MAINE STATE LEGISLATURE

The following document is provided by the

LAW AND LEGISLATIVE DIGITAL LIBRARY

at the Maine State Law and Legislative Reference Library

http://legislature.maine.gov/lawlib

Reproduced from scanned originals with text recognition applied

(searchable text may contain some errors and/or omissions)

118th MAINE LEGISLATURE

FIRST REGULAR SESSION-1997

Legislative Document	**No. 1241**
S.P. 382	In Senate, February 25, 1997

An Act to Improve the Delivery and Financing of Long-term Care.

Reference to the Committee on Health and Human Services suggested and ordered printed.

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator BENNETT of Oxford.
Cosponsored by Representative WINSOR of Norway and
Representatives: DONNELLY of Presque Isle, MARVIN of Cape Elizabeth, OTT of York.

Printed on recycled paper

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

2

Sec. 1. 22 MRSA §1708, sub-§3, ¶C, as amended by PL 1995, c.
4 696, Pt. A, §32, is further amended to read:

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

10 **Sec. 2. 22 MRSA §1708, sub-§3, ¶¶E to G** are enacted to read:

12 E. Ensure that, with respect to covered services provided by nursing facilities having 60 or fewer beds, the rate of
14 reimbursement per day of service provided or the amount otherwise reimbursed for any service rendered may not be
16 reduced by the application of any occupancy standard or adjustment that decreases the amount paid in response to a
18 decrease in the number of residents residing in the facility or the percentage of the beds in that facility that are
20 occupied during a given period. Any existing rules that reduce the rate of reimbursement based on an occupancy
22 standard or a decrease in the number of residents do not apply on the effective date of this paragraph;

24

F. Do not impose or incorporate any reduction in
26 reimbursement as a sanction for errors or inaccuracies in the facility's records of assessments of residents'
28 functional capacities. Any existing provisions of the department's rules that provide for decreases in
30 reimbursement due to specified error rates in assessment records, including the "Minimum Data Set Plus," do not apply
32 on the effective date of this paragraph; and

34 G. Provide that any form, instrument or protocol used to assess residents, their conditions or the resources required
36 to care for them must be designed and used for both reimbursement purposes and determinations of eligibility, so
38 that separate forms, records or assessments are not required for those purposes.

40

Sec. 3. 22 MRSA §1711-C is enacted to read:

42

§1711-C. Facility access to resident assessment information

44

1. Definitions. As used in this section, unless the
46 context otherwise indicates, the following terms have the following meanings.

48

A. "Aggregate data" means information derived from resident
50 assessment information made available in a form that can not

be used to identify individual residents. Aggregate data must exclude information that directly identifies any individual and must substitute cumulative information pertaining to groups of persons for information pertaining to specific individuals, when the specific information could be used to indirectly identify an individual.

B. "Resident information" means all of the information that nursing facilities are required by rules of the department to submit to the department or its designee to provide assessments of the functional capacity of each resident and to group residents into classes based on assessed conditions and resources required to provide care. "Resident assessment information" includes all elements of information in the "Minimum Data Set Plus" required by the department in its principles of reimbursement for nursing facilities and any similar data sets or information requirements that the department may adopt.

2. Access. No later than October 1, 1997, the department shall adopt rules and, by appropriate arrangements with any designee or contractor of the department responsible for accepting submissions of resident assessment information from facilities, provide for any facility or association of facilities to obtain aggregate data containing all elements of resident assessment information for all facilities submitting that information, organized and presented in a manner that permits assessments of levels and trends in quality, resource use, case mix and other factors that can be determined from the elements of information collected by the department. The department may provide for necessary safeguards to prevent identification of individual residents and, in the case of requests by a facility or association for information about more than one facility, to prevent identification of individual facilities. Rules adopted pursuant to this subsection are major substantive rules as defined by Title 5, chapter 375, subchapter II-A.

Sec. 4. 22 MRSA 3174-I, sub-§1, as amended by PL 1995, c. 696, Pt. B, §1, is further amended by amending the first paragraph to read:

1. Needs assessment. In order to determine the most cost-effective and clinically appropriate level of long-term care services, the department ~~or its designee shall~~ may require nursing facilities to assess the medical and social needs of each applicant to a nursing facility. ~~If the~~ The department ~~chooses a designee to carry out assessments under this section, it shall~~ may provide guidelines for nursing facilities to ensure that the assessments are comprehensive and objective.

Sec. 5. 22 MRSA §3174-I, sub-§1, ¶B, as amended by PL 1993, c. 410, Pt. FF, §10 and affected by §19, is further amended to read:

B. The department shall determine, based on the assessment results reported by the facility, whether the services provided by the facility are medically and socially necessary and appropriate for the applicant and, if not, what other services, such as home and community-based services, would be more clinically appropriate and cost effective.

Sec. 6. 22 MRSA §3174-I, sub-§1, ¶E, as amended by PL 1995, c. 696, Pt. B, §1, is further amended by amending subparagraph (2) to read:

(2) If the individual is initially assessed as needing the nursing facility's services under the assessment criteria and process in effect at the time of admission or is admitted as covered by Medicare for nursing facility services, but is reassessed as not needing those services at the time the individual is found financially eligible, then the department shall reimburse the nursing facility for services it provides to the individual in accordance with the principles of reimbursement for residential care facilities adopted by the department pursuant to section 3173. The department may not adopt or construe its rules for reimbursement under this subparagraph to deny payment for services actually rendered on the ground that the bill or request for reimbursement was submitted to the department after the individual was discharged from the facility. In calculating the fixed-cost component of per diem rates for nursing facility services, the department shall exclude days of service for which reimbursement is provided under this subparagraph.

Sec. 7. 22 MRSA §3174-I, sub-§1, ¶¶H and I are enacted to read:

H. In determining Medicaid eligibility pursuant to this subsection and providing for assessments of the medical and social needs of applicants and residents, the department may not delegate or designate contractors or persons other than the affected nursing facilities to perform the required assessments and the department may not employ contractors or other designees to make eligibility determinations on the basis of the assessments performed.

I. In prescribing the manner in which assessments are to be carried out, recorded and reported pursuant to this section, the department shall adopt rules no later than October 1, 1997 for a single assessment instrument, including forms and protocols, that may be completed and followed by facilities and the department to both determine resource use and resident condition in calculating reimbursement and determining eligibility.

SUMMARY

This bill eliminates occupancy-related penalties applied to nursing facilities with 60 or fewer beds in the reimbursement principles. It corrects a technical reading of the days awaiting placement provision of the statute. It eliminates reductions in payment currently used as a means of sanctioning facilities for paperwork errors. It requires that the forms now used to calculate case mix adjustments for payment purposes and the forms used to determine medical eligibility must be combined, so that a single set of forms and protocols is required for both purposes. It requires that nursing facilities perform these assessments in accordance with guidelines by the Department of Human Services. It requires the department to provide a means for facilities to gain access to meaningful data concerning quality and efficiency.