiled from the articles I received from NCSL and my own online research.

Summaries of Nursing Home Pay for Performance Program Articles

Miller, E.A. and Doherty, J. Pay for Performance in Five States: Lessons for the Nursing Home Sector. *Public Administration Review*. 73(S1):S153-S163, 2013.

- Examines pay-for-performance in five Medicaid nursing programs: IA, MN, OK, UT and VT.
- To minimize the risk of provider opposition and to promote long-term sustainability, states should consider using "new" dollars to fund pay-for-performance rather than reallocating existing dollars.
- Use of a range of measures is preferred because it spreads the risk of poor performance across multiple dimensions, thereby minimizing the chances of unduly penalizing providers that perform well overall while reducing the chances that providers might gain rewards by focusing on a single quality dimension to the exclusion of others; it also minimizes the risk of gaming or outright fraud.
- Key to gaining stakeholder acceptance and therefore the chances of program success is engaging industry and other stakeholder representatives early on and throughout the pay-for-performance design and adoption process.
- The composite score approach is generally preferred because it evaluates and allocates rewards on the basis of each facility's actual performance while simplifying the calculation and reporting of program outcomes compared to systems that do so separately for each individual measure.
- To incentivize low- and middle-level performers while also rewarding good performers, states could reward relative improvement and procedural advances, as well as absolute performance.
- Minimizing the administrative burdens associated with the adoption of P4P is particularly important, including permitting providers to use existing data systems to report performance where appropriate.
- State subsidization of the additional data collection costs, say, by contracting with a vendor, would likely reduce provider resistance while promoting systematic compilation and assessment of the data recorded.
- The fixed per diem add-on approach is preferred because it is dependent exclusively on the basis of facility performance rather than on how much money facilities happen to be paid.
- States should build in flexibility to provide state officials with opportunities to adjust pay-for-performance programs, thereby enabling both facilities and the state to take advantage of new knowledge and experience to improve program effectiveness.
- Phasing in pay for performance slowly, beginning with performance measurement, followed by public report cards and, finally, introducing pay-for-performance incentives, maximizes opportunities

for stakeholder acceptance and learning. Moreover, an emphasis on measurement ensures that facilities have access to important performance data; provides richer data for report cards and state-level quality monitoring; and, where funding for pay for performance is available, provides a fair basis for distributing incentive payments.

Werner, R.M., Konetzka, R.T., and Liang, K. The Effect of Pay-for-Performance in Nursing Homes: Evidence from State Medicaid Programs. *Health Services Research*. 48(4):1393-1414, August 2013.

- Most states use a payment model based on a point system that is translated into per diem add-ons.
- Quality improvement under pay-for-performance was inconsistent. While three clinical quality measures (the percent of residents being physically restrained, in moderate to severe pain, and developed pressure sores) improved with the implementation of pay-for-performance in states with pay-for-performance compared with states without pay-for-performance, other targeted quality measures either did not change or worsened. Of the two structural measures of quality that were tied to payment (total number of deficiencies and nurse staffing) deficiency rates worsened slightly under pay-for-performance while staffing levels did not change.
- Medicaid-based pay-for-performance in nursing homes did not result in consistent improvements in nursing home quality. Expectations for improvement in nursing home care under pay-for-performance should be tempered.
- The incentives themselves may have been too small to effectively motivate changes in performance, particularly for the measures of staffing as staffing increases are very costly.
- There may be ways to get more of a return without increasing the size of the reward. Most nursing homes received annual bonuses for their performance. However, more frequent feedback on performance in the form of quarterly or even monthly payments may increase attention to performance in these areas because it provides frequent positive reinforcement.
- Another reason the current pay-for-performance programs may have failed to consistently achieve quality improvement is that the incentives were paid to the nursing home, rather than to the individual staff members.

Miller, S.C., Looze, J., Shield, R., Clark, M.A., Lepore, M., Tyler, D., Sterns, S., and Mor, V. Culture Change Practice in U.S. Nursing Homes; Prevalence and Variation by State Medicaid Reimbursement Policies. *The Gerontologist*. Mar. 20, 2013.

- In 2009-10, a survey was conducted of a stratified proportionate random sample of nursing home directors of nursing and administrators at 4,149 U.S. nursing homes; contact achieved with 3,695.
- 85% of directors of nursing reported some culture change implementation.
- Controlling for nursing home attributes, a $10 higher Medicaid rate was associated with higher nursing home environment scores.
- Compared with nursing homes in non-pay-for-performance states, nursing homes in states with pay-for-performance including culture change performance had twice the likelihood of superior culture change scores across all domains, and nursing homes in other pay-for-performance states had superior physical environment and staff empowerment scores.
- Changes in Medicaid reimbursement policies may be a promising strategy for increasing culture change practice implementation. Future research examining nursing home culture change practice implementation pre-post pay-for-performance policy changes is recommended.

Comparison of State Medicaid Pay-for-Performance Programs for Nursing Homes

According to an article on the Kaiser Health News website (http://www.kaiserhealthnews.org/stories/2012/august/15/ohio-medicaid-nursing-homes.aspx), there are currently 10 states with nursing home pay-for-performance programs. There are also two states (VA and IN) with proposed programs, and two states (MD and TX) have received legislative approval for nursing home pay-for-performance programs. The 10 states with active nursing home pay-for-performance programs are listed in the table below.

	Use Performance Measures?	Incentive Payment
California Skilled Nursing Facility Quality and Supplemental Payment System (Welfare and Institutions Code §14126.022)	Yes	Supplemental payments; amount is not specified
Colorado Nursing Facility Pay for Performance Program (CO Department of Health Care Policy and Financing, 2012)	Yes	Per diem add-on $1.00 - $4.00 per day, depending on points awarded
Georgia Nursing Home Quality Incentive Program (Briesacher et al., 2009)	Yes	Per diem add-on 1% of per diem rate
Iowa Nursing Facility Pay-for-Performance Program (Admin. Code §81.6(16)(g)	Yes	Per diem add-on 1%-5% of the direct care plus non-direct care cost component patient-day-weighted medians, depending on points awarded
Kansas Nursing Facility Quality and Efficiency Outcome Incentive Factor (Briesacher et al., 2009)	Yes	Per diem add-on $1.00 - $3.00 per day
Nevada Supplemental Payment to Free-Standing Nursing Facilities (NV State Plan, Attachment 4.19-D)	Yes	Per diem add-on 50% of supplemental payment is based on Medicaid occupancy, MDS accuracy and quality measures
Ohio Long-Term Care Quality Initiative (OH Revised Code §§5165.15 and 5165.25)	Yes	Per diem add-on $3.29 - $16.44, depending on points awarded
Oklahoma Focus on Excellence (Briesacher et al., 2009; Miller and Doherty, 2013)	Yes	Per diem add-on 1%-5% ($1.09-$5.45) of per diem rate, depending on points awarded
Utah Nursing Home Quality Improvement Initiative (Briesacher et al., 2009; Miller and Doherty, 2013)	Yes	Per diem add-on $0.50-$0.60 per patient per day
Vermont (Werner et al., 2010; Miller and Doherty, 2013)	Yes	Bonuses not based on per diem add-ons Each facility that qualifies for a bonus payment receives $25,000 To be eligible, facilities must be deficiency free on most recent health and fire safety inspection survey and participate in the Gold Star Employer Program

Sources:

Briesacher, B., Field, T.S., Baril, J., and Gurwitz, J.H.: Pay for Performance in Nursing Homes. *Health Care Financing Review* 30(3): 1-13, 2009.Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/09Springpg1.pdf.

Colorado Department of Health Care Policy and Financing. 2012 Nursing Facilities Pay for Performance Review. Available at http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251825889266&ssbinary=true.

Kuhmerker, K. and Hartman, T.: Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs. 2007. Available at: http://commonwealthfund.org/publications/publications_show.htm?doc_id=472891.

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U.S. Department of Health and Human Services. Report to Congress: Plan to Implement a Medicare Skilled Nursing Facility Value-Based Purchasing Program. Available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF-VBP-RTC.pdf.

Werner, R.M., Konetzka, R.T., and Liang, K. The Effect of Pay-for-Performance in Nursing Homes: Evidence from State Medicaid Programs. *Health Services Research*. 48(4):1393-1414, August 2013.

Werner, R.M., Konetzka, R.T., and Liang, K. State Adoption of Nursing Home Pay-for-Performance. *Medical Care Research and Review*. 67(3):364-377, 2010.

APPENDIX E

Application for Financial Assistance for Facility Costs

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Application for Financial Assistance for Facility Costs

This application is for help with Nursing Facility expenses, cost of nursing care in your home or cost of care in a Residential Care Facility.

Return to:

I am asking for help with:

(check one)

____ Support Waiver
____ MR Waiver

____ Nursing Facility care
____ Nursing care in my home
____ Residential Care Facility

The term **"YOU"** as used in this application means the person who needs financial assistance.

Information about you:

Your Name (First, Middle, Last)	Social Security #	Birthdate	Age

Mailing Address: Street, PO Box, (Include apartment number, care of, etc.)	U.S. Citizen No Yes	Sex M F

City	State	Zip Code	Telephone or Message Number

Street address and town where you actually live. Please give directions to your home.

_____

Race: White ____ Black ____ Hispanic ____ Other _____

Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____

Medicare number: Effective date: Part A _____ Part B _____

Do you have a disability? No ____ Yes ____ Do you receive SSI? No ____ Yes ____
Have you ever received SSI? No ____ Yes ____

Have you ever served in the Armed Forces? No ____ Yes ____

Information about your spouse:

Spouse's Name (First, Middle, Last)	Social Security #	Birthdate	Sex M__ F__

Medicare number: Effective date: Part A _____ Part B _____

Does your spouse live with you? → No ____ Yes ____
If no, list your spouse's mailing address:

Has your spouse ever served in the Armed Forces? No ____ Yes ____

Date received:_____ Date logged on:_____ 45th day: _____

The asset questions on pages 2 and 3 are about you and your spouse. You need to provide proof of all assets.

- Cash not in bank
- Savings Account
- Checking Account
- Certificate of Deposit
- Credit Union Shares
- Other
- IRA, 401K, Keogh Accounts

Name(s) on Account	Type of Asset See Above	Name of Bank or Institution	Account Number	Current Balance Or Value

If you need more space to list accounts, use a separate sheet and check here. ⟶ ☐

If you are presently in a Nursing Facility or Residential Care Facility, do you have a **Patient Account?** **No** ____ **Yes** ____

If so, what is the balance of your account? $_____

You need to tell us about any annuities, stocks, bonds, profit sharing, trust funds and any other financial investment instruments that you or your spouse have an interest in.

Do you or your spouse have any **Stocks, Bonds, Profit Sharing, Annuities, or any type of Trust Funds?** **No** ____ **Yes** ____

If yes, list here:

Other:

Do you or your spouse have any Life Insurance? If yes, list below: **No** ____ **Yes** ____

Owner	Who is insured	Company name and address	Face Value	Cash Value
			$	$
			$	$
			$	$

Do you or your spouse have a Funeral Plan or Prepaid Burial? **No** ____ **Yes** ____

Does your name or your spouse's name appear on **anyone else's** Bank Account, Savings Account, Checking Account, Credit Union Account, Stocks, Bonds, Money Market Certificates or any type of Property other than those already listed? **No** ____ **Yes** ____

Do you or your spouse have a Safe Deposit Box? **No** ____ **Yes** ____

Name of Bank:

Do you or your spouse have Land, Buildings, Timeshares, jointly-held Real Estate, or a Life Estate, including where you live? **No** ____ **Yes** ____

Do you intend to return to your residence when you no longer need care in a Nursing Facility or an Assisted Living/Residential Care Facility? **No** ____ **Yes** ____

Do you or your spouse have, or jointly own, any cars, trucks, boats, campers, motorcycles, snowmobiles, ATVs, trailers, skidders, tractors, or other motorized vehicles? **No** ___ **Yes** ___

If yes, please list below:

Year	Make	Model	Name(s) of Owner(s)	Amount Owed
				$
				$
				$

Have you or your spouse disposed of any **Personal Property** or **Real Estate** or closed any **Savings**, **Checking**, or **any other Financial Accounts** in the last 60 months? This includes all things you may have given away or sold during the past 60 months. (Examples of things you may have owned: money, bank accounts, checking accounts, stocks, land, buildings, camps, automobiles, boats, campers, etc.) **No** ___ **Yes** ___

If yes, please list here:

Have you or your spouse recently received, or do either of you expect to receive in the near future, any retroactive government benefits, pay raises, lawsuit settlements, inheritances, or compensation of any other kind? **No** ___ **Yes** ___

If yes, please list here:

These income questions are about you and your spouse. Please provide proof of income.

* Alimony
* Social Security (Retirement or Disability)
* Self-Employment
* Other Disability Income
* Military Allotment
* SSI
* Other Income
* Railroad Retirement
* Pensions
* Worker's Compensation
* Veteran Benefits (List Claim # _____)
* Dividends or Interest
* Earnings – Wages
* Civil Service Annuity or Other Annuities

List Type (See Above) →	Your Income				Your Spouse's Income			
Gross Amount →	$	$	$	$	$	$	$	$
How often received? →								

Do you or your spouse receive rent money from property? → **No** ___ **Yes** ___

Do you or your spouse receive money from someone who pays room and board? → **No** ___ **Yes** ___

Do you or your spouse receive money from irregular income during the year? → **No** ___ **Yes** ___

If you are in a hospital or nursing facility and your spouse is living at home, please list your **spouse's shelter expenses.** (Do not include past due payments and Security Deposits.)

Lot Rent	$____per____	Rent	$____per____	Cooking Fuel	$____per____
Mortgage	$____per____	Heat	$____per____	Water	$____per____
Property Taxes	$____per____	Telephone	$____per____	Sewer	$____per____
House Insurance	$____per____	Electricity	$____per____	Trash Collection	$____per____

Is your heating cost included in your rent? **No** __ **Yes** __

Does your mortgage payment include taxes and house insurance? **No** __ **Yes** __

Does anyone else live in the household of your spouse? **No** __ **Yes** __

Do you need help with any medical bills incurred within the past three months? **No** __ **Yes** __

Which months?

Please send proof of income and assets for these months.

Do you have any medical insurance? **No** __ **Yes** __

Name of insurance company: _____ Premium $ _____ How often paid? ____

Please provide the latest receipt for the premium paid.

If you are now, or in the past 90 days have been in a Hospital, Nursing Facility, or Residential Care Facility, please tell us about this.	Facility Name _____ Address _____ Date admitted _____ Date discharged _____	Facility Name _____ Address _____ Date admitted _____ Date discharged _____

Do you have a power of attorney, conservator, or court-ordered guardian? **No** __ **Yes** __

Name: _____ Telephone #: _____

Address: _____

Please provide a copy of the court order or the power of attorney.

Is there someone else who knows about your financial situation, and whom we may contact to help with this application? **No** __ **Yes** __

Person's Name: _____ Relationship: _____

Address: _____ Telephone #: _____

If someone helped you fill out this form, please write his or her name and telephone number below:

Name: Telephone #:

Assignment of Rights to Medical Payments: If MaineCare pays a bill for you, MaineCare has the right to collect for that bill from other medical support or medical insurance you may have.

Estate Recovery: If you receive MaineCare benefits and are age **55 or older**, the State may make a claim on the assets of your estate to recover the money that MaineCare has paid for your care. **No claim will be made if the only service you receive is the Medicare Buy-In.** For more information about the Estate Recovery Program, please call MaineCare Member Services at 1-800-977-6740.

I understand all the information requested on this form. I certify (under penalty of perjury) that all my answers are correct and complete to the best of my knowledge—including those concerning citizenship and alien status. I agree to give paperwork or other information to prove what I have said. I also agree that the Department of Health and Human Services and Federal officials may check with other people to verify the information I have provided.

_____ _____

Signature Date

APPENDIX F

Letter to Speaker Eves Regarding Maine Aging Initiative

SEN. MARGARET M. CRAVEN, CHAIR
SEN. DAVID C. BURNS
DIANE M. BARNES
PHILIP A. CYR
RICHARD A. ERB

REP. PETER C. STUCKEY, CHAIR
REP. RICHARD R. FARNSWORTH
REP. BETH P. TURNER
BRENDA GALLANT
JAMES MARTIN
S. JOHN WATSON JR.

STATE OF MAINE

ONE HUNDRED AND TWENTY-SIXTH LEGISLATURE

COMMISSION TO CONTINUE THE STUDY OF LONG-TERM CARE FACILITIES

November 21, 2014

The Honorable Mark W. Eves, Speaker
Maine House of Representatives
State House
Augusta, ME 04333

Dear Speaker Eves,

We are writing on behalf of the Commission to Continue the Study of Long-term Care Facilities to express our support of your efforts to address the challenges and seize the opportunities presented by Maine's aging population. It is widely known that Maine is the oldest state in the nation. The Maine Aging Initiative, which you launched in conjunction with the Maine Council on Aging, can play an important role in providing community-based solutions and legislative leadership toward addressing the needs of Maine's growing segment of older residents. The Commission is interested in this initiative and has a particular interest in planning for long-term care along a continuum of services.

Thank you for your willingness to attend the Commission's second meeting as a presenter to share information about not only the Maine Aging Initiative, but also the roundtables and summit on aging which were held earlier this year and led to the "Blueprint for Action on Aging." Furthermore, thank you for inviting legislative members of the Commission to serve as founding members of the bipartisan Aging Issues Legislative Caucus during the 127th Maine Legislature.

Pursuant to Public Law 2013, chapter 594, the Commission is pleased to submit its final report. The Commission was charged with studying, among other things, funding mechanisms for long-term care facilities and access to nursing facility services statewide. It is our hope that the Commission's report will be helpful to you and other interested parties as you examine aging issues in Maine.

Again, we are grateful for your initiative toward addressing the challenges and recognizing the opportunities associated Maine's aging population. Toward that end, we look forward to working with you.

Sincerely,

Margaret Craven

Sen. Margaret M. Craven
Senate Chair

Rep. Peter C. Stuckey, Chair
House Chair

cc: Members, Commission to Continue the Study of Long-term Care Facilities