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THE REPORT OF MAINE'S LONG TERM CARE STUDY

MARCH 1986

"Let us think . . . of values, of myths, of solutions, and the wonders that could emerge from a society which truly committed itself to the vitalization rather than the institutionalization of its elders and disabled."[1]

MEMBERS OF THE JOINT SELECT COMMITTEE

Representative Merle Nelson, Chair
(Human Resources)

<u>Senators</u>

Georgette B. Berube*
(Human Resources)

Beverly M. Bustin
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Charles G. Dow*
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Susan J. Pines
(Human Resources)

*Senator Berube and Senator Dow were reassigned to other Joint Standing Committees in January 1986, but remained active on this Joint Select Committee until the report was completed.

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RECOMMENDATIONS

1. ESTABLISH A SINGLE, COMPREHENSIVE, STATE-WIDE PLAN FOR LONG TERM CARE, DEVELOPED AND REVISED BY AN INDEPENDENT ORGANIZATION.

2. EVALUATE THE IMPLEMENTATION OF THE CURRENT POLICY OF BALANCED GROWTH IN LONG TERM CARE.

3. INCREASE THE RESOURCES AVAILABLE IN ORDER TO INCREASE ACCESS TO THE LONG TERM CARE SYSTEM.

4. APPROVE AND FUND A MINIMUM OF 270 NEW ICF BEDS AND REEVALUATE METHODOLOGY USED TO DETERMINE BED NEEDS.

5. EVALUATE REIMBURSEMENT POLICIES, DEVELOP ELIGIBILITY ADVOCACY PROGRAMS, AND CONSIDER HOSPITAL BED USAGE, IN ORDER TO ADDRESS ACUTE SHORTAGE OF SNF BEDS.

6. REEVALUATE THE ADEQUACY AND EFFECTS OF THE PROSPECTIVE REIMBURSEMENT SYSTEM.

7. A REEVALUATE THE CURRENT RULES CONCERNING THE VALUATION OF ASSETS UPON SALE OF A NURSING HOME, INCLUDING THE EFFECT OF THOSE RULES.

8. EVALUATE LONG TERM CARE SCREENING TO INCREASE ITS UTILITY IN MAINE'S LONG TERM CARE SYSTEM.

9. EXPLORE THE POSSIBILITY OF UTILIZING HOSPITAL BEDS FOR LONG TERM CARE, INCLUDING THE USE OF "SWING BEDS".

10. REEVALUATE THE CURRENT LEVEL AND SKILL REQUIREMENTS OF ALL LONG TERM CARE STAFF AND OF THE ADEQUACY OF STAFF WAGES. REQUIRE GERIATRIC AND GERONTOLOGY TRAINING FOR ALL LONG TERM CARE STAFF DEALING WITH THE ELDERLY.

11. CONTINUE EFFORTS TO EXPLORE THE POSSIBILITY OF LONG TERM CARE INSURANCE AS AN ALTERNATIVE METHOD OF FUNDING LONG TERM CARE.

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INTRODUCTION

Purpose of the Study

The 112th Legislature, during its First Regular Session, enacted a "RESOLVE, to Assess the Current and Projected Needs of Maine citizens for Additional Nursing Care Services" (Chapter 47, Resolves 1985. See appendix A for complete text.) This Resolve established a Joint Select Committee on Nursing Care Needs, composed of 9 members of the Legislature as follows: 5 members of the Joint Standing Committee on Human Resources, 2 members of the Joint Standing Committee on Appropriations and Financial Affairs, and one Representative and one Senator appointed at-large.

The purpose of the study was to identify the population age classifications through the year 2010 and determine the medical and nursing needs of those classifications. The committee was authorized to recommend any legislation necessary to meet the needs of those populations and to make other necessary provisions for care. In addition, the committee was to examine how those needs can best be met, the projected costs of those needs, the reimbursement policies of the Department of Human Services, the relationship of the reimbursement policies to the construction of new beds and the provision of services, the rate of return on capital investment of nursing home owners and other service providers and what policies determine that rate, and alternative methods of reimbursement (including the "fair rental" method of determining the value of services.)

The Committee determined that to carry out its responsibilities it would be necessary to examine Maine's long term care system for all Maine citizens, the projected population which would be utilizing the services of Maine's long term care system, and how the needs of that population were being met and could best be met in the future.

Long Term Care Defined

Long term care has existed in one form or another for as long as human beings have suffered from chronic illness and disabilities. At first long term care consisted of what you could do for yourself and what your family could do for you. Beginning in the 16th century, governments, employers, and social service organizations helped ease the burden on the individual and the family. Today there is a vast array of services available to deal with those who need long term care. Unfortunately, the efforts to deal with long term care are largely uncoordinated and are becoming woefully inadequate to deal with the complex and rapidly increasing needs of our

long term care population. The long term care system involves the population being served, the programs or agencies providing that care, the varied services being provided, and the funding sources for those services.

The complexity of the long term care system has made it difficult to define. For the purposes of this study, the committee adopted a broad definition of long term care which had been used as the definition of long term care at the American Health Planning Association - Veterans Administration (AHPA-VA) Conference on Long Term Care held in Washington, D.C. during September, 1984.

> "Long term care refers to the range of health and social services for persons who are so functionally disabled that they require assistance in activities for daily living. Activities for daily living include personal care (such as bathing, dressing, and eating) and actions for independent community living (such as shopping, housekeeping, and managing money). Functional disability may be due to either a chronic physical or chronic mental condition. The care, either continuous or intermittent, is required for an extended period of time, hence the label "long term". Long term care can be provided by either a formal organization or family and friends. It includes the areas of health care, social services, housing, transportation, income security, and jobs."[2]

Committee Procedure

The Committee met during the Fall of 1985 and the Winter of 1985-86. During the course of its proceedings, it conducted many meetings involving various state and private agencies and organizations, as well as individuals, involved in the long term care system. In addition to oral testimony received at the meetings, specific written questions were submitted to all interested parties. A summary of those questions and responses is contained in Appendix B.

The Committee determined that the scope of the study was too complex a task to accomplish with the limited time and budget allotted to it by the Resolve. The issues raised in an evaluation of Maine's long term care system are extremely complex. The long term care system is multi-faceted, warranting the coordination of many discrete efforts. And finally, long term care is a dynamic discipline, responding to the changing population and their needs. A comprehensive attempt to address the long term care issues in Maine requires a continuing effort instead of a single committee of limited duration.

It is noted that the 1980 Governor's Task Force on Long Term Care for Adults took a year to complete. That Task Force conducted 24 meetings in the course of its study of long term care in Maine. This Committee recognizes and appreciates the pioneering effort of the Task Force when it undertook to perform one of the first studies of long term care in the United States. Many of the Task Force's recommendations have been met since that report; yet, many of its recommendations have still not been accomplished. This committee has found that report continues to be a timely resource for determining the long term care needs of Maine's citizens. This report is not meant to replace that Task Force report on Long Term Care, but to supplement it.

The committee deliberated on how best to meet its goals as established by the Resolve. In view of the dynamic nature of long term care, we have recommended a unified state-wide long range planning procedure for long term care in Maine to provide a continuing focus on all long term care issues. In addition, we have identified several specific issues as particularly significant. This report discusses each of those issues.

Long term Care Goals

The committee recognizes the diversity of the long term care population and the variety of needs that population exhibits. Within this broad range of long term care users and their needs, there are certain goals common to all. Accordingly, this committee finds that the long term care system should:

1. maximize the independence of the individual in performing the activities of daily living;

2. provide multiple access to long term care services;

3. permit easy movement among levels and types of care, according to the needs of each individual;

4. maximize the quality of life for each individual in the long term care system;

5. provide appropriate cost-effective care in the least restrictive setting; and

6. provide support for the family and friends who are an active part of the long term care support system.

POPULATION PROJECTIONS OF MAINE CITIZENS OVER AGE 65

In 1980, Maine had 141,000 persons aged 65 or older. This figure represents 12.5% of the total population of Maine or approximately one in every eight persons. Maine ranked 11th nationally in the percentage of persons 65 and older as a proportion of state population.

Maine also has a higher number of persons age 85 and over. In 1980, 10% of all Maine persons over the age of 65 were in the 85 and older age cohort. Nationally, the figure is only 8.8%. In 1985, Maine ranked 6th nationally in the percentage of persons 85 and over as a proportion of the population age 65 and older.[3]

The percentage of older persons as a proportion of state population is expected to grow in the future. During the late 1990's, the rate of growth is expected to decrease because fewer babies were born during the depression. However, the rate of increase is expected to peak between 2010 and 2030 when the "baby boom" children reach age 65.

In 1980, 32.1% of the population over 65 lived in two counties, York and Cumberland. These two counties contained 31.6% of the state's population.[4]

The Division of Data and Research in the Department of Human Services has projected Maine's elderly population through the year 2010 by sex and age cohorts. The most rapid increase over the next 25 years will take place in the age 75 and older categories. In other words, the old will get older. (A detailed copy of the projections is contained in Appendix C.)

Any population projection is at best a crude attempt to speculate, based on the available data, future trends. "The accuracy of population projections cannot be determined in any precise way except, of course, after the fact. Projections of future population can only be evaluated in approximate terms, by looking at the logic of the projection method and at how well that method has worked in the past."[5] With that qualification, the committee feels that the information we have obtained is the best indicator available of the population projections for Maine citizens over age 65. This committee is not suggesting that the population figures are exact. The projections are, however, a useful tool to determine population trends.

LONG TERM CARE NEED PROJECTIONS

If it can be said that the population projections are inexact, it is infinitely more difficult to determine the health care needs, particularly the long term care needs, for the future. The population group in need of long term care services does not consist of only the elderly. It includes people of all ages who are physically disabled, chronically mentally ill, mentally retarded, and developmentally disabled. One source estimates that one-half the people in need of long term care are under the age of 65.[6]

One difficulty in obtaining any statistical data concerning the long term care population is that much of the data is gathered from the viewpoint of individual programs and not from the viewpoint of individuals. Some people may fall into more than one category and may be counted two or more times, once in each program in which they are included. On the other hand, some individuals who are listed as having a severe chronic illness may not actually be in need of long term care because of their determination to function independently from the assistance of anyone else. The homeless, many of whom may be chronically mentally ill, are often not included in statistical data gathering for the long term care population. Some chronically mentally ill spend their time in and out of local jails, never appearing on a statistical analysis of who needs long term care. Information on non-institutionalized individuals who utilize some form of long term care is not available, even for the elderly. Nursing home care data, although more available, still contains many unknowns concerning the characteristics of that population, e.g. do nursing homes house a fairly large population of one-time users or a smaller group of repeat users.

In spite of the lack of hard data on the long term care population and projections of future need, some generalizations may be useful concerning the long term care needs of the elderly. Institutionalization increases markedly as people get older. 5.8% of the individuals 65 years and older are estimated to be residents of long term care facilities. A recent survey showed that 63% of the Skilled Nursing Facility residents, 93% of the Intermediate Care Facility residents, and 65% of the board care residents are elderly.[7] In Maine, 26.6% of the people 85 years of age and older were in nursing homes in 1980.[8]

Even these generalizations are of limited value in projecting future needs. It is a common mistake to treat the elderly as a homogenous group when in reality they are as diverse as the general public. The need for long term care is spread unevenly, even among those over age 75. In addition, there is an intense debate in the scientific community over the future patterns of disability for the elderly. Some

gerontologists have argued that the elderly will be healthier in the future than they are now and will need less in the way of long term care.

This committee does not have the expertise nor is it the proper forum to determine the projected long term care needs of future populations. However, it is safe to say that the long term care needs of Maine's citizens will continue to increase in the future, even though the precise extent and nature of those needs cannot be determined at this time.

STATE-WIDE LONG TERM CARE PLANNING

The long term care system is designed to serve individuals with a wide diversity of physical and mental disabilities. A variety of long term care providers are needed to meet this need. In addition, the long term care system is characterized by constant change. The population in need of long term care, the types of services available, and the best way to meet those needs all present dynamic problems requiring responses flexible enough to meet the changing needs. This complex system of care is ill-coordinated. Long term care is characterized by conflicting and fragmented mandates, policies and programs.

In 1980, the Governor's Task Force on Long Term Care recommended that "a single State Long Term Care Plan for addressing the long term care needs of individuals" be developed and revised every two years. The Department of Human Services and the Department of Mental Health and Mental Retardation were to be responsible for developing and updating the plan. The plan was to be submitted to the Legislature every two years beginning in 1983. This recommendation has never been implemented.

The State of Maine still does not have a clearly articulated, comprehensive plan for long term care. Repeatedly during the course of this study, advocates for the long term care population and providers of long term care services have advised this committee that there is a lack of a coherent, comprehensive long term care policy at the Federal or state level.

State agencies and private organizations are involved in many excellent efforts to provide quality long term care services. Numerous dedicated individuals have given their time and talents to develop their particular part of the long term care system. Yet, there is no systemic effort being made to coordinate these services to meet the needs of the long term care population. There is no state wide long term care plan available to the Legislature when it is asked to fund the individual pieces of the long term care puzzle. This must inevitably result in a duplication of effort and inefficient utilization of human and financial resources.

The committee finds that there is an urgent need for a single, comprehensive, state-wide plan for long term care to coordinate the current long term care services and to evaluate and plan for the changing needs of the long term care population.

We recommend that one organization, independent from the Executive and Legislative branches of government, be responsible for developing a state-wide plan for long term care for Maine's citizens and for periodically revising that plan. That plan should include, but need not be limited to, an assessment of the long term care needs of the state and how those needs can be met and a recommendation of who should be responsible to meet those needs.

It is further recommended that the long term planning organization present that plan to both the legislative and executive branches of government at least every two years, with special reports as needed.

The committee has identified several specific areas of long term care that should be addressed in a state long term care plan as soon as possible. These items, which are discussed in greater detail later in the report, include:

1. An evaluation of the balanced growth policy, including an assessment of the cost of each type of long term care alternative;

2. Medicaid reimbursement rates, including their adequacy and the incentives they offer for access, cost containment, and quality of care;

3. General access to all forms of long term care;

4. Long term care screening; and

5. Hospital beds for long term care use.

The Maine State Health Coordinating Council (SHCC) is an independent agency which is currently responsible for health planning in general in the state. As part of its general health planning responsibility, SHCC has recently formed a Long Term Care Subcommittee to develop a systematic plan for intermediate care and skilled nursing facilities. We recognize and support their initiative in long term care planning.

We strongly recommend that the Maine State Health Coordinating Council assume responsibility for developing, on a continuing basis, a state health plan as outlined in this section for long term care. This could be a natural extension of its current role in developing a state health plan and an extension of their current efforts concerning long term care planning.

The Committee urges the SHCC to formally assume this responsibility and to initiate a biennial report to the Legislature and the Executive on Maine's long term care needs. Since the SHCC would be submitting its report to both the executive and legislative branches of government, this committee feels that it is crucial, at least in its development and revision of a long term care plan, for SHCC to develop a staffing arrangement that is structurally independent of the executive and legislative branches of government. We understand that the SHCC is currently evaluating the issue of independent staffing and hope they will review our concerns for independent staff in regard to any long term care planning they choose to undertake.

The SHCC is not a legislatively created organization. To a certain extent the SHCC and its functions are a result of Federal legislation. In view of the relationship of the SHCC to the Federal government, this committee has not prepared legislation to mandate the SHCC become the long term health care planning organization. We have, however, sent a letter to the SHCC strongly urging them to formally assume this role. A copy of that letter is contained in Appendix D.

A POLICY OF BALANCED GROWTH

This state is currently pursuing a policy of "Balanced Growth" for the development and funding of the long term care system. Balanced growth can best be described as the intentional effort of the state to encourage, develop and fund, to the extent possible, a balance of all types of long term care services, based on the need for those services without overemphasizing any particular type of service.

This committee believes that a balance of institutional and noninstitutional services is the most desirable and the most feasible means of best meeting the growing needs of the long term care population. The committee, however, is concerned that the policy of balanced growth is not being implemented aggressively. The committee finds that no money was appropriated for nursing home facilities during the First Regular Session of the 112th Legislature and that an insufficient amount of funding was appropriated for alternative programs. In addition, the Governor's budget document submitted to the Second Regular Session of the 112th Legislature deappropriates over 3.5 million dollars from the Intermediate Care Account.[9] This deappropriation represents money the Department claims is not needed, for a variety of reasons, for payments for nursing home care. Unfortunately, the money is removed completely from any other type of long term care and reappropriated for other programs. We fear that this disregard for long term care needs can turn a balanced growth policy into one of no growth.

Accordingly, we strongly recommend that the implementation of the long term care policy of balanced growth be evaluated by an independent agency, preferably the same organization which is responsible for the long term care planning for the state (SHCC). As a part of that evaluation, this committee recommends that those individuals who are self-paying recipients of long term care be included in the assessment of need and that the self-care communities be included in the assessment of the providers who are meeting the long term care needs of the state.

ACCESS TO APPROPRIATE CARE

Ideally, the long term care system should provide multiple access to long term care services and should permit easy movement among levels and types of care, according to the needs of each individual. The most highly sophisticated and well coordinated long term care system is of no use to an individual who does not have access to that system.

The committee finds that the major problem in providing access to care for individuals in need of long term care services is the lack of resources for these individuals. The lack of long term care facilities and other services and the lack of sufficient funding to bring additional services "on-line" will only increase the difficulty for an individual seeking access to long term care as the long term care population increases.

The committee finds that the ability of the long term care system to meet present and future needs of the long term care population will require the combined effort of the state, local and other sub-state governmental bodies, local communities, private service providers, charitable organizations, family and friends who provide support services, and the long term care population itself. This committee urges all those involved to aggressively pursue a solution to the long term care problems before it is too late.

The committee is also concerned about access to care for Medicaid patients. During the First Regular Session of the 112th Legislature, legislation was introduced to prohibit discrimination in admissions to nursing homes based on whether the potential resident was Medicaid funded or private pay. The committee does not condone discrimination against Medicaid patients and supports the effort to ensure equal access to care for all of the long term care population regardless of the source of payment for those services. We further note that discrimination can also occur from many varied sources other than the structure of the reimbursement system. We condemn all forms of discrimination, regardless of the source.

INTERMEDIATE CARE FACILITY BEDS

As of February 7, 1986, Maine had 145 Intermediate Care Facilities with a total of 9,629 ICF beds. This total includes state beds at the two Mental Health Institutes and federal beds at the Togus facility. There are currently 140 beds which have received Certificates of Need, but are not yet ready to receive residents. (Source: Office of Health Planning and Development.)

Approximately 80% of the residents in nursing homes are funded by Medicaid payments. Maine has chosen to fund ICF beds prospectively. The prospective payment system will be discussed in greater detail later in this report. It should be noted, however, that the current prospective payment system requires the state to approve the authorization of any new beds by committing itself to fund the residents who will be in those beds and who will be utilizing Medicaid as a source of payment prior to Certificate of Need approval. Thus approval of new ICF beds is tied directly to authorization of funding in the state budget.

Within the current policy of balanced growth, the criteria for approval and funding of Intermediate Care Facility (ICF) beds includes:

1. that the need for new beds be balanced with the need for alternative forms of long term care;

2. that the "need" for new beds be balanced against the "affordability" of new beds to determine not only how many beds are needed, but how many the state can afford;

3. that the growth of ICF beds be gradual and predictable rather than adding a large number of beds at one time. This is to avoid low occupancy rates, increased labor costs and financial hardships.

The committee endorses the current policy of balanced and gradual growth. We are concerned, however, that recently the policy appears to be implemented in such a way that has created a "no growth" situation instead of "gradual growth." This committee has heard testimony from state agencies, service providers, and advocacy agencies that there is a desperate need for additional ICF beds in Maine. There are growing numbers of individuals in need of long term care who are waiting to obtain a place in a nursing home. Access to care is being denied because of the lack of available spaces.

Based on its analysis of affordable need, the Bureau of Medical Services recommended an additional 180 ICF beds be placed on line by 1988. A two or three year delay in approving and constructing these new beds requires that these beds be approved legislatively in the 1985-1986 biennium. As a part of the Executive budget process, the Department of Human Services recommended that 180 new beds be included in the budget request for the First Regular Session of the 112th Legislature. The Governor, of course, determines the number of new beds actually included in the budget request after evaluating all the budget requests from all the departments. This determination is based partly on the impact on the State's Medicaid budget.

Unfortunately, no provisions for new beds were included in the Governor's budget request during the First Regular Session of the 112th Legislature (1985). Although a preliminary determination of need had been made, this need assessment had not been transmitted to the Legislature. With no budget request for new beds and no Legislative knowledge of the need for new beds, there was no provision for funding new beds made in the 1985 budget. The committee was disappointed that it had not received any information on the need for new ICF beds, even if the Executive branch was recommending that the limited state funds be utilized elsewhere.

Unless immediate action is taken, the shortage of ICF beds will increase and the access to care will be denied many individuals in need of nursing home services. The original recommendation for the 1985-86 biennium was for 180 new beds - an average of 90 new beds per year. That recommendation was never presented to the Legislature. Another year has gone by, increasing the need for ICF beds by an additional 90 beds (based on last year's average annual projected need). This committee recommends that the state commit the necessary funding to allow for Certificate of Need approval for 270 new beds (180 plus the additional 90) during the next year. Legislation accompanying this report will be introduced to accomplish that. (See Appendix E.)

The committee hopes that implementation of the its recommendation to authorize an independent agency to develop and periodically revise a long term care plan for the state will create a means for the Legislative branch, as well as the Executive branch, to receive adequate data concerning the long term care needs of the state. This will better enable the legislature to appropriately evaluate the adequacy of the state's long term care efforts and take appropriate action as necessary to meet that need consistent with a policy of balanced growth.

It is difficult for this committee to determine the actual number of new ICF beds needed, regardless of the number of beds the state can afford under a balanced, gradual growth policy. One detailed report received by the committee indicated a need, based on the 1980 use ratio, for 1,300 new ICF beds by 1990.[10] The Department of Human Services has only recommended 180 new ICF beds by 1990. The committee is not sure that its recommendation of 270 is an adequate figure, based solely on the need for additional beds. Whatever the real number is, we are sure of one thing: there is a present, urgent need for additional ICF beds in Maine.

This committee strongly urges the Department of Human Services to reexamine its methodology in determining the need for ICF beds.* We recommend that the initial determination of need be distinguished from the number of beds which the state recommends be authorized based on the need for balanced, gradual, affordable growth. The committee requests that the Department make the results of this evaluation known to the Joint Standing Committee having jurisdiction over human resources.

The Committee has two additional concerns regarding ICF beds. First, we recommend that other methods of providing ICF beds be explored in addition to new construction. The conversion of acute care hospital beds to ICF beds may actually provide a more immediate response than new bed construction can. We strongly urge the Department to seriously evaluate this possibility. Hospital beds for long term care use is discussed later in this report.

Second, some members of the committee expressed concern regarding the geographic distribution of ICF beds and would encourage the Department to approve new beds in areas of greatest need.

SKILLED NURSING FACILITY BEDS

Skilled nursing facilities (SNF) are designed to provide a less costly alternative to hospitalization for individuals who require less care than an acute care hospital, but more than an intermediate care facility. As the name implies, skilled nursing facilities provide skilled nursing services or other

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* Just prior to completion of this report, the department advised the committee that it recognizes the methodology is outdated and is reevaluating that methodology. Our committee is pleased with this initiative and looks forward to progress in this area.

skilled rehabilitation services. Maine currently has 454 licensed skilled nursing facilities. 262 of these are in freestanding facilities and 192 are based in hospitals.[11]

There is a universal agreement among everyone in the state that there is an intolerable shortage of SNF beds in this state. In 1982, Maine had 58 ICF level beds per 1,000 population over age 65 and only 3.3 SNF level beds per 1,000 population over age 65.

SNF beds require more labor and more skilled care and are costly to operate. The Federal Department of Health and Human Services (DHHS) Draft Report To Congress On Medicare's Skilled Nursing Facility Benefit (April, 1985) identified a national average cost for freestanding SNF beds at $48 per day and for hospital based facilities at $95 per day.*

The DHHS draft report found that "The current retrospective, reasonable cost reimbursement system contains no incentives for facilities to admit Medicare or heavy care patients." (DHHS Draft Report p. 10.) It indicated that the reimbursement system provided strong incentives for SNFs whose costs were in excess of the reimbursement levels to admit patients who required less care in order to reduce costs. In addition, some facilities declined to participate in Medicare, creating "inadequate access and costly hospital back-up of patients awaiting nursing home placements." (DHHS Draft Report, p. 10.)

Testimony before this committee reinforced the inadequacy of the reimbursement system and suggested that it actually discouraged the development of SNFs. Operators of Skilled Nursing Facilities are looking for other places to invest their capital.

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* The report identified several possible reasons for this cost differential: differences in patient casemix, quality of care, efficiency of operation, overhead allocations, and staffing (e.g. it appeared from data that hospitals provided more rehabilitation services than freestanding facilities.) The cost differentials were less for rural areas than urban localities. The report indicated more studies were necessary to isolate the specific reasons for the cost differentials more accurately. DHHS is currently sponsoring more research. (pp. 14-15 of the DHHS Draft Report.)

The committee has further noted that Federal Medicare and Medicaid both provide reimbursement for SNF care, but the eligibility and benefits are substantially different. These differences in the administration of the programs has potentially resulted in a disproportionate number of SNF placements being paid for by Medicaid (instead of Medicare.) Individuals not eligible for Medicaid, but in need of skilled nursing care, find themselves denied Medicare also. As the Department of Human Services has noted: ".. persons with Medicare Health Insurance, that is the elderly and disabled, are being denied a benefit to which they are entitled because of the unavailability of the service. Many persons, therefore, are sent to ICF's and if not Medicaid eligible, they have to pay out of their own funds for a benefit which they should receive."[12]

There are reports that many of these individuals in need of skilled nursing care are being incorrectly denied Medicare eligibility. "Nationally, many providers and state governments believe Medicare fiscal intermediaries are inappropriately denying reimbursement for skilled nursing care to a substantial number of beneficiaries....Some states...have established state supported agencies which help those Medicare eligible who are denied SNF coverage file appeals of the Medicare fiscal intermediary's denials."[13]

This committee recognizes the acute need for more SNF beds, and recommends the reimbursement rates and system be carefully reevaluated. This committee also recommends programs be considered in Maine such as those in other state which advocate for potential recipients who have been denied eligibility. We feel that the state organization which is to be responsible for long term care planning would be the appropriate agency to address these issues.

The committee wishes to note that underutilized hospital beds may serve as a potential source of additional SNF beds. The use of hospital beds for long term care is discussed later in this report.

MEDICAID REIMBURSEMENT RATES

Medicaid has become the "principal public financier of both long term care for the elderly and disabled and institutional care for the mentally retarded"[14]

Currently this program, administered by the Department of Human Services, utilizes a prospective payment system. "The Department establishes a prospective per diem rate for ICF's which it has determined to be reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformity with applicable State and federal laws, regulations and quality and safety standards."[15]

The Department has advised us that the rate includes the level of care residents of nursing homes are receiving by taking into account the level of staffing skills needed in that nursing home to adequately care for the needs of the residents in that home. A percentage factor for profit is not included in the prospective payment system, although the rate structure includes a factor for the salary of the owner-operator. There are three ways that additional "profit" can be realized by the nursing home operator: the return on equity upon sale of the nursing home, and, in some instances, an ongoing allowance for equity; the amount over the Medicaid rate that private pay residents are charged; and any cost savings realized by the nursing home.

Cost savings are shared by the nursing home and the Department. Sixty-seven nursing homes (63%) had savings in fiscal year 1983, the first year of the prospective payment system. Cost overruns are not reimbursable. The department establishes a ceiling on reimbursement for each facility.

Since the rates are set prospectively, the operator knows in advance how much money he or she has to spend over the coming year. This system provides a cost-control incentive since the operator knows that no more than the pre-specified amount will be paid. This incentive of awarding efficient operators must be balanced against the fact that residents are sicker and more dependent on nursing home services than ever before. The prospective cost estimates may not reflect the actual money spent to provide an adequate level of services. Some operators may be tempted to reduce their expenditures by reducing their food and staffing costs.

The committee has heard testimony that the current Medicaid rate of reimbursement is inadequate. The Health Policy Unit of the Human Services Development Institute is currently examining the impact of the prospective reimbursement system on nursing home care in Maine. It is conducting "A Longitudinal Study of the Impact of Medicaid Prospective Reimbursement on Nursing Home Care in Maine." This study "has three major objectives (1) to examine the design, implementation and administration of Maine's nursing home prospective payment system; (2) to evaluate the impact of the payment system on the cost of nursing home care, access to care for Medicaid patients and the quality of care: and (3) to evaluate nursing home response over time to that change in Medicaid reimbursement policy."[16]

Preliminary data from that report indicates that in the first and second years of the prospective payment system approximately 50% of the nursing home facilities experienced savings, while approximately 25% broke even and the remaining 25% experienced losses. (In this context savings and losses reflect a difference between actual costs incurred and actual costs reimbursed.)[17]

The HSDI study is evaluating the effects of Medicaid prospective reimbursement by examining data for a three year period before and a three year period after the implementation of the prospective reimbursement system. We believe this report will be extremely helpful in analyzing the effect and adequacy of the Medicaid reimbursement rates for nursing homes. We urge the Department to carefully review the results of that study along with changes and trends in the nursing home industry (such as the suspected increased level of care required for nursing home residents) as well as the effect of the reimbursement system on the quality of care. We recommend that the Department reevaluate its rate structure in relation to the above factors and determine if it is adequate.

NURSING HOMES: VALUATION OF ASSETS UPON SALE

The final report of the Governor's Task Force on Long Term Care for Adults (1980) recognized that certain "depreciation policies relating to nursing homes lend themselves to unsound and undesirable financial practices, and contain potentially undesirable features."[18] Under the Department of Human Services Principles of Reimbursement, depreciation and interest on long term debt were treated as an automatic "pass-through" expense for purposes of calculating the Medicaid reimbursement to nursing homes. Reimbursement for these expenses was based on the actual allowable costs. This practice made it extremely profitable for a nursing home owner to sell his nursing home and then repurchase it, each time at an inflated price. Under the reimbursement formula, the Medicaid reimbursement to the facility would have increased solely because of the higher selling price.

This increase in Medicaid rate is explained as follows. The formula used to calculate the rate is composed of fixed costs and variable costs. The fixed costs include depreciation on buildings and interest on long term debt and were basically passed on as an expense to Medicaid. The higher the depreciation and the higher the interest (both of which relate directly to a higher purchase price), the greater the Medicaid reimbursement would be.

The Governor's report did not find widespread evidence of that type of activity in Maine. However, since that report, there had been evidence of incidences of such artificial increase in the purchase price and consequent increased state obligation for Medicaid reimbursement.

This problem was not unique to Maine and had drawn national attention. In 1984, the Federal government amended the Medicare and Medicaid laws, with subsequent amendments to the Federal regulations, which limited the ability of state

Medicaid programs to recognize increases in the valuation of the capital assets of nursing home facilities that changed ownership. It established a second reimbursement limit on State Medicaid payment rates. (Prior to that change, the Medicare upper limit* was the only ceiling on State Medicaid payment rates.) The second limit basically provided that Medicaid payments for medical assistance "cannot reasonably be expected to increase solely as a result of a change in ownership, in excess of the increase which would result from applying Section 1861 (v)(1)(O) of the (Deficit Reduction) Act, to owners of record on July 18, 1984."[19]

Section 1861 (v)(1)(O) provided that for purposes of determining an appropriate allowance for depreciation and interest on capital indebtedness when a facility has changed ownership, the valuation of the asset (which had changed ownership) would be the lesser of the allowable acquisition cost of the asset to the first owner of record on or after July 18, 1984, or the acquisition cost of the asset to the new owner.

Maine's response to those regulations was to amend its Principles of Reimbursement to only account for a purchase price which was equal to the acquisition cost of the facility plus a factor for inflation or the actual purchase price paid by the new owner, whichever was less. (Maine had previously based its reimbursement on the actual purchase price.)

The effect of Maine's regulations was to severely limit reimbursement for capital costs, virtually eliminating bank loans for nursing home construction. Small entrepreneurs have been eliminated from purchasing nursing homes because of the inability to get capital. Entry into the nursing home market is now restricted to large organizations which have their own source of capital sufficient to construct new homes.

The Department of Human Services maintains that the specific regulations it has promulgated are mandated by federal law. The nursing home industry has indicated they feel that the states' have a range of responses which they may make to the changes in the federal law and Maine has chosen the most

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*Medicare upper limit is a limit upon payments to long term care facilities by state Medicaid programs which restricted those payments to no more than would be paid, in the aggregate, for those services under the Medicare principals of reimbursement.

restrictive response. The nursing home industry proposed an alternative capital cost reimbursement methodology upon the sale of a nursing home, A Fair Rental Valuation. This approach would be based on the current appraised value of the facility. The Health Policy Unit of the Human Services Development Institute (HSDI) completed a study of that proposal in May, 1985. As a part of that study, HSDI evaluated whether Maine could consider adopting a fair rental payment methodology. The study concluded that "It is clear from the review of federal regulation, that the implementation of a fair rental payment methodology as a substitute for the current cost-based reimbursement of capital related costs, is not precluded for the State Medicaid program, but is constrained by the stipulations of the Medicare upper limit requirement."[20]

In an follow up report to that study, HSDI analyzed 8 states which currently utilized some form of a fair rental value (FRV) reimbursement methodology. They concluded that "there are as many FRV systems as there are states implementing the systems. The room for variation is great and while many of the programs are too new to have explicit cost data available, it appears that the costs of such systems can vary substantially."[21]

It is clear to this committee that the State has some flexibility, although limited, in developing its capital cost reimbursement methodology. In view of the detrimental effect the current method appears to have on the nursing home industry's ability to finance nursing home construction, we strongly recommend that the Department review its current regulations concerning the valuation of assets upon sale of a nursing home. Part of that review should include a feasibility and financial impact assessment of any potential alternative methods.

Late in this study, the committee was advised that the Department and representatives of the nursing home industry had begun formal discussions of this issue. This committee applauds that effort and strongly encourages both parties to actively work towards a resolution which addresses the detrimental limitations of the current regulations without returning to the previous limitless method of automatically passing through any increased cost upon sale regardless of whether it realistically reflected the value of the asset.

The committee wishes to note that there is currently legislation in Congress which would amend the Federal laws and regulations concerning capital cost reimbursement methodology. This legislation would allow a reevaluation of assets at the time of sale of up to 50% of the increase in the construction index to account for increases in the value of the asset. It is not clear at this time what the final disposition of that legislation will be.

LONG TERM CARE SCREENING

Long term care screening is an assessment process conducted to determine an individual's functional abilities and needs for services and living arrangement. Long term care screening, utilized effectively, can avoid inappropriate placement of individuals in need of long term care and promote more efficient utilization of the long term care resources. Long term care screening is currently conducted by a variety of service providers and agencies. Those who provide that service may include, but are not limited to: boarding home staff, nursing home staff, area agencies on aging, hospital discharge planners, home health nurses, social workers, and physicians. A standardized form is currently being experimented with to provide uniform information for screening. There is currently no centralized effort to coordinate the screening process in Maine to avoid duplication of screening and to utilize the data received from the screening process.

The committee recognizes the importance of long term care screening and the necessity for an efficient and meaningful program in Maine. It is an important element in helping people seek and obtain long term care services. An effective screening program is the first step in obtaining access to care.

The committee recommends that data from long term care screening be made available to the agency responsible for long term care planning so it might be utilized for long term care planning in this state.

In addition, the committee recommends that the Department of Human Services study long term care screening and report its findings and conclusions to the First Regular Session of the 113th Legislature by January 15, 1987. This study should include, but need not be limited to the following:

1. Models of long term care screening programs in other states;

2. The advantages and disadvantages of a mandatory vs. a voluntary screening program;

3. Effectiveness and desirability of multiple entry points vs. a single entry point;

4. Desirability of screening for public pay individuals only or for both public pay individuals and private pay individuals;

5. The utility and methodology of coordinating multiple entry screening programs; and

6. Any recommendations for long term care screening in Maine, including recognition of the costs associated with that recommendation.

HOSPITAL BEDS FOR LONG TERM CARE

One of the phenomena of the changing health care system in Maine is the decrease in hospital inpatient utilization and the subsequent increase in unoccupied hospital beds. "In 1984, the average occupancy rate of the 4,800 beds among all 42 acute (care) facilities was 56% and during the first half of 1985 occupancy was not higher."[22] One way to address the underutilization of hospital beds and the need for long term care beds would be to use the acute care hospital beds for long term care.

When Congress passed the Omnibus Reconstruction Act of 1980, they authorized rural hospitals with fewer than 50 beds (or other hospitals with similar characteristics) to receive Medicare and Medicaid reimbursement for providing skilled, intermediate, or lower level care to patients who no longer required acute hospital services. Medicare certification for the utilization of acute care beds for long term care services requires that hospitals be able to meet the psychosocial and rehabilitative needs of the long term care patient. This requires specialized rehabilitative services (physical, occupational, speech, and hearing therapy); dental services; social services; patient's activities; discharge planning; and specific patient's rights for long term care patients. In Maine this certification would also require Certificate of Need approval by the Department of Human Services.

There are currently 413 beds (in 10 Maine hospitals) approved for skilled or intermediate long term care. However, nearly all Maine hospitals are managing long term care patients in an acute care setting. This is the result of "excessive acute care inpatient stays resulting from the inability to discharge patients to the appropriate level of post-acute care."[23] Intercept Associates was recently commissioned by the Southern Maine Association of Cooperating Hospitals (SMACH) to study days awaiting placement, i.e. the phenomenon of post-acute care patients waiting in the hospital for long term care services. They collected data from 7 of the 8 SMACH hospitals over a four month period in 1985. In that report they note that "the great majority of post acute hospital stays were caused be the unavailability of either ICF or SNF beds."[24]

In addition to the 413 beds currently designated for long term care, the Maine Hospital Association estimates that there are currently 521 additional beds potentially available for long term care.

One program under the Omnibus Reconstruction Act authorizes the certification of "swing beds" in hospitals. These beds could be utilized as acute care beds or long term care beds, depending upon the needs of the hospital. There are currently more than 200 hospitals in over 30 states that have been certified by Medicare to provide swing-bed services. The Robert Wood Johnson Foundation, starting in January, 1981, funded a swing-bed demonstration to promote the concept. Beginning in 1983 they awarded grants to 26 small, rural hospitals in 5 states to set up "models" of the swing bed concept. They have completed an initial evaluation of their project through September 1984 which shows the following results:

1. Utilization and discharge data: "Swing-beds were used mainly for skilled level patients (78%), whose post-acute care is covered largely by Medicare."[25] Upon discharge, 41% of the patients went home, 11% were discharged to a SNF, over 17% to an ICF, under 4% to a residential or custodial care facility, and over 14% went back to acute level care. About 10% of the swing-bed patients died while receiving swing-bed care.

2. Financial impact: "The financial impact of the swing-bed program on the grantee hospitals has not been documented at this point....However, (its) impact appears to be highly dependent on the time and resources required by the swing-bed patients, and how well the program is managed in terms of staff assignments and use of other personnel and supplies."[26]

3. Benefits to Patients: The hospital staff has reported benefits to all swing-bed patients. Some of the benefits identified are avoiding transfer to nursing homes long distances from their families and friends and remaining under the care of physicians and staff who are known to them.[27]

4. Specialized services: Hospitals in areas with the necessary special skills (rehabilitation, social, dental, etc.) required for certification have easily obtained that certification. Geographical isolated hospitals are more likely to have difficulty obtaining those skilled personnel or finding someone to contract with.[28]

5. Implementation problems: Implementation problems include adapting the nursing staff and other personnel to the new roles (outside traditional acute care roles) required, poor financial status of hospital that makes it difficult to hire additional personnel for restricted use, and educational needs of staff to adapt them to long term care setting and requirements.[29]

The study, concludes that the swing-bed program appears to be a way for small hospitals to meet the challenges presented by the rapidly changing hospital reimbursement environment (by providing a means to supplement acute care revenue) while helping alleviate the shortage or absence of nursing home beds in their communities.[30]

The Maine Hospital Association advocates increasing the utilization of hospital beds for long term care needs, both by permanent conversion from acute care to long term care and by utilizing the swing bed concept. In addition to the above noted benefits, the MHA indicates that increasing the use of hospital beds for long term care will shift the funding from the current (state supported) Medicaid funding of patients awaiting placement who are unable to find appropriate institutional care to (predominantly Federal) Medicare funding of those patients in the long term care setting.

In response to a specific suggestion by the MHA to explore the possibility of swing beds for Maine, the Department of Human Services has indicated numerous disadvantages of the swing bed concept. Economically the Department has indicated it would be administratively difficult for licensing purposes; difficult, if not impossible, to adapt to the prospective payment system; and could not be accommodated within the current method of approving additional ICF beds. In addition, the Department indicated they felt that the utilization of swing beds would "result in a new increase in expenditures by the Maine Medicaid Program". The Department also expressed concerns that "the hospital and its staff would be ill-prepared to deal with this type of patient, with their special needs, on an ongoing basis unless the beds were made 'permanent' and appropriate adjustments made to accommodate them." The Departments concerns in this area center around the need for special services oriented particularly for nursing home care, such as activity programs, day rooms, and dining rooms. The department expressed a strong preference for permanently converting hospital beds to ICF or SNF level of care.[31]

This committee finds that the use of acute care hospital beds may indeed be a viable way of meeting some of the long term care needs in this state. We are not convinced that such utilization need always be on a permanent basis. Based on the information concerning the demonstration project, we are not convinced that the problems mentioned with the Swing-bed concept are insurmountable. Indeed, it seems that quality of care is a matter which must be satisfactorily addressed before Medicare certification is granted. Instead of being an impossible burden, it is merely a pre-condition to certification which seems to have been met by more than one hospital.

This committee does not have enough data to determine if swing beds are practical in Maine; but neither have we seen sufficient evidence to eliminate them as a realistic part of the balanced growth of long term care. Accordingly, we urge the Department of Human Services to evaluate the feasibility and desirability of using acute care beds on a "swing" basis.* This committee hopes that the long term planning agency will also explore that possibility with an open mind.

STAFFING

The quality of staffing for long term care relates directly to the quality of care. Staffing levels and the skill levels of that staff are important in maintaining the overall quality of long term care.

Staffing is a matter of growing concern for long term care providers. They are having difficulty attracting and retaining staff. The annual turnover rate for direct care staff is 200%. Some providers attribute this to low pay and poor benefits. The level of skill required of nursing home staff may be increasing due to the increasing level of care required for individuals requiring long term care, particularly in nursing facilities.

This committee recommends that the current level and skill requirements of all long term care staff be reevaluated, particularly for ICF care. It is understood that the current ICF staffing requirements have not been reevaluated in over 20 years.**

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* This committee has been recently advised that the department is reevaluating hospital bed use for long term care.

** This committee has been recently advised that the Department of Human Services is studying staffing issues, including the issues of nurses aides' wages in nursing homes.

In addition, geriatric and gerontology training should be required for all staff dealing with the elderly in a long term care setting. These requirements can and should be incorporated in training programs for long term care staff.

The committee also feels that staffing is extremely important to the quality of care and that the problems with staffing should be evaluated by the long term care planning organization. Among the items considered, the agency should include the kinds of staffing needed and the number of staff personnel needed for each level of care. In addition, the committee recommends that the nursing home industry should study the current status of and the need for work incentives, such as career ladders, for nursing home staff.

Whatever recommendations for solutions are proposed, the committee strongly urges the Department of Human Services, the members of the long term care industries, and the professional organizations to coordinate their efforts to implement those proposals.

LONG TERM CARE INSURANCE

One of the issues which is a key element in many of the proposed solutions to long term care problems is funding. Long term care expenses can often be a major problem for individuals seeking long term care services. Future trends are not promising as the need for long term care services and the cost of those services both seem to be increasing. Current funding sources are fragmented in who they will provide for and what services are covered. "Neither (the Medicare nor Medicaid) program pays for a comprehensive range of long term care nor does either pay for critical social services such as meals, transportation, chore(s), and personal care assistance."[32]

Long term care insurance has been suggested as one way to relieve some of the pressure from the current funding sources for long term care. In 1981, private insurance payments represented about 1% of the total amount ($24.2 billion) spent on nursing home care. Today more insurers are experimenting with long term care insurance than ever before. Sixteen insurance companies are currently offering some type of policy for long term care services below the skilled nursing level. This coverage can range from benefits that duplicate existing Medicare benefits to a benefit package that offers extended insurance coverage for nursing home and home health care. Nine of those companies are offering some form of long term care insurance in Maine.

In addition, the Department of Human Services and a task force established by Blue Cross]Blue Shield are exploring the options for long term care insurance including what form that coverage might take and how feasible that type of coverage is. The difficulty in establishing a long term care product, and the reason for such caution in entering this market, includes many factors unique to long term care coverage. They include such issues as:

1. Marketing the product. Most older Americans believe that they are already covered by insurance or federal programs for long term care services; and

2. A limited risk pool. If only the old or sick purchase long term care insurance, the risk pool is too limited to make the product feasible.

This committee recognizes the efforts of the insurers and the executive branch in exploring the options and feasibility of long term care insurance in Maine. In addition, the Joint Standing Committee on Business & Commerce of the Maine Legislature has begun to focus its attention on the feasibility and utilization of long term care insurance. We hope that these efforts will be continued and lead to an additional alternative method of funding long term care.

CONCLUDING REMARKS

The committee has, in too short a period of time, looked at a broad overview of long term care policies and issues. In addition, we have reviewed several specific areas of long term care in greater detail. There are important areas of concern which we have not had the opportunity to examine. It is the intent of this committee that those items of significance which have not been discussed in this report, such as boarding home care, respite care, home health care, etc., be examined in greater detail as part of the State's long term care plan, as recommended by this report.

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FOOTNOTES

1. Goldbeck, Willis. "The Next Generation." Plenary address. HPA-VA Conference. Sept.24,1984. Washington, D.C.

2. The Complex Cube of Long Term Care, William Oriol, 1985, p. 15.)

3. Forecasting Long-Term Care Needs: Techniques and Methodologies with Application to Maine, John Oliver, Nov. 1985, pp.37 & 56.

4. Profile of Maine's Population Aged 65 and Over, Bureau of Maine's Elderly, October 1985

5. Letter from Michael H. Fleming, Deputy Director for the Division of Data and Research, dated November 19, 1985.

6. The Complex Cube of Long Term Care, William Oriol, 1985.

7. Profile of Maine's Population Aged 65 and Over, Bureau of Maine's Elderly, October 1985

8. Forecasting Long-Term Care Needs: Techniques and Methodologies with Application to Maine, John Oliver, Nov. 1985, p. 46.

9. AN ACT Making Appropriations from the General Fund and Allocations from Other Funds for the Expenditures of State Government and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Year Ending June 30, 1986, and June 30, 1987. Legislative Document 2006, 112th Legislature, Feb. 12, 1986.

10. Forecasting Long-Term Care Needs: Techniques and Methodologies with Application to Maine, John Oliver, Nov. 1985.

11. Skilled Nursing Facilities in Maine, Office of Health Planning and Development, Sept. 1985.

12. Memo from Trish Riley, Director, Bureau of Medical Services, dated 10 Feb. 1986, p. 3.

13. Skilled Nursing Facilities in Maine, Office of Health Planning and Development, Sept. 1985.

14. The Complex Cube of Long Term Care, William Oriol, 1985, p. 90.

15. Gordon Browne, letter to the committee, Nov., 1985.

16. A Longitudinal Study of the Impact of Medicaid Prospective Reimbursement on Nursing Home Care in Maine, Preface to Report #1 (Draft), Health Policy Unit, Human Services Development Institute, October, 1984.

17. A Longitudinal Study of the Impact of Medicaid Prospective Reimbursement on Nursing Home Care in Maine, Preliminary Project Report # 3, Health Policy Unit, Human Services Development Institute, August, 1985.

18. Governor's Task Force on Long Term Care for Adults, 1980. p.150

19. HCFA Publication 45-6, Interim Manual Instruction 84-1.

20. A Feasibility Assessment and Financial Impact Assessment of the Adoption of a Fair Rental Payment System by the State of Maine Medicaid Program, Health Policy Unit, Human Services Development Institute, May, 1985, p. 10.

21. Memorandum of transmittal for the Fair Rental Value Reimbursement Methodologies: Analysis of Eight State Systems, Health Policy Unit, HSDI, Nov. 1985, p.2 of the memorandum.

22. Maine Hospital Association Position Paper: Long Term Care Bed Need in Maine, November 1985, p. 1.

23. ibid., p. 4.

24. Days Awaiting Placement in Southern Maine Hospitals, Intercept Associates, January 1986, p. 7.

25. "Update on the National Swing-Bed Demonstration", Kentucky Hospitals, Winter, 1985, p.21.

26. ibid., p. 21.

27. ibid., p. 21.

28. ibid., p. 22.

29. ibid., p. 22.

30. ibid., p. 20-22

31. Gordon Browne letter to Ted Hussey, dated 3 June 1985.

32. Memorandum concerning long term care insurance dated 5 February 1986 from Patricia Riley, Director, Bureau of Medical Services.

APPROVED

JUN 2 5 '85

BY GOVERNOR

CHAPTER

47

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-FIVE

S.P. 528 - L.D. 1423

Resolve, to Assess the Current and Projected Needs of Maine Citizens for Additional Nursing Care Services.

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

Whereas, much controversy exists over whether the present and future needs for medical and nursing care are and will be met; and

Whereas, information is needed on health and illness expectations and the medical and nursing services necessary to provide care and meet the needs of present and future citizens; and

Whereas, policies and facilities established in recent years to provide or require the development of alternatives for care may not be adequate for all levels of care; and

Whereas, these issues are of grave concern to the public and the Legislature; and

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

Joint Select Committee on Nursing Care Needs es-

tablished. Resolved: That there is established a Joint Select Committee on Nursing Care Needs made up of 5 members of the Joint Standing Committee on Human Resources, 2 members of the Joint Standing Committee on Appropriations and Financial Affairs, one Representative appointed by the Speaker of the House of Representatives and one Senator at-large appointed by the President of the Senate to study the following issues and report to the next special or regular session of the Legislature occurring after September 21, 1985.

1. What are the Maine population age classification projections through the year 2010?

2. What are the medical and nursing service needs of those classifications during that period, including:

A. Hospital beds;

B. Skilled nursing home beds;

C. Intermediate care beds;

D. Home-based care personal services; and

E. Rehabilitation services, including occupational and physical therapy?

3. How can the identified needs be met?

4. What are the projected capital costs?

5. What is the relationship between the Department of Human Services' reimbursement policies and the construction of new beds and provision of services?

6. What is the rate of return on capital investment of nursing home owners and other service providers and what policies determine that rate?

7. What alternative methods of reimbursement are in practice in other states, including the "fair rental" method of determining the value of services?

8. What changes in state law are necessary to respond to the needs identified and make necessary provisions for care?

; and be it further

Departmental cooperation. Resolved: That departments of State Government that have the necessary information assist the committee in its study, including the Department of Human Services, Department of Mental Health and Mental Retardation, Department of Labor and the State Planning Office; and be it further

Staff assistance. Resolved: That the Legislative Council shall provide staff assistance to the committee; and be it further

Appropriation. Resolved: That the following funds are appropriated from the General Fund to carry out the purposes of this resolve:

	1985-86
LEGISLATURE	
Legislature	
Personal Services	$1,800
All Other	5,000
Total	$6,800

Emergency clause. In view of the emergency cited in the preamble, this resolve shall take effect when approved.

In House of Representatives, ... 1985

Read and passed finally.

.... Speaker

In Senate, ... 1985

Read and passed finally.

.... President

Approved 1985

.... Governor

LONG TERM CARE STUDY

SUMMARY OF RESPONSES TO WRITTEN QUESTIONS

NOTE: The following pages summarize more than 100 pages of responses to questionnaires sent by the Committee to participating agencies and organizations. A copy of the questions is attached at the end of this document.

Please refer to the original documents containing each respondent's answer for a more complete and more detailed discussion. Any omissions or misrepresentations of the original respondent's view is unintended.

APPENDIX B

A. MAJOR NURSING HOME AND LONG TERM CARE ISSUES DURING THE NEXT 25 YEARS.

1. Bureau of Maine's Elderly (T. Riley):

   a. Development of a wider range of services (levels of care) as a continuing balanced long term care system.

   b. Consistency of funding sources.

   c. Quality of care; improving, enhancing, measuring.

   d. Education, support, and training for people providing long term care services.

   e. Pre-admission screening.

   f. Nursing homes: the evolution of nursing homes for
      1) providing traditional resident services, and
      2) development as a community resource.

   g. Long term care insurance.

2. J. Kuther (Dir. of Soc. Work Services, CMMC):

   a. Increasing number of long term care clients.

   b. Reimbursement; recognizing cost of complex care.

   c. Staffing; recruiting and retention for facilities and home based care.

   d. Service availability; shortages of ICF and SNF beds, adult day care, home based care.

   e. State's role in determining and defining its committement to care for elderly and infirm.

3. Maine Health Care Association:

LONG RANGE RECOMMENDATIONS (R. Thurston)

a. How will long term care be provided?

b. Who will pay for long term care?

c. Who will oversee the quality of long term care?

SHORT RANGE RECOMMENDATIONS (T. Forgione)

a. Build at least 1,300 new beds by 1990.

b. Permanently convert excess hospital beds to nursing home beds rather than adopt "swing beds".

c. Streamline C-O-N process.

d. Increase staffing levels (upgrade standards, new training programs, and improved compensation.)

d. Adopt fair rental reiumbursement system for capital costs.

e. Modify prosepective reimbursement system to encourage the admissions of Medicaid and Level 3 patients.

f. Study impact of DRG's and home care on the nursing home population and the services that population needs.

g. Increase nursing home utilization (through respite care programs and adult day care programs.)

h. Address SNF reimbursement and patient classification problems (which will increase Medicare utilization.)

4. Maine Committee on Aging:

a. The demographics of the elderly; elderly population is increasing and also getting older.

b. Lack of alternatives (or the availability of alternatives) for the long term care population.

c. Lack of coherent long term care policy at the Federal and State level.

d. Health care burden for the elderly will increase in cost.

B. PROPOSALS FOR STATE ACTION, GOALS, AND OBJECTIVES.

1. J. Kuther (Dir. of Soc. Work Services, CMCC):

a. Health care should be viewed as a continuum of care, not separate and distinct systems.

b. Maintain and develop further options for care.

c. Develop more consistent policies that affect health care providers (and the implementation of those policies.)

2. Maine Health Care Association (R. Thurston):

a. Maine's long term care sector should be viewed as an important sector of the state's economy.

b. Legislature should create a Joint Standing Committee on Long Term Care with oversight responsibilities for state long term care policy.

c. State should commit itself to provide adequate services to meet long term care needs of its citizens.

d. DHS should create a Division, with no line responsibility, to be accountable to Governor and Legislature for long term care planning and analysis.

e. Long term care givers have basic and continuing educational needs which should be met. Univeristy could create an Educational Division for Long Term Care.

3. Maine Committee on Aging:

a. The increased aging of the population must be recognized and taken seriously.

b. Public policy should reflect the wishes of the citizens and their preference is to remain at home if possible.

c. A wide variety of options for long term care should be available.

C. <u>WHAT PHILOSOPHY SHOULD BE ADOPTED AS PUBLIC POLICY FOR THE LOCATION OF NEW BEDS AND THE NUMBER OF NEW BEDS</u>?

1. Maine Committee on Aging:

a. Beds should be located all over the state, in both urban and rural areas.

b. Current policy of placing an individual not more than 50 miles from home should be enforced.

c. Whatever philosophy adopted, more beds are needed. There is a dire need for SNF beds. Alternatives to ICF beds can be developed (funded) while waiting for ICF beds to get "on line".

2. Bureau of Maine's Elderly (Elaine Fuller):

a. There is a need for future growth in both the community based home care and the nursing home service components of the long term care system; however, continued emphasis should be placed on increasing the development of community based home care services. It may influence the demand for nursing home care. Need for additional beds should be carefully assessed.

3. Maine Health Care Association (T. Forgione):

a. Recognize the dire need for beds. (See, also, the report by John Oliver outlining bed needs and distribution.)

4. Bureau of Medical Services (G. Browne):

a. Balanced growth in long term care services.
1) Equitable distribution of beds through planning and C-O-N program based on an analysis of bed availability in nursing home analysis areas.
2) Make long term care services more available and achieve a greater balance between nursing homes and other services.

b. Recognition of need to consider how many beds are "affordable"

c. Gradual and predictable growth rather than adding too many beds at one time. Avoids disruptive effects, low occupancy rates, increased labor costs, and financial hardship.

d. See also policy guidline in 1980 report of Governor's Task Force on Long Term Care emhasizing in-home and community support services to reduce the "percentage of consumers of long term care services (that) would have to live in more restrictive and more expensive settings, such as nursing and boarding homes."

e. "New beds are approved for construction only in areas where needed to achieve a more consistent statewide ratio of beds or to replace obsolete facilities if needed to maintain the desired ratio of beds."

D. WHAT ARE THE PROBLEMS IN GETTING NEW BEDS "ON LINE"?

1. Maine Health Care Association (T. Forgione)

   a. C-O-N Process:

      1) unnecessarily long, cumbersome, and expensive.

      2) places too much emphasis on capital costs per bed. Quality of life issues regarding the living environment should be major criteria.

      3) encourages litigation, adding costs and delays. (Perhaps RFP, Request for Proposal, format administered by Dept. is solution.)

   b. Prospective Reimbursement:

      1) limits operating revenues. (Prospective reimbursement is a major portion of nursing home revenues.) Requires nursing homes to maintain an adequate self pay census to be judged financially feasible (a major C-O-N criteria.) This limits access to nursing home beds for Medicaid eligible clients and encourages cost shifting from Medicaid program to self-pay residents.

   c. New depreciation rule:

      1) freezes reimbursement for capital costs. "This (asset revalutation) has essentially eliminated bank loans for nursing home constructions - a traditional source for the small nursing home owner." This limits entry into nursing home industry to firms or organizations that have sufficient capital to construct the homes, usually large ones.

      2) to the extent that this limits nursing home revenues it has the same affect as item "b." above.

2. Bureau of Medical Services (G.Browne):

a. C-O-N Process:

1) It is neither a help nor a hinderance in getting new beds on-line, but merely an integral and vital part of the process of developing a balance-growth long-term care system. It provides an indispensable process for the orderly distribution of the new beds into the areas of greatest need.

b. Prospective reimbursement:

1) Insignificant role in getting new beds on line. Number of applicants for new beds has not been reduced by introduction of prospective reimbursement.

2) Believe prospective reimbursement system is generally viewed as fair and equitable.

c. New depreciation rule:

1) Actually "revaluation of assets rule".

2) Adoption required by Federal law.

3) No evidence that it has affected willingness of organizations or individuals to enter the nursing home field, nor evidence that it has driven any existing operator from the field.

4) Evidence in two areas of the state shows 2 or more applicants competing vigorously for approval for new beds.

d. Litigation causing costly delays:

1) Biggest delay in process occurs after C-O-N has been issued and one of parties not receiving C-O-N brings suit against successful applicant and DHS.

3. Maine Committee on Aging:

a. C-O-N Process:

1) both help and hinderance in getting new beds on-line.

2) help:

(a) provides for public scrutiny in the application process.

(b) assures some measure of commitment and accountability of the prospective owner.

(c) provides needed control of the industry.

2) hinderance: C-O-N process raises barriers to actually getting nursing homes built. Litigation after C-O-N issued causes costly delays. (Suggests alleviating problem without abolishing C-O-N.)

b. Prospective reimbursement:

1) Not aware of any affect prospective reiumbursement has in getting new beds on line.

2) However, reimbursement system provides the wrong incentive to operators. It encourages them to deny access to residents with the highest need for service.

c. New depreciation rule:

1) has not stopped new bed construction.

2) has made transfers of ownership less attractive (and almost impossible) to anyone but large chains. The affect of this should be issue for Committee to study.

E-1. THE PROSPECTIVE REIMBURSEMENT PROCESS FOR NURSING HOMES IN MAINE. WHAT IS IT?

1. Bureau of Medical Services (G. Browne):

   a. A prospective method of payment. "The Department establishes a prospective per diem rate for ICF's which it has determined to be reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated facility in order to provide care and servcies in conformity with applicable State and federal laws, regulations and quality and safety standards."

   b. Savings (when expenses are less than the prospective rate) are shared by nursing home and Department. Sixty-seven nursing homes (63%) had savings in fiscal year 1983 (first year of prospective payment system.)

   c. Cost overruns (when expenses are more than the prospective rate) are not reimbursable.

   d. Implementation of this system has led to decrease in rate of growth for nursing home payments.

   e. Objectives of prospective reiumbursement process:

      1) reward more cost-efficient management and patient care practices.

      2) encourage nursing homes to accept Medicaid patients.

      3) penalize homes achieving more efficient operation at the expense of quality of care.

2. Maine Committee on Aging (R. Turyn):

   a. A facility is assigned a specific rate per day, per resident.

   b. Rates are set prospectively (in advance). This lets operator know in advance how much money he or she has to spend over the coming year. This system provides a cost-control incentive since operator knows that no more than the pre-specified amount will be paid. This incentive of awarding efficient operators must be balanced against the fact that residents are sicker and more dependent on nursing home services than before. Also, since Medicaid rates are set and can't be increased, operator may reduce expenditures in order to realize his profits. Perhaps easiest way to cut costs is to reduce staffing and food costs. "There may be no fully satisfactory was to reconcile cost control and quality of care."

c. NOTE: USM Human Services Development Institute has studied Maine's Medicaid Prospective Reimbursement System. Some preliminary findings include the following:

1) Medicaid reiumbursable costs decrease with additional activity of daily living (ADL) dependency and with each additional behavioral problem.

2) Since implementation of prospective payment system, Medicaid patients have received less therapy services.

3. Maine Health Care Association (R. Thurston):

a. Nursing homes are reimbursed from a variety of sources.

b. Medicaid: approximately 78% of patient days. Prospective rate is set for operating costs. In first year of prospective payment system average reimbursement for operating costs was $36.00 per patient day. Actual cost was $36.48 per patient day.

c. Private pay: generally the source of operator's profit. Private pay differentials are approximately 10-15% over Medicaid rates.

d. Medicare: pays a small percentage of patient days in a limited number of facilities. Insignificant.

e. Veterans Administration contracts: Limited use. VA pays a per diem rate.

f. Private insurance: A small, but increasing, number of residents have private insurance which pays a per diem rate.

4. Bureau of Maine's Elderly (T. Riley):

a. Expense of nursing home care seems to indicate that reimbursement system (from public policy viewpoint) should limit the rate in growth of expenditures. Present system appears to have led to a decrease in the rate of growth in nursing home payments.

E-2. MAINE'S PROSPECTIVE REIMBURSEMENT PROCESS FOR NURSING HOMES - ACCESS.

1. Bureau of Medical Services (G. Browne):

   a. Defined: The degree to which an individual's entry to the health care system and receipt of services is inhibited or facilitated.

   b. Prospective reimbursement system in Maine does not prohibit or hinder access to nursing home care. Present system ensures financial stability of nursing homes in Maine, thus facilitating access.

2. Bureau of Maine's Elderly (T. Riley):

   a. Present prospective reimbursement system may hinder access to some Medicaid clients. Lack of open ended reimbursement system inhibits facility in attempting to increase staff salaries and number of staff employed at facility. (Although rates can be changed, Bureau has been told that process to change rates is difficult and discourages operators from trying.)

   b. Some persons who have a high degree of need for care are not accepted by many nursing homes.

   c. Note: Proposed changes in Medicaid regulations that are designed to affect admission policies in nursing homes may assist in alleviating this problem.

3. Department of Human Services (B. McKeagney):

a. When Bureaus in a Department differ (see BMS and BME resonses above), Department benefits from the different perspectives. However, Department must then reconcile these differences for the "full Departmental perspective".

b. Prospective payment system does not directly hinder access to nursing home care. System is neutral and provides sufficient resources to ensure financial stability of efficiently operated homes while creating incentives to keep rate of costs increases acceptable.

c. Low availability of vacant beds, high cost of care, and Department's efforts to keep costs down does create a situation which often makes securing a bed difficult. Solution is to invest more money in entire long-term care system, not by changing payment methods.

d. Many individuals who are not Medicaid eligible have long term care needs which they or their family can't afford. Increased funding for community based long term care appears to be necessary to provide access for these individuals.

4. Maine Health Care Association (R. Thurston):

a. "Medicaid system may hinder access because of its failure to even cover costs." Nursing homes need to survive.

5. Maine Committee on Aging (R. Turyn):

a. Present reimbursement system hinders access to nursing homes for individuals who are eliglbe for Medicaid and individuals with heavy care needs.

b. Specific rate per day, per resident, provides no incentive to admit or retain the heavy care individual.

c. If rates are too low, operator has option of taking only relatively heatlhy patients, requiring less care, or reducing Medicaid patient load in favor of private-pay patients (whose rates are unregulated.)

d. High state occupancy rate allows operators more discretion in whom they admit.

F. ALTERNATIVE REIMBURSEMENT SYSTEMS.

1. State Health Coordinating Council (Exec. Comm.):

    a. the life care community.

    b. private comprehensive long-term care insurance.

    c. the social-health maintenance organization (a capitation payment based model providing a range of medical and long-term care services to the elderly.)

    d. the conversion of home equity into monthly income that would be used to pay for long-term care.

2. Maine Committee on Aging (R. Turyn):

    a. Long term care insurance (e.g. the American Association of Retired Persons, AARP, developed policy). Source of much confusion to the elderly. Results of Gallup survey showed that 79% of those asked believed Medicare would cover an extended stay in nursing home. 50% said they believe their private insurance would cover such costs. (In 1984, Medicare paid only 1.8% of nursing home bills...private insurance paid only 0.8%)

    b. Minnesota has enacted a rate equalization law which prohibits facilities from charging private pay residents more than the Medicaid rate. High private pay rates merely exhaust the residents' resources that much quicker and create shorter transitions to Medicaid. This allows and could encourage providers to increase profit margins by consuming private paying residents' resources at the ultimate expense of the taxpayer. Maine claims its prospective reimbursement (Medicaid) rates are adequate to provide quality care in an efficient manner while allowing a reasonable return on investment (profit margin). If it is a fair rate, equalize it for private pay and Medicaid.

3. Bureau of Maine's Elderly (T. Riley):

    a. long term care insurance. Bureau is studying this and has a representative on BC/BS advisory committee.

4. Maine Health Care Association (R. Thurston):

    a. Long term care insurance. BC/BS of Maine is studying it. AARP is test marketing a program. This committee should consider the encouragement and support of LTC insurance as a major priority.

5. Bureau of Medical Services (G. Browne):

    (Identical to SHCC response above.)

G. LONG TERM CARE ALTERNATIVES.

1. Bureau of Maine's Elderly (T. Riley):

   SEE Attachment 1 to their original response for a chart of the alternatives and a discussion of each one. (Attachment 1 has been duplicated on the following page.)

Department of Human Services, Bureau of Maine's Elderly
Continue of Long Term Care Services
From least restrictive, promoting independence
and client control to most restrictive, fostering
dependency and loss of control by client

In person's own home	User population	Effectiveness/ Appropriateness	Cost/Client	Funding sources
Emergency response systems Housekeeping chore Homemaking Adult Day Care Personal Care Assistants Certified nurses aides Home health aides Licensed practical nurses Registered professional nurses Therapists Physician services	Nursing home or boarding care level of need - Assistance with activities of daily living (ADL); Supervision may be needed Wide range of needs from few hours/day to 24 hour care.	Uniform assessment form with scoring for HBC & Medicaid waiver. Regional Quality Assurance Review Committees. Monitoring/site visits and home visits by BME staff.	HBC - Average $342/month; $1,576/year Home Health - Regular Medicaid $1,123/year to $3,803/year (from Medicaid waiver proposal)	Regular Medicaid Elderly Medicaid waiver. Home Based Care (State funds) Medicare for skilled services only. Social Services Block Grant Nursing Home Demonstration
Congregate Housing	Nursing home or boarding care level of need as above. 24 hour care not appropriate.	Uniform assessment form with scoring upon admission. Monitoring & site visits.	Average $150/ month/client for services.	State funded
Other living arrangements				
Foster Homes Boarding Homes	No longer able to maintain own home. Needs supervision, minimal assistance. Not SNF or ICF level need.	Homes are licensed, approved. No level of care/ need determination.	$347/mo. Flat rate $413/ mo.; cost homes up to $590 + capital costs.	State funded
Nursing Homes				
Intermediate Care Skilled Nursing Care	Assistance with ADLs. Nursing needs; may require skilled nursing/ therapy services.	Level of care determination for Medicaid clients by Patient Classifiers, assessments. Facilities licensed.	Average cost to Medicaid program (not rate) ICF - $1,153/mo. SNF - $1,690/mo.	Medicaid. Very limited Medicare (see question #5)

2. Maine Health Care Association (R. Thurston):

a. Encourage more adult day care. This is currently in place in a limited number of facilities.

b. Develop a respite care program. Currently there is no Medicaid reimbursement system for this.

c. University of Southern Maine has evaluated Maine's alternative long term care program.

d. The Oliver report summarizes the results of several studies on the effectiveness of home care as a substitute for nursing home care.

3. Bureau of Medical Services (G. Browne):

a. Institutional services such as ICF and SNF. Available in Maine.

b. Congregate housing. Being developed in Maine. U.S. Dept. of Housing and Urban Development and Farmers Home Administration have monies available for this.

c. Other housing alternatives are under development in Maine and nationally. They include: shared living, housemate services, cooperative housing, renovations of large homes into shared living quarters, and eating and lodging facilities. (No data available yet for analysis.)

d. Adult foster care for the elderly is available in Maine for any elderly adult who can no longer live independently and who needs and wants to be placed in a family living situation. Licensed by Bureau of Medical Services.. Maximum of 4 residents. More needed. More being licensed as funds become available.

e. Boarding care is available in Maine and is licensed by the Bureau of Medical Services. Provides boarding care for individuals who cannot remain at home due to physical, social, or mental deficiency; but who don't need more sophisticated care of ICF. Minimum of 3 beds required.

f. Adult day care provides assistance to families and friends of elderly who need supervision and health or social service, and may be at risk of institutionalization. May only postpone institutionalization, but by doing so saves resources and benefits elderly since persons cared for in non-institutional settings don't decline mentally or phsyically as rapidly as their institutional counterparts.

g. Family assistance. Vast majority of elderly receiving assistance have that help delivered through family members. BMS believes DHS should begin to identify the needs of these family members providing this support.

4. Maine Committee on Aging (R. Turyn):

See BME and BMS responses.

5. State Health Coordinating Council (Exec. Comm.):

a. See "Home Care Reimbursement Initiatives in Maine" included as Attachment I to their original response. It is too lengthy to reproduce here, but it contains:

1) a concise description of services delivered by home care agencies in Maine,

2) cost of same,

3) effectiveness of same, and

4) historical information on the development of the Alternate Long Term Care Project (ALTC), the Home Based Care Program (HBCA), and the Medicaid Home and Community Based Wavier for the Elderly.

H. ADMISSION SCREENING PROGRAM.

1. Maine Committee on Aging (R. Turyn):

   a. Maine does not have one. Method of entry is fragmented, admission is from a variety of sources: Area Agencies on Aging, hospitals, home health agencies, and individual effort.

   b. One should be developed.

   c. Provides a single point of entry to the long term care network. Each individual would receive a comprehensive assesment, assistance in planning and obtaining either community or institutional services. The appropriateness of the services would be monitored on an on-going basis.

2. Bureau of Maine's Elderly (T. Riley):

   a. Pre-admission screening is designed to determine if people who need a level of care which might be met in a nursing home can also have their needs met through in-home services. Focus is to determine if there are alternatives to nursing home care for the particular individual. Should be an official program to make sure people are aware of all options available to them and have an opportunity to choose. (Bureau realizes more funds would be needed to support in-home service programs.)

   b. Pre-admission screening is not the same as the "level of care determination" currently done under the Medicaid program.

   c. Private-pay patients have no pre-admission assessment other than nursing home staff. Pre-admission screening (to determine if this was only option available to them) could be required (as in Maryland) by statute. In that case, failure to obtain screening results in loss of eligibility for Medicaid for a specified period of time (e.g 6-12 months.)

   d. Area agencies on aging presumably assess all persons living at home seeking nursing home placement under the Medicaid program. However, majority of admissions to nursing homes come directly from hospitals under direction of hospital discharge planners.

3. Bureau of Medical Services (G. Browne):

a. Admission screening programs are designed to develop comprehensive plans of care with aging and disabled population and adults applying for long-term care services. The procedure would be to:

1) perform a complete screening for each individual,
2) include assessment of individual's health and social needs,
3) determine individual's functional level, and
4) make available a continuum of care to help individual function as independently as possible.

b. Five regional area agencies on aging perform assessments of all elderly and disabled individuals who contact the agency. (This program recieves DHS funding.) Both consumers and providers consider this an effective program.

4. Department of Human Services (B. McKeagney):

a. When the Bureaus in a Department differ (See BME and BMS, above), the Department benefits from the different perspectives. However, the Department must then reconcile these differences from the "full Departmental perspective."

b. Pre-admission screening has value.

c. Some screening already being provided by BMS patient classifiers, Area Agency on Aging care managers, hospital discharge planners, and home health agencies.

d. Future development should not duplicate current screening efforts and should balance "needs assessment" (with a clear focus on individual needs) and "eligibility determination" (avoiding the establishment of barriers to services.)

5. Maine Health Care Agency (R. Thurston):

a. Maine has admission screening program for Medicaid patients. State determines financial and medical eligibility. Physicians, discharge planners, family, and other are also involved.

b. Private pay residents are not screened by state. Test is more vigorous for them - they must pay for their own care.

c. No more admission screening is needed than what exists now.

6. Maine State Health Coordinating Council (Exec. comm.):

a. No in-depth study of this issue by SHCC.

b. 1985 State Health Plan recommended that DHS, hospitals, nursing homes, and area agencies on aging all use one assessment form. Purpose: to increase uniformity and decrease duplication of patient assessment. This would assure appropriate placement and minimize disruptions when patients are transferred from one level of care to another.

I. ACCESS TO CARE.

1. Maine Health Care Association (R. Thurston):

    a. A planned shortage of nursing home beds currently exists which requires Nursing Home Admission Committees to choose among persons, all of whome have a demonstrated need. Person denied admission often feels discriminated against.

    b. Problem is that there are not enough beds to meet the need.

2. Maine Committee on Aging (R. Turyn):

    a. There are waiting lists for home care, nursing homes, congregate housing, subsidized housing, and every other service alternative.

    b. Problem: inadequate resources for services.

3. Bureau of Medical Services (G. Browne):

    a. Difficult for people seeking long term care to gain access to the system unless they have sufficient heatlh insurance coverage or private resources to pay for that care themselves.

    b. Major problem is inadequate funding for in-home services.

    c. Ratio of nursing home beds to elderly is adequate.

    d. There is need for future growth in both community based home care and nursing home care, but emphasis should be on developing community based home care service system.

    e. Major unmet short term need: SNF beds. (See next item, "J", for more complete discussion.)

4. Maine State Health Coordinating Council (Exec. Comm.):

    a. SHCC has received comments that indicate some clients and patients seeking long term care have difficulty in receiving appropriate care.

    b. One cause is that no state organization has developed a model to project needs and to recognize (and project needs for) other health and social services.

J. SHORTAGE OF SKILLED NURSING FACILITIES.

1. Maine Health Care Association (R. Thurston):

a. Lack of planning standard to provide, at a minimum, guidelines for the number of beds Maine ought to have.

b. Reimbursement system causes most SNF providers to lose money and look for other places to invest.

c. Fiscal intermediary has defined what is covered by Medicare so narrowly that no one qualifies.

d. Lack of understanding or acceptance of the entire SNF concept by Federal Government and Medicare.

2. Maine Committee on Aging (R. Turyn):

a. Maine has 58 ICF level beds per 1,000 over age 65 and only 3.3 SNF level beds per 1,000 over age 65. Ratio of ICF to NSF beds in Maine is among highest in nation (25 to 1).

b. Legal Assistance for Medicare Patients Program (similar to Conn.,) is being explored which would assist Medicare beneficiaries in obtaining Medcare services they are entitled to.

3. Bureau of Maine's Elderly (T. Riley):

a. Maine SNF bed supply has always been inadequate. Currently 355 SNF beds available in Maine.

b. Problem: Medicare beneficiaries are being denied benefits they are eligible for under the Medicare Health Insurance for the Aged Program. Action should be taken to remedy this.

c. Bureau intends to determine what people who need SNF level care do now in Maine. Some are in ICF level care with 24 hour licensed nurses available. Bureau suspects some are in hospital beds waiting placement, some may be being cared for at home.

d. State needs legal advocacy for Medicare benefiaries who are being unfairly denied this type of care.

4. Bureau of Medical Services (G. Browne).

a. Increases in SNF beds will not solve problem by itself. Maine needs to develop a refined methodology to assess long-term care needs. (See item "M" for more discussion of this.

b. Efforts in other states to help those denied Medicare coverage by the fiscal intermediary, a denial which some feel is inappropriate, have been successful in increasing the number of patients receiving Medicare reimbursement.

K. <u>ADEQUACY AND QUALITY OF STAFFING</u>.

1. Maine Health Care Association (R. Thurston):

a. Number 1 priority for all long term care providers. It is fundamental to development of rational state policy for long term care.

b. Home Care providers have difficulty attracting and retaining adequate staff in spite of better pay and better staffing ratio. (Home care ratio is 1:1, while other long term care ratios reach 1:8 and 1:12.)

2. Bureau of Maine's Elderly (T. Riley):

a. Some nursing homes are closing beds and some home health agencies can't serve clients at home because of lack of staff.

b. Salary levels appear to be inadequate in some nursing homes. It may be necessary to provide for higher salaries for direct care providers in long term care settings if we are going to adequately care for people placed in these institutions.

c. Training is also needed to improve skill levels.

3. Maine Committee on Aging (R. Turyn):

a. Turnover rate for direct care staff is 200%. Largely attributed to low pay and poor benefits.

b. High turnover is in staff with most direct contact with residents. Consequently this turnover rate is affecting quality of care.

4. Maine State Health Coordinating Council (Exec. Comm.):

a. Training in geriatrics and gerontology for personnel in nursing homes and long term care settings should be required. This would improve overall quality of care.

b. Solution to lack of staff for nursing homes may lie partly in creative use of existing administrative structures for alternative care, e.g. respite care and adult day care, or other innovative programs.

5. Bureau of Medical Services (G. Browne):

a. Staffing needs for long-term services are generally being adequately met.

b. Present reimbursement system allows for the maintenance of staffing at adequate levels. It provides for adjustment of staffing patterns and payment to accomodate changes in the intensity of care delivered to changing patient populations.

c. Quality of care and adequacy of staffing are inseparable.

d. There is evidence of chronic failure of some facilities to maintain adequate staff, particularly at lower skill levels. These problems are very limited and do not appear to be related to the level of the prospective payment presently made by DHS.

L. HOSPITAL BEDS FOR ICF LEVEL OF CARE.

1. Maine Hospital Assocation (T. Hussey):

   a. Maine hospitals should be encouraged to participate in the federal Medicare swing-bed program. This would help alleviate the shortage of beds and allow the cost of these patients to be picked up by the Federal program instead of state appropriations.

   b. From 5 to 15 percent of patients in acute care facilities are awaiting transfer to long term care. 97% of these patients are supported by the Medicaid Program.

   c. C-O-N review should be waived for hosital implementation of the Medicare swing-bed program. The Maine Health Care Finance Commission law should be amemded.

   d. Larger hospitals that do not meet the current swing-bed criteria should be encouraged to convert underutilized acute-care nursing facilities to long term care.

   e. Reimbursement rates for hospital based long term care facilities should reflect the greater severity of illness of long term patients retained in hospitals.

   f. No hospitals are currently operating ICF beds within their acute-care setting. There are approximately 521 beds that could be made available through the swing-bed approach without any construction. (Hospitals are experiencing declining utilization, thus more beds are becoming unoccupied.)

   g. Some hospitals are operating permanent SNF units.

   h. Swing bed program minimizes risk of trauma to patient which is caused by transfer from one facility to another.

   i. See also the "Maine Hospital Association Position Paper: Long Term Care Bed Need in Maine."

2. State Health Coordinating Council (Exec. Comm.):

a. Interfacility transfer of the elderly (which may cause trauma) should be reduced by encouraging the development of multi-level facilities which may include SNF, ICF, acute care and boarding care, as appropriate. These facilities may be encouraged by financial incentives and by eliminating existing financial disincentives.

b. Location of permanent ICF beds in acute care facility may be appropriate under some circumstances. SHCC has not endorsed swing bed concept.

c. SHCC's Long Term Care Subcommittee will review this subject during the coming year.

3. Bureau of Medical Services (G. Browne):

a. Some excess licensed acute care beds should be permanently reclassified as ICF or SNF beds instead of utilizing them in that capacity only when needed.

b. Economic danger of Swing Bed concept:

1) administrative nightmare for DHS licensing divisions,

2) difficult for HCFC to administer since no knowledge of how many beds needed would be available.

3) Would be financially hard on Medicaid Program. Shifts cost from hospital costs (of which DHS pays 10%) to ICF costs (of which DHS pays 77%).

c. Quality of Care problems in swing bed concept:

1) Hospital and staff are ill-prepared to deal with nursing home patients. E.g. generally inadequate activity rooms, day rooms, or dining rooms to acommodate nursing home patients and inadequate training for staff.

d. Possible that patients initially scheduled to stay for a short time would turn into long term patients.

4. Maine Committee on Aging (R. Turyn):

   a. Hospital beds should not be used as ICF beds. a hospital might have an incentive to discharge earlier than the average length of stay for the patient's DRG, thus making money on the discharge. There are also freedom of choice implications.

   b. Hospitals should be considered for SNF beds.

5. Bureau of Maine's Elderly (T. Riley):

   a. Hospitals should not be utilized as ICF beds.

   b. Hospitals should be considered for SNF beds provided that the staff of hospitals be educated to deal with other than acute care patients and that the units have facilities to promote independence rather than dependency.

   c. Bureau does not support swing bed concept. Type of care provided to persons in swing beds would too much replicate the acute care models of care and will not provide a safe level of long term care services.

6. Maine Health Care Association (R. Thurston):

   a. Hospital beds are currently being used for ICF care, primarily while the patient waits for a bed in another facility. While there may have been a payment problem in the past, the MHCA believes that this is no longer a serious problem under the HCFC.

   b. Hospital beds should not be utilized as swing beds. If hospitals want to utilize their excess capacity they should make a committment to full time nursing care.

M. STATE PLAN FOR BALANCED GROWTH.

1. Bureau of Medical Services (G. Browne):

   a. The State's short term plan activities include:

      1) Securing the approval of the federal Health Care Finance Administration for implementation of the Home and Community Based Waiver for services to the physically disabled.

      2) Phasing review and modification of the Alternate Long Term Care Program to make it more cost effective.

      3) Developing a program of specialized boarding care for those with special needs. The short term project is to develop a boarding home, geriatric evaluation unit and training and resource center for Alzheimer's disease victims.

      4) Implementing recently enacted amendments in home health licensure laws.

      5) Initiating in-depth analysis of licensure status of existing nursing homes so that any necessary corrective actions can be taken.

      6) Disbursing and monitoring additional Home Based Care Act funds for biennium and completing study on co-payment.

      7) Extending the utilization of one assessment form for admission to all levels of long-term care.

2. Maine State Health Coordinating Council (Exec. Comm.):

   a. A Long Term Care Subcommittee will be appointed to study intermediate care and skilled nursing facilities. The Subcommittee will invite interested organizations to designate representatives as technical advisors to the Council. A draft plan will be prepared by late 1986.

3. Department of Human Services (B. McKeagney):

   a. DHS has a Long Term Care Policy Management Committee, chaired by Deputy Commissioner McKeagney.

September 4, 1985

TO: ALL PARTIES INTERESTED IN THE NURSING HOME SERVICES STUDY:

The Joint Select Committee on Nursing Home Needs held a brief organizational meeting on August 27, 1985 to outline the scope and nature of the study concerning Nursing Home Services as authorized by Resolves 1985, Chapter 47. As a part of that meeting, several of you who were there shared your concerns with the committee. These concerns included the availability of ICF and SNF beds, a long term care plan for the state, a reimbursement system which would recognize different levels of care, staffing of nursing home facilities, hospital "swing" beds, and other issues.

The committee will be meeting again on Thursday October 17, 1985 in Augusta. It would be very helpful for us if you would take a few minutes and share some of your thoughts with us about the focus of our study. We are particularly interested in the following:

1. What do you perceive to be the major problems or issues concerning nursing homes and long term care in the next 25 years?

2. What do you think should be done by the state or encouraged by the state to address these issues and needs?; and

3. What do you believe the goals and objectives of the state should be in the areas of nursing homes and long term care over the next 25 years?

Your assistance in responding to these questions would be extremely helpful to our work. Please send your response to our staff:

John R. Selser
Office of Legislative Assistants
State House Station # 13
Augusta, Maine 04333

ATTN: Nursing Home Study

It would be helpful if we could receive your comments by September 13, 1985. For your information, I have enclosed a copy of the Resolve establishing this study committee.

We are in the process of developing our mailing list. If you have no interest in this study, please advise our staff and you can be removed from the mailing list. If you know of others who may be interested and are not already on the mailing list, please let us know and we will be sure to add them to the list. Once again, thanks for your attention to this request.

Sincerely,

Representative Merle Nelson,
Chairperson

3439/jrs

STATE OF MAINE
HOUSE OF REPRESENTATIVES
AUGUSTA, MAINE 04333

October 9, 1985

Dear

The Joint Select Committee to Study Nursing Home Services has scheduled a meeting for October 17, 1985, at 9:00 A.M.in room 436 of the State House. I have enclosed a tentative agenda for your information.

As a part of this study the Committee is interested in the opinion of people who are involved with nursing homes and with residents of nursing homes. We would appreciate your response (or your designee's) to a few brief questions. We are hoping that each participant will make a 3-5 minute presentation on each question and will also have a written statement to be distributed to the committee members.

The questions are:

1. WHAT PHILOSOPHY SHOULD BE ADOPTED AS PUBLIC POLICY FOR THE LOCATION OF NEW BEDS AND THE NUMBER OF NEW BEDS? (Agenda Item II-C.)

2. WHAT ARE THE PROBLEMS IN GETTING NEW BEDS "ON LINE"? Please include the following aspects:
   a. Is the Certificate of Need Requirement a help or a hinderance?
   b. What role does prospective reimbursment play in getting new beds on line?
   c. Has the new depreciation rule effectively stopped new bed constructions?

   (Agenda Item III.)

We appreciate your participation in this study and look forward to hearing from you on the 17th.

Sincerly,

Representative Merle Nelson,
Chairperson, Joint Select Comm.

November 1985

NURSING HOME STUDY QUESTIONS

1. THE REIMBURSEMENT PROCESS FOR NURSING HOMES

a. Please explain the reimbursement process <u>from your perspective</u>. How is reimbursement calculated? Who pays for what services? Are there services that the nursing home provides which are not reimbursed that you feel should be reimburseable?

b. Does the present reimbursement system hinder or prohibit access to nursing home care?

c. Are there ways of paying for nursing home care other than the current reimbursement system, e.g. long term care insurance? Are any of the other ways currently being explored?

2. LONG TERM CARE ALTERNATIVES:

Maine's current policy of "balanced growth" in long term care services includes the idea that a continuum of services should be available which are appropriate to the needs of a variety of clients or patients.

a. What are the specific services that are, or could be available, on that continuum of services? What segment of the long term care user population will each of these services best serve? (What is the eligibility criteria for each service?) What Federal or state reimbursement is available (or is being applied for) to provide these services?

b. How many of these alternatives are currently being implemented in Maine? Are there plans to implement additional alternatives not currently being utilized in Maine?

c. Has the effectiveness or appropriateness of any of these services been evaluated? If so, how was it measured and what were the results?

d. What is the cost of each alternative on a per client or patient basis? How is that cost measured? If no cost figures have been developed, are there plans to develop such information?

3. ADMISSION SCREENING PROGRAM.

Please describe what an admission screening program is, how it operates, and what its goals are. Does Maine have an admission screening program? Should Maine have one? Why or why not?

4. ACCESS TO CARE.

Is it difficult for clients and patients seeking long term care to gain access to that care? If so, where does the problem exist? In your opinion, what are the causes for that problem?

5 SKILLED NURSING FACILITIES:

Testimony before the Joint Select Committee has indicated that there is a shortage of SNF beds in Maine. What do you feel is the reason for this shortage? What should be done to correct this shortage?

6. STAFFING:

Are staffing needs adeaquately met today? If future projections show a greater need for all types of care, what is being done and what needs to be done to keep staffing at an adequate level to account for the increased need? Is adequacy of staffing considered in developing the state policy for long term care? Should it be?

7. HOSPITAL BEDS FOR ICF LEVEL OF CARE.

a. Should hospital beds be utilized as ICF beds for long term care? Are any hospital beds currently being used as ICF beds, either short term or long term? If yes, please describe the circumstances under which they are used and any difficulties in that program? Include a description of the typical patient who is using hospital beds for ICF care.

b. (If this has not been discussed in part "a".) Please describe the program which uses hospital beds as "swing beds". What are the strengths and weaknesses of this program? Is Federal funding available for this program? Is this being used in Maine?

8. STATE PLAN FOR BALANCED GROWTH.

The Joint Select Committee has been advised that the state's "policy of 'balanced growth' in long-term care services (was) adopted by the Brennan Administration and the Maine Legislature in 1980."

a. Short Term Plan: The Committee was advised that the short term plan is essentially the budget proposal each biennium. Please provide a brief narrative of the state's short term plan for balanced growth in long term care services. Incorporate the components of the plan which are represented in the current budget enacted during the last session of the Legislature. Please include, as a separate item, any components of the short term plan which are to be incorporated in the Part II budget request during the next session.

It is hoped that this narrative will include a brief description of the plan and the amount of state funds appropriated (or to be requested) for each component of the plan and any related Federal funds anticipated.

The Committee recognizes that the Part II budget is a document which may not be in final form yet and, even when submitted, is a document that requires both executive and legislative branch approval. We are not asking the Department and the Governor to make a firm committment to a Part II budget request at this time. But the committee recognizes that, for planning purposes, there must be at least a preliminary short term plan for long term care services; and, of course, that the plan is subject to change. It would be extremely beneficial for the purposes of this study if the Department would share that tentative plan with us and indicate, to the best of your ability, which areas of the plan are firm and which areas of the plan are subject to potential changes prior to submission to the Legislature. (We recognize the Legislative role in aproving the final plan.)

When the short term plan for long term care services is presented to the Legislature, is it presented as a comprehensive program for long term care, showing all the components of the continuum of care along with the requested funding? (If you feel that the Legislative process hinders this comprehensive understanding of the state's long term care plans, please describe the parts of the process which interfere with that understanding and any recommendations for improving that process.)

This Committee has been provided with a one page draft of the "Department of Human Services' Long Term Care Services Action Plan". That document indicates that "The policy of balanced growth recognizes that a continuum of services is required to meet the varied needs of the wide range of people in need of long term care." It further indicates that the past emphasis has been on the availability of nursing home beds with a lack of attention paid to other long term care services. It also identifies specific target groups for long term care. In addition, we have a memorandum dated July 9, 1984 from Michael Reid concerning "The concept of 'balanced growth' in State policy for Long Term Care Services." That document

discusses moderating the growth of ICF beds (in relative terms), incorporating the concept of affordability into the ICF program, and encouraging non-institutional long term care, particularly home care.

The Committee has also received the State Health Plan for 1985 which discusses the "balanced growth" policy and contains several recommendations concerning future goals for long term care.

a. Long Term Plan: Using the full range of specific long term care services identified in question # 2, what is the state's current long term plan in relation to each of those services over the next 25 years. Although this question may overlap, to a certain extent, the information in question # 2 (and possibly other questions), a brief evaluation of the state's current policy goals in each area would be extremely beneficial to this study. Please be as specific as possible, e.g. breaking down "home care" into its various components and identifying any "other long term care services" in addition to home care and nursing home care. The committee recognizes that a plan is subject to modification as new information is revealed and as circumstances change. However, such a plan is essential in order to get from today into tomorrow in an orderly fashion. A brief narrative description of the state's long range goals, itemized by type of service, can be a useful tool in our study.

b. Long Range Goals: Studies, Task Forces, Commissions. Other than this Committee, what studies, task forces, commissions or other research and special policy analysis groups are in operation or planned for the near future to evaluate long range goals in one or more aspects of long term care in Maine? A brief description of the group, their goals, and their anticipated target date for completion would be helpful. In addition, do you see a need to establish a special commission to undertake a comprehensive evaluation of long term care in Maine?

THANK YOU VERY MUCH FOR TAKING THE TIME TO RESPOND TO THESE QUESTIONS.

3880

PROVISIONAL PROJECTIONS OF MAINE'S ELDERLY POPULATION
BY SEX, FOR THE YEARS 1990, 2000, 2010

Age Group	Total Population			
	April, 1980	July, 1990	July, 2000*	July, 2010*
Age 65 and Over	141,000	169,450	178,700	196,200
Age 65-74	82,300	96,420	93,100	95,400
Age 75-84	44,600	53,330	59,100	66,500
Age 85 and Over	14,100	19,700	26,500	34,300

Age Group	Male Population			
	April, 1980	July, 1990	July, 2000*	July, 2010*
Age 65 and Over	56,300	68,050	69,000	74,300
Age 65-74	35,900	43,900	41,800	43,100
Age 75-84	16,400	19,330	21,200	23,900
Age 85 and Over	4,000	4,820	6,000	7,300

Age Group	Female Population			
	April, 1980	July, 1990	July, 2000*	July, 2010*
Age 65 and Over	84,700	101,400	109,700	121,900
Age 65-74	46,400	52,520	51,300	52,300
Age 75-84	28,200	34,000	37,900	42,600
Age 85 and Over	10,100	14,880	20,500	27,000

* Derived from sources listed below.

Sources of Data: Population Projections for Maine: 1984-1993, Office of Health Planning and Development (July, 1985) and Provisional Projections of the Population of States, by Age and Sex: 1980 to 2000, Bureau of the Census, Series P-25, No. 937 (August, 1983).

Table prepared by Division of Data and Research
Office of Health Planning and Development
Bureau of Medical Services
Maine Department of Human Services
August, 1985.

MAINE STATE LEGISLATURE
Augusta, Maine 04333

25 March 1986

Mr. Daniel Willett
State Health Coordinating Council
State House Station #11
Augusta, Maine 04333

Dear Mr. Willett:

The 112th Legislature established a Joint Select Committee on Nursing Home Needs to study the long term care needs of Maine citizens over the next 25 years. Two of our major findings were that:

1. The scope of the study was too complex a task to accomplish within the time and budget allotted to the Committee; and

2. A comprehensive effort to address long term care issues in Maine requires a continuing effort instead of a single committee of limited duration.

Accordingly, our first recommendation was that "one organization, independent from the Executive and Legislative branches of government, be responsible for developing a state-wide plan for long term care for Maine's citizens and for periodically reviewing that plan." We further recommend that this plan be presented to the Legislative and the Executive branches of government at least every 2 years, with special reports as needed.

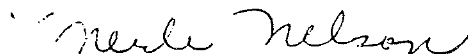
We have been advised of the role of the SHCC in developing an overall state health plan and of your recent initiative to look at parts of the long term care system in Maine. Because of your current role and your initiatives into long term care planning, we feel that the SHCC is the most appropriate agency to implement our recommendation.

We strongly urge you to formally assume responsibility for developing, on a continuing basis, a state health plan for long term care. This could be a natural extension of your role in developing a state health plan and an expansion of your current efforts concerning long term care planning.

This Committee believes that this report should be as independent as possible from the Executive and Legislative branches of government. To maintain this independence, we strongly urge you to consider independent staffing in developing the long term care plan. We hope that in your current evaluation of staffing arrangements for the SHCC you will seriously consider our recommendation for independent staff in regard to long term care planning.

We are sending you a copy of this report, under separate cover. This report outlines our general concerns for long term care planning and identifies specific areas on which we hope you will focus your immediate attention. It is our firm recommendation that the SHCC is ideally suited for this role.

Sincerely,



Rep. Merle Nelson
Chair

5490

JRS/HRS/4842

SECOND REGULAR SESSION

ONE HUNDRED AND TWELFTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY SIX

AN ACT to Authorize Additional Facilities for Long Term Care.

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

Legislative intent. It is the intent of this Legislature to authorize the Department of Human Services to include the cost of 270 new intermediate care facility (ICF) beds in its current services budget in the next biennium. It is further the intent of this Legislature that the Department of Human Services solicit proposals for new beds and complete the Certificate of Need approval for those 270 new beds as soon as possible; but, in any case, not later than July 1, 1989.

FISCAL NOTE

The addition of 270 new beds will add $5.4 million in annual expenditures to the Medicaid program: $1.7 million of state general funds and $3.7 million in federal Medicaid matching funds. These funds, and consequently the additional appropriations, will not be needed until Fiscal Year 1988 because of the lead time required to approve and construct ICF facilities.

STATEMENT OF FACT

The Joint Select Committee on Nursing Home Needs studied the long term care needs for Maine's citizens. That study determined that Maine's population in need of long term care will increase considerably over the next 25 years. The committee identified a severe shortage in Intermediate Care Facility beds and Skilled Nursing Facility beds in Maine. This shortage was exacerbated by the fact that no new beds have been funded during the last fiscal year. There is a two to three year delay in constructing new beds from the time they are authorized because of the competitive Certificate of Need Process to determine who will receive the new beds and because of the time required for construction. Unless immediate action is taken, the shortage of beds will increase and access to care will be denied an ever increasing number of Maine citizens.

This bill provides authorization for 270 new beds. This will authorize the 180 beds which should have been authorized during the last biennium and an additional 90 beds for the following year. While this number will not meet the total need for new long term care beds, it will allow an affordable beginning to reduce the bed deficit.