MHCA

Maine Health Care Association

Testimony of Angela Westhoff, President & CEO
Maine Health Care Association

Testimony before the Committee on Health and Human Services In Opposition to:

LD 979, Resolve, Regarding Legislative Review of Chapter 113: Assisted Housing Programs Licensing Rule, a Late-filed Major Substantive Rule of the Department of Health and Human Services

Senator Ingwersen, Representative Meyer, and Distinguished Members of the Health and Human Services Committee:

My name is Angela Westhoff, and I serve as the President & CEO of the Maine Health Care Association. We represent approximately 200 nursing homes, assisted living centers, and residential care facilities across the state. Our mission is to empower members to ensure the integrity, quality, and sustainability of long term care in Maine.

On behalf of our members, I am testifying in strong opposition to **LD 979, Resolve, Regarding Legislative Review of Chapter 113: Assisted Housing Programs Licensing Rule.** As major substantive rules, they are subject to legislative review. First, this committee needs to know that under Title 22, Chapter 1664, Section 7853, the law states that the rules for assisted housing must be developed in consultation with the long-term care ombudsman program established under section 5106, subsection 11 C, consumer representatives, and providers in the type of assisted housing facility to which the rules will apply.[1]

These rules were not developed with meaningful provider input. The Department has referenced a listening session from December 2023 in which they asked a limited group of people questions about the *current* rule to see if there were terms or definitions in the current rule that providers disagreed with, or found confusing, if they were easy to navigate, did they like or dislike the idea of a consolidated rule, issues with interpretation or difficulties in understanding the current rule, etc. There was no in-depth conversation about a complete repeal and replacement of the 10 sections of

[1] Title 22, §7853: Rules: https://legislature.maine.gov/statutes/22/title22sec7853.html. Accessed March 30, 2025.

rules into two sections or a new rule that would significantly increase staffing ratios, add new training requirements, and institute numerous regulatory changes.

Staffing Ratios:

These proposed changes are extensive. Among many problematic changes, the staffing ratios proposed in Part B for residential care facilities stand out as one of the most concerning. While the initially proposed staffing ratios were even higher and, in some cases, higher than nursing home staffing, the Department has amended those ratios to a phased approach that would still significantly increase staffing requirements. One Year from the Date of Final Adoption, the staffing ratios will be 1:12 from 7 am to 11 pm and 1:25 from 11 pm to 7 am. Two Years from the Date of Final Adoption, the ratios will be 1:10 from 7 am- 11 pm and 1:20 from 11 pm- 7 am. The staffing ratios are even higher for memory care units. One Year from the date of final adoption, the ratios will be **1:10** from 7 am – 11 pm (Day) and **1:22** from 11 pm- 7 am (Night). Then two years from the date of final adoption, the ratios will be **1:8** from 7 am- 11 pm (Day) and **1:15** from 11 pm- 7 am (Night).

We researched every other state's assisted living/ res care staffing ratios. For the 50 states, a total of **33 states have minimum no staffing ratios**. Their regulations state that homes must have enough staff to meet the residents' needs. Of the 17 remaining states, **only two have staffing ratios that are as high or slightly higher than what Maine is proposing**. South Carolina's ratios are higher than what Maine is proposing but only in the day category of 1:8 day, yet they have less staff required at night (1:30). The other state is West Virginia of 1:10; 1:15; 1:18 for "special needs residents." It is not clear how this definition would compare to our assisted living and residential care residents. For memory care staffing ratios, I found only one state, North Carolina, with **a higher ratio** than what is being proposed: "1:8 day, 1:8 evening, 1:10 night, and .8 hours of staff time for each additional resident."

In other words, if this bill were to pass, Maine would have among the highest overall combined assisted housing and res care staffing ratios in the country. The new provisionally adopted rules also would no longer allow any ancillary staff (like housekeeping or dietary staff) to count toward staffing ratios, and volunteers are also not able to be counted. So, providers will be forced to meet higher

ratios, with fewer staff members who can count toward meeting them and **zero dollars** to support these new requirements.

Workforce Crisis and Cost to Implement New Staffing Minimums:

As you know, Maine continues to face historic work force shortages. Long term care continues to have the slowest workforce recovery compared to other healthcare sectors. In Maine, we estimate we lost between 10% and 15% of long term care employees during the pandemic. There isn't a single provider who wouldn't gladly take more staff. The challenges are: where will these individuals come from, and how will they be paid for?

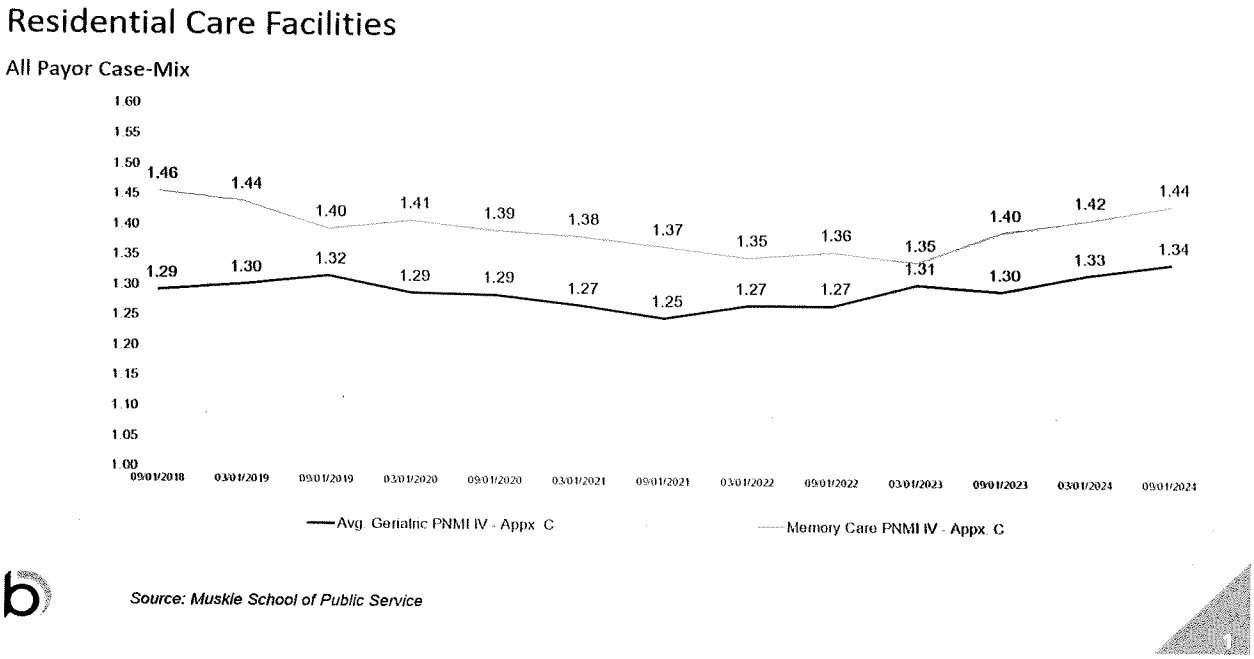
MHCA developed a calculator to compute the current number of caregiver work shifts required under the current staffing minimums and compared it to the number of work shifts under the new rules with higher staffing ratios. We estimate that the sector would need an additional **623 full-time equivalents** to meet the Year 2 staffing minimums. The cost of labor and benefits for Part B providers would be approximately **$30-40 million annually** to meet these staffing ratio requirements. Where will these dollars come from? Is the plan for the legislature to cover this considerable expense, or should we simply trust the privately paying families to foot the bill?

MaineCare (Medicaid) is a primary payor for residential care facilities that are Private Non-Medical Institutions. But MaineCare rates already do not keep pace with cost. The MaineCare reimbursement shortfall for the 120 PNMI-Cs was $21 million in 2023. These facilities are already experiencing a workforce crisis, with reimbursement rates in the red, and now the state is saying that they must comply with additional staffing requirements with no financial support. The proposed regulations are another unfunded mandate that would force more homes to take beds offline or, worse, close their doors.

Acuity of Residents:

The Department has made clear that a leading motivation for these changes is in response to an apparent increase in the needs of current residents. For example, the response to rulemaking comments document states repeatedly that the "proposed changes to the rule address the rise in

acuity levels of resident needs."[2] In fact, the word "acuity" is in the document 77 times. To better understand the data, MHCA partnered with BerryDunn to analyze Muskie School of Public Service case mix data, a foundational indicator of resident acuity. From September 2018 to September 2024, **there has not been a significant increase in acuity**. The statewide average case mix for geriatric PNMI-Cs was 1.29 compared to 1.34 – a mere 4% increase. And for Memory Care PNMI Level IV- Appendix C the case mix is actually slightly lower in 2024 at 1.44 compared to 2018's 1.46 measure.



Source: Muskie School of Public Service

The perception is that the acuity of residents in residential care settings has gone up significantly. However, the data does not demonstrate that.

Another claimed reason for these rule changes was that current regulations, particularly staffing levels, are inadequate to ensure residents' needs and safety concerns are well met. Again, MHCA looked at concrete data rather than anecdotes to gain insight into the factual record of insufficient care. 2024 had over 10,000 assisted housing beds and 243 complaints investigated. Of those 243 complaint investigations, only 91 were found to be substantiated. To put it differently, there were 91 validated complaints made from more than 10,000 beds over 365 days; less than 1% of all beds had

[2] Chapter 113 Response to Comment Document: https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/10-144%20CMR%20Ch%20113%20Comments%20and%20Responses%20FINAL.pdf Accessed March 30, 2025.

a substantiated complaint. Moreover, some of these substantiated complaints were related to issues not directly tied to staffing levels.

We have also asked the Department to provide us with information pertaining to the Statements of Deficiencies, and any associated Plans of Correction or Directed Plans of Correction for all Assisted Housing Providers for 2023 and 2024. MHCA has submitted an official Freedom of Access Act request for this data because we would really like to better understand the concerns that are potentially driving these proposed changes. To our knowledge, no in-depth review or analysis of such data exists. This only deepens our concern that these regulations come before the legislature prematurely and needing further time and study.

Assisted Living Facilities No Longer Have Dementia Care/ Alzheimer's Beds:

While it is nowhere in either the Part A or Part B rule, the response to comments document says that these new rules include a subtle yet consequential change so that any assisted living facility with dementia care beds will no longer be allowed to have licensed beds for Dementia/ Alzheimer's; they will have to become licensed as a Part B residential care facility, evict memory care residents, or close. We estimate this will impact at least eight facilities and approximately 240 beds. Physical plant changes, including construction, would be required along with increased staffing. This surreptitious change is just not realistic for many. If that change occurs and those facilities cannot adapt, where will those residents go? Will there be a grandfathering phase or a waiver application process? The rules don't address any of these questions.

Also, some providers may be licensed under Type I or Type II Assisted Living today but are reimbursed under a different section of MaineCare. It is unclear how they will be treated under the new rules.

Additional Administrators Needed:

In the new rule, a licensed administrator cannot oversee more than 160 residents in a single facility. If overseeing multiple facilities, they cannot manage more than three sites with a total licensed capacity of 50 residents. An administrator who has oversight of more than one facility will be limited to 50 beds in total- that's 1/3 of the total beds if they were in one site. We are unclear as to why this

is being implemented. The Department may limit the number of beds through a Directed Plan of Correction if they believe an administrator is not able to effectively oversee multiple locations. Respectfully, we disagree with these new limitations, particularly in light of the staffing challenges and if the administrator has experience and evidence of successfully managing multiple facilities. This rule would require more administrators to be hired without providing any funding to make this possible.

Conclusion:

An update to the Assisted Housing Programs Licensing Rules was needed. However, the process of updating the rules failed to adequately include the feedback of residents, families, and providers. Consequently, the original proposed new rules were not grounded in reality. The provisionally adopted rules are marginally improved, yet the stark reality is that Maine continues to face a historic work force crisis. Over the last ten years, we have seen over 50 closures or conversions of long term care homes in our state. If these rules are implemented as proposed and without funding, it will accelerate the closure of many more homes.

Further, PNMI-Cs are overdue for a rate assessment. That work was supposed to be done simultaneously with nursing facility rate reform. Unfortunately, it was set aside, and as we all know, ensuring COLAs for MaineCare providers remains a challenge in the Biennial Budget. We are constantly asking providers to do more with less. They simply cannot comply with these proposed regulations. Where will the staff come from? Who will pay for their wages and benefits? And for those residents who are private pay, these policies will hasten spending down their assets faster and ending up on MaineCare sooner.

We urge the Committee to vote no on LD 979 and require DHHS, LTCOP, providers, residents, and families to engage in meaningful dialogue, planning, and developing consensus recommendations. Thank you for your time and consideration.