120th MAINE LEGISLATURE

FIRST REGULAR SESSION-2001

Legislative Document **No. 1514**

S.P. 461 In Senate, March 8, 2001

An Act to Ensure Fairness in the Regulation and Reimbursement of Nursing Facilities.

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

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator MARTIN of Aroostook.
Cosponsored by Representative KANE of Saco and
President MICHAUD of Penobscot, Representatives: ANDREWS of York, LAVERRIERE-BOUCHER of Biddeford, FULLER of Manchester.

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

Sec. 1. 22 MRSA §1812-H, as amended by PL 1993, c. 410, Pt. FF, §§4 to 7, is further amended to read:

§1812-H. Participation in the Medicare health insurance for the aged program

1. Medicare. Any nursing facility with more than 60 licensed beds that participates in the Medicaid program ~~must~~ shall participate in the Medicare health insurance for the aged program as a skilled nursing facility.

2. Compliance. Any nursing facility with more than 60 licensed beds required to participate in the Medicare health insurance for the aged program shall:

A. File an application to become a Medicare provider by January 1, 1994;

B. Follow required federal procedures for certification and become certified within 90 days of the department's recommendation for certification;

C. Submit an annual application for Medicare participation at the same time applications for licensure and Medicaid certification are due; and

D. Participate in the Medicare program by billing Medicare for care provided to eligible recipients prior to billing Medicaid.

2-A. Rules. The department shall adopt rules to implement this section. The rules must consider the unique needs of different parts of the State. Nursing facilities in different parts of the State may be required to certify different numbers or percentages of beds depending on the number of Medicare recipients in those areas, the number of patients in hospitals who are waiting for nursing facility admission and other relevant demographic information. Nothing in this subsection prohibits the department from requiring ~~all~~ nursing facilities with 60 or more licensed beds to certify ~~all~~ a portion, no greater than 20%, of their beds as Medicare skilled nursing facility beds.

2-B. Transition for facilities with 60 beds or fewer. After January 1, 2000, facilities with fewer than 60 licensed beds that have previously obtained Medicare certification may terminate their Medicare certification upon making necessary filings with federal Medicare authorities.

3. Sanctions. Failure to comply with any of the provisions listed in this section may result in the imposition of a penalty. The department may impose a penalty of $100 per bed for failure to comply with any of these provisions. This penalty must be imposed for each day a facility fails to comply with subsection 2, paragraph D. A repeated failure to comply with any provision results in fines of $200 per bed. The imposition and collection of these penalties are governed by section 7946.

Sec. 2. 22 MRSA §1817-A is enacted to read:

§1817-A. Coordination of state nursing facility inspection activities with federal requirements

1. Inspection process. In carrying out its inspection and correction authority related to licensed nursing homes, licensed assisted living facilities and other long-term care providers, the department shall comply with all pertinent requirements set forth in federal law and regulations, including, but not limited to, 42 Code of Federal Regulations, Part 488, even if the inspection or correction arises from or is carried out pursuant to state law.

2. Informal dispute resolution procedures. Consistent with applicable federal regulations, including 42 Code of Federal Regulations, Section 488.331, the department shall provide nursing facilities with an opportunity for informal dispute resolution prior to making a final determination or recommendation to authorities of the federal Health Care Financing Administration.

A. The initial statement of deficiencies must be issued by department staff consistent with applicable provisions of federal regulations. The statement of deficiencies must set forth with particularity findings of fact upon which the alleged violations of state laws and rules and federal regulations are based. The statement of deficiencies must be issued no later than 5 business days following completion of the inspection.

B. In the course of this informal dispute resolution process, the affected facility must be afforded appropriate due process and fair opportunity to dispute the survey findings and must have access to related inspectors' notes and any other background material necessary to understand the basis of the proposed finding. The nursing facility may present witnesses, question state inspectors and present other evidence in support of its position.

C. When the department does not have final authority to determine and impose a civil monetary penalty or fine and its role is limited to recommending to the federal Health Care Financing Administration the imposition of civil monetary penalties, the Director of the Division of Licensure and Certification shall directly participate in the informal dispute resolution process and hear and carefully consider all evidence and information presented by the facility and is responsible for making the final recommendation to the federal Health Care Financing Administration.

D. The department shall ensure that the informal dispute resolution process is carried out in a timely fashion to give the facility adequate time to prepare its case and, consistent with the provisions of this section, in sufficient time to permit the department to convey its findings and conclusions to the United States Department of Health and Human Services within any time limits set forth in federal regulations.

3. Administrative hearings. When the department has final authority to determine the amount of and finally impose civil monetary penalties under federal law and regulations or fines under state law and the department is not merely making recommendations to the federal Health Care Financing Administration, the department shall also provide informal dispute resolution mechanisms and shall follow the applicable provisions of subsection 2 prior to making a final determination of the amount of the civil monetary penalty. In addition, the determination of the amount of the civil monetary penalty or the fine by the Director of the Division of Licensure and Certification is not final, but rather is subject to a de novo hearing upon request of the affected facility under applicable provisions of the Maine Administrative Procedure Act governing adjudicatory proceedings. The hearing officer for an appeal must be an individual who is not employed by the department.

4. Use of civil monetary penalty funds. The department shall make application and seek approval for appropriate waivers from the federal Health Care Financing Administration in order that any civil monetary penalties collected from nursing facilities may be returned to those facilities and used by them to remedy deficiencies and improve care. Authorized expenditures may include, but are not limited to, salaries and benefits for nursing facility staff involved in the direct care of residents. The department's waiver request to the federal Health Care Financing Administration must also request authority from the Health Care Financing Administration to permit nursing facilities to be relieved of the obligation to pay civil monetary penalties

in circumstances in which those facilities demonstrate that they will apply significant financial resources to remedy the identified deficiencies.

5. Relationship to certificate of need findings. A determination or recommendation by the department to impose civil monetary penalties or fines on a particular nursing facility that is owned or controlled by or affiliated with a nursing facility management or ownership corporation or other legal entity that owns or manages other nursing facilities may not, by itself, be sufficient to disqualify that nursing facility ownership or management entity from obtaining subsequent certificates of need or management contracts with respect to other nursing facilities or other health care institutions. In carrying out the certificate of need program and related activities, the department shall give due accord to the entire management record of the nursing home ownership or management entity for purposes of making findings as to whether or not the entity is fit, willing and able to undertake an additional certificate of need or management responsibility.

Sec. 3. 22 MRSA §3174-I, sub-§4 is enacted to read:

4. Cost of care determinations and adjustments. The department may carry out periodic adjustments to an individual Medicaid recipient's cost of care consistent with this subsection and applicable federal laws and regulations.

A. To the extent reasonably practicable, the department shall determine, on a prospective basis, the Medicaid cost of care of an individual Medicaid recipient residing in a nursing facility or other health care institution, referred to in this subsection as "a health care institution." The department shall simultaneously determine:

(1) The amount of the Medicaid payments to be paid to the health care institution; and

(2) The amount of the income and other resources that the individual Medicaid recipient and the recipient's spouse may retain for their personal use.

B. When it is not reasonably practicable for the department to make its initial cost of care determinations effective prior to the beginning of a particular month, the department shall make its initial determination as soon as practicable thereafter and that determination may be effective retroactively for up to 3 months prior to the date of the determination.

C. The department shall make monthly prospective Medicaid payments to the health care institution for care rendered to each Medicaid recipient in accordance with the cost of care determination it has made in accordance with paragraph A or B.

D. When the department has already made an initial determination pursuant to paragraph A or B and the department subsequently determines to adjust that determination in a manner that reduces the cost of care amount that is paid to the health care institution by the Medicaid program, the department may not retroactively reduce the amount of the Medicaid payment to the health care institution unless the individual Medicaid recipient, or the recipient's responsible party, has paid to the health care institution the additional amount for which the individual is determined responsible following the department's redetermination.

E. The department, and not the health care institution, has the obligation to recover from the individual Medicaid recipient the amount by which the previously determined Medicaid cost of care payment has been determined to exceed the amount of Medicaid benefit that individual is entitled to receive.

F. When the individual is not able to pay the increased amount to the health care institution, the department may not recoup from the health care institution any portion of the Medicaid payments the department was obligated to pay to the health care institution based on the prior determination. When the individual Medicaid recipient residing in the health care institution is unwilling or unable to pay the additional amount, the Medicaid program continues to be responsible for the full amount of the originally calculated cost of care portion that was allocated to the Medicaid program pursuant to that prior determination.

Sec. 4. Alternative process for compliance with federal requirements. The department shall, prior to November 30, 2001, carry out a study to evaluate the feasibility under applicable federal regulations of an alternative regulatory scheme for imposition of fines and penalties. The department shall seek appropriate input from affected parties, including, but not limited to, consumers, nursing facility residents, representatives of nursing facilities and other advocacy groups. The department shall explore the implementation of an alternative scheme modeled on voluntary

safety programs carried out by the Department of Labor. Under such an alternative approach, a nursing facility that voluntarily participates in such a program would work with department inspectors to increase its compliance with applicable regulations and related standards. Voluntary participants who comply with the program's requirements are exempted from the imposition of civil monetary penalties and other fines during participation. The department shall address the constraints that may be imposed by federal law and regulation and shall consider the feasibility of waivers or pilot projects and make appropriate recommendations. The report must be filed with the Joint Standing Committee on Health and Human Services on or before November 30, 2001.

SUMMARY

This bill addresses several rules and practices of the Department of Human Services that hamper the ability of nursing facilities to provide cost-effective care and meet the needs of their residents, while receiving fair compensation for the costs of doing so. The bill provides a fair and orderly process for resolving disputes that arise when the department's Division of Licensure and Certification inspects and finds deficiencies in nursing facilities. The bill requires the department to follow the same procedures in the case of deficiencies with respect to state law that are followed in the case of deficiencies with respect to federal law. In addition, it provides for a fair and objective review of determinations made by the Director of the Division of Licensure and Certification. It also requires the direct involvement of the director in making recommendations to federal authorities with respect to the imposition of penalties. It also requires the department to study the feasibility of an alternative regulatory scheme for fines and penalties. This bill directs the department to weigh the entire management record of a management entity and not just particular deficiency findings in the overall assessment of an applicant's fitness for a certificate of need.

Because small nursing facilities may find it impracticable from both a financial and patient-care perspective to provide all of the services necessary to qualify for Medicare certification, the bill allows small facilities to choose not to participate as Medicare certified skilled nursing facilities. Small facilities are defined as those with 60 beds or fewer, consistent with other provisions of the Medicaid program that recognize facilities in this size range as requiring special attention.

The bill addresses the problem that arises when cost of care determinations affecting particular Medicaid beneficiaries are

delayed because information is unavailable to the department and the facility. The bill prevents the department from imposing on the facility the cost that should be borne by the resident of the facility, when that resident's obligation to pay for a portion of the cost of care changes due to change in circumstances that affects eligibility for coverage.