STATE OF MAINE
126th LEGISLATURE
FIRST REGULAR SESSION

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

December 2013

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Rep. Peter C. Stuckey, Chair
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Executive Summary

In 2013 the 126th Maine Legislature established the Commission to Study Long-term Care Facilities with the passage of Resolve 2013, Chapter 78. The resolve established the commission, specified the duties of the commission and set December 4th, 2013 as the due date for the report of the commission to the full Legislature. A copy of Resolve 2013, Chapter 78 is included as Appendix A. The deadline for the report was extended from December 4th to December 12th by vote of the Legislative Council on November 21st pursuant to Joint Rule 353, section 7.

The President of the Senate, Speaker of the House of Representatives and Governor completed their appointments during the late summer. The members include two State Senators, three State Representatives, an owner of a long-term care facility, a representative of a statewide association of long-term care facility owners, a representative of a statewide association of long-term care facilities, a city manager, a representative of the Governor's Office, and the director of Maine's long-term care ombudsman program. A copy of the membership list of the commission is included as Appendix B. The 11 member commission met on October 11th and 25th, November 8th and 15th and December 4th. All meetings were held in the Cross State Office Building in Augusta and were open to the public and broadcast through the Legislature's public Internet system.

The commission focused its work regarding long-term care facilities on adequate funding, staffing and regulatory requirements and access to nursing facility services in rural and urban areas. The 14 recommendations of the commission include: recommendations designed to assist facilities in achieving adequate reimbursement for the care of residents whose care is reimbursed by the MaineCare program; a recommendation that Maine retain the current nursing facility staffing requirements and ratios; a recommendation to address the use of consumer life insurance as a resource to pay for nursing facility care; recommendations relating to errors in Cost of Care overpayments to facilities; and recommendations for further study of long-term care. The recommendation for further study by a Blue Ribbon Commission on Long-term Care reflects an understanding that more work needs to be done to study and make recommendations on a state plan for long-term care services in the community and in facilities. The recommendation for further study by a Commission to Continue the Study of Long-term Care Facilities reflects an understanding that further review and recommendations are needed on adequate reimbursement for facilities, ensuring access in rural and urban areas and providing incentives for high quality care through the nursing facility principles of reimbursement of the MaineCare program. Specific recommendations, including the votes for each recommendation are below.

1. Rebase to 2011 and every two years. Direct the Department of Health and Human Services to amend the Principles of Reimbursement for Nursing Facilities, Chapter 101, MaineCare Benefits Manual, Chapter III, Section 67 in the direct care cost component for nursing facilities in subsection 80.3.3(1) to establish a facility's base year by reference to the facility's 2011 audited cost report, or if the 2011 audited report is not available by reference to the facility's 2011 as filed cost report, and rebase every two years thereafter. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in the routine cost component in subsection

80.4.5.1 in a similar manner to the direct care cost component. Vote: 9 for, 0 against, 1 abstain.

2. Increase peer group upper limit. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to increase the peer group upper limit on the base year case mix and regionally adjusted cost per day to 110% of the median in the direct care cost component in subsection 80.3.3.4(b) and in the routine cost component in subsection 80.5.4. Vote: 8 for, 2 against.

3. Repeal administrative and management ceiling. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 43.4.2(A) to repeal the administrative and management ceiling in the routine cost component. Vote: 7 for, 3 against.

4. Cost of living adjustment included in budget request. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 91.1 to require the Department of Health and Human Services to set the inflation adjustment cost of living percentage change in reimbursement on an annual basis and by reliance on a publicly available index such as the Consumer Price Index Medical Care Services Index and to require that budget requests submitted by the Department of Health and Human Services include that annual adjustment. Vote: 9 for, 0 against.

5. Health insurance as fixed cost component. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to move health insurance costs for nursing facility personnel in subsection 41.1.7(3) from the direct care cost component and in subsection 43.4.1(16)(c) from the routine cost component to the fixed cost component in subsection 44. Vote: 6 for, 3 against.

6. Supplemental payment for high MaineCare census. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to provide a supplemental payment, subject to cost settlement, to nursing facilities with a MaineCare census above 70%. The supplemental payment would provide additional reimbursement to those high MaineCare census facilities of 40 cents per resident per day for each 1% MaineCare census above 70%. The supplemental payment would be enacted on an emergency basis with payments beginning July 1, 2014. Vote: 7 for, 3 against. The minority favored a supplemental payment for nursing facilities with a Medicaid census above 70% that is identical to the majority proposal but that is not cost settled.

7. Increase acuity for dementia. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 80.3.2 to increase the specific resident classification group case mix weight that is attributable to a resident who is diagnosed with dementia. Vote: 9 for, 0 against, 1 abstain.

8. Maintain current staffing ratios. Recommend that no changes be made to staffing ratios and requirements for licensed staff coverage adopted in Chapter 110, Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities, Chapter 9, subsection 9.A.3 and 9.A.4. Vote: 10 for, 0 against.

9. Support life settlement contract legislation. Recommend to the Insurance and Financial Services Committee that they consider, amend and report out favorably LD 1092, An Act to Increase the Use of Long-term Care Insurance, on life settlement policy conversion. The bill proposes to allow an owner of a life insurance policy to enter into a life settlement contract with a life care benefits company and to use the proceeds for long-term care expenses. The bill proposes amendments to the MaineCare program so that the policy and benefits under it do not disqualify the owner from eligibility for MaineCare long-term care services. Vote: 7 for, 0 against, 1 abstain.

10. Collect Cost of Care overpayments. Direct the Department of Health and Human Services to take all necessary actions to collect Cost of Care overpayments to nursing facilities and private non-medical institutions which were paid when the department's computer systems, when providing reimbursement owed by the department, failed to take into account the financial contributions paid by residents in the nursing facilities and private non-medical institutions. Vote: 10 for, 0 against.

11. Correct Cost of Care overpayments. Direct the Department of Health and Human Services to require that Molina make adjustments to the MIHMS computer system to correct and discontinue overpayments in the calculation and deduction of Cost of Care in the payment of nursing facilities and private non-medical institutions. Vote: 10 for, 0 against.

12. Cost of Care recoupment used for nursing facilities. Recommend that the first $10 million collected from Cost of Care overpayment recoupments collected under recommendation 10 be appropriated to pay for initiatives recommended by the commission. Vote: 10 for, 0 against.

13. Continue the commission. Recommend establishing a Commission to Continue the Study of Long-term Care Facilities, based on the 2013 commission, with added duties of reporting to the Blue Ribbon Commission on Long-term Care and reviewing payment methodologies and removing the duties completed in 2013. The recommendation includes the duty to report to Legislature and to the Blue Ribbon Commission on Long-term Care by October 15th, 2014. Vote: 10 for, 0 against.

14. Establish Blue Ribbon Commission on Long-term care spectrum. Recommend establishing a Blue Ribbon Commission on Long-term Care to review the State's plan for long-term care and the provision of services in the community and in nursing and residential care facilities. The recommendation includes broad representation on the commission, funding for contracted staffing and consultant services and the duty to draft a plan for long-term care for presentation to Legislature and the Department of Health and Human Services. The recommendation also includes the duty to receive and consider recommendations from the Commission to Continue the Study of Long-term Care Facilities. The Blue Ribbon Commission must submit the report to the Legislature by November 4th, 2014. Vote: 10 for, 0 against.

I. INTRODUCTION

In 2013 the 126th Maine Legislature established the Commission to Study Long-term Care Facilities with the passage of Resolve 2013, Chapter 78. The resolve established the commission, specified the duties of the commission and set December 4th, 2013 as the due date for the report of the commission to the full Legislature. A copy of Resolve 2013, Chapter 78 is included as Appendix A. The deadline for the report was extended from December 4th to December 12th by vote of the Legislative Council on November 21st pursuant to Joint Rule 353, section 7.

The President of the Senate, Speaker of the House of Representatives and Governor completed their appointments during the late summer. The members include two State Senators, three State Representatives, an owner of a long-term care facility, a representative of a statewide association of long-term care facility owners, a representative of a statewide association of long-term care facilities, a city manager, a representative of the Governor's Office, and the director of Maine's long-term care ombudsman program. A copy of the membership list of the commission is included as Appendix B. The 11 member commission met on October 11th and 25th, November 8th and 15th and December 4th. All meetings were held in the Cross State Office Building in Augusta and were open to the public and broadcast through the Legislature's public Internet system.

II. RESOLVE 2013, CHAPTER 78

The duties of the commission were outlined in Resolve 2013, Chapter 78 and included issues relating to reimbursement, staffing and regulatory requirements and access, particularly in rural communities. The specific duties and policy areas in the resolve are as follows:

- **Reimbursement.** The commission was directed to study different reimbursement mechanisms, including pay-for-performance, acuity of residents, supplemental payments for nursing facilities with a high MaineCare population, and cost of living adjustments for MaineCare reimbursement.
- **Staffing.** The commission was directed to study the development of minimum staffing requirements based on a 24-hour time period.
- **Access.** The commission was directed to study the viability of privately owned facilities in rural communities, the impact on rural populations of nursing home closures, and the possibility of collaborative agreements with critical access hospitals to share resources.

The Resolve specifically referred to other legislative bills, resolves and reports that were folded into the duties of this commission. Several of these were from the First Regular Session of the 126th Legislature (LDs 928, 1245 and 1246). The Resolve also specifically referred to the report of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities established in Resolve 1997, chapter 81 (partly enacted as Part BBBB of Public Law 1999, Chapter 731).

III. COMMISSION PROCESS

A. First Meeting

The first meeting of the commission was held on October 11th. After welcoming the public, Senator Margaret Craven and Representative Peter Stuckey, the chairs of the commission, introduced the members of the commission: Diane Barnes, Senator David Burns, Philip Cyr, Richard Erb, Representative Richard Farnsworth, Brenda Gallant and John Watson. (Kenneth Albert was unavailable for the first meeting and Representative Beth Turner was appointed to the commission between the first and second meeting.) The commission reviewed the major policy issues that led to passage of the resolve and the bills, resolves and studies that were considered by the Joint Standing Committee on Health and Human Services when they crafted the language of the resolve. Major policy areas included access in urban and rural areas, staffing and regulatory requirements and reimbursement issues. Bills, resolves and studies from 2013, the subject matter of which was incorporated into Resolve 2013, Chapter 78, included LD 928, LD 1245 and LD 1246. Also considered were the final report of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities issued in accordance with Resolve 1997, Chapter 81 and the progress report on alternatives to minimum staffing ratios from Commissioner Mary Mayhew to the Joint Standing Committee on Health and Human Services, January 7, 2013. The commission received background information from the Berry, Dunn, McNeil and Parker accountancy firm regarding the nursing facility MaineCare reimbursement shortfall between allowable costs and reimbursement. The Berry, Dunn, McNeil and Parker materials are included as Appendix C.

B. Second Meeting

The second meeting of the commission was held on October 25th. After welcoming the public and introducing the members of the commission, Senator Margaret Craven and Representative Peter Stuckey introduced Julie Fralich, Program Director on Disability and Aging at the Muskie School of Public Policy at the University of Southern Maine. Ms. Fralich provided an overview of the aging of Maine's population, reviewed Maine's long-term care system and compared it to systems in other states. She discussed trends in long-term care services, presented options for paying bonuses to nursing facilities providing particularly high quality care and introduced other initiatives regarding long-term services and supports to persons with disabilities and older persons. A copy of Ms. Fralich's materials is included as Appendix D.

The commission heard testimony from the perspective of direct care workers and a family member of a nursing facility resident. Written materials, included as Appendix E, were submitted by Michelle Heath, CNA, Helen Hanson, CNA and Roy Gedat, a personal support worker, owner of a private duty non-medical home care business and advocate for direct care workers. Together with Norman O'Halloran, husband of a nursing facility resident, they spoke with the commission and answered questions. They spoke with passion and understanding of the challenges of providing high quality care, the difficult work performed for low wages by overworked staff and the need for personalized care that meets the needs of the residents of nursing facilities.

Stephanie Rice, CPA, with the Berry, Dunn, McNeil and Parker accountancy firm in Portland, spoke with the commission and provided financial data on nursing facilities, occupancy percentages, payor mix data and an overview of the underfunding of Maine's nursing facilities for the past decade. Ms. Rice provided information about changes in nursing facility populations and reimbursement over recent years. She spoke of the increasing level of acuity of resident needs, the decreasing Medicare pay rates and the decreasing percentage of residents whose care is reimbursed through the Medicare program. Ms. Rice explained the operation of the nursing facility Principles of Reimbursement, adopted in Department of Health and Human Services rules as Chapter 101, MaineCare Benefits Manual, Chapter III, Section 67.

Ms. Rice provided information on acuity-based reimbursement using the Resident Assessment Instrument, which consists of the Minimum Data Set (MDS) specified for use by the federal Centers for Medicare and Medicaid Services and the Resident Assessment Protocols. Commission members learned that the MDS assesses residents for hearing, speech and vision, cognitive patterns, mood, behavior, preferences for customary routine and activities, functional status, bladder and bowl function, active diagnoses, health conditions, swallowing and nutritional status, skin conditions, medications, special treatments, procedures and programs, restraints and participation in assessment and goal setting. A copy of the Minimum Data Set, Version 3.0 is included as Appendix F.

MaineCare reimbursement for nursing facility services, through the Principles of Reimbursement for Nursing Facilities, is critical to the operations and financial health of Maine's nursing facilities. Of the 6,974 licensed nursing facility beds in Maine as of July 15, 2013, the occupancy rate was 90.72% or 6,327 beds. Reimbursement was provided to the nursing facilities by MaineCare, Medicare and an "other" category that includes private pay, private insurance and other payment sources. In July 2013 percentages of residents in each pay category were 67.43% MaineCare, 10.68% Medicare and 21.89% Other.

The Principles of Reimbursement provide the mechanism by which MaineCare reimburses nursing facilities' costs that are determined to be allowable and that are included in the facilities' cost reports. The mechanism includes dividing facilities into peer groups based on the facility being (1) hospital-based, (2) non-hospital-based with a licensed number of beds of up to 60, or (3) non-hospital-based with a licensed number of beds over 60. Costs that are reimbursable by the MaineCare program, called reimbursable costs, are divided into three categories: fixed costs such as capital expenses and real estate and property taxes; direct care costs such as nursing and certified nursing assistant and ward clerk salaries; and routine costs such as administrative expenses. Reasonable fixed costs are not subject to a limit except that approval for capital expenditures and expansions and additional bed capacity require the approval of the Department of Health and Human Services through the Certificate of Need process under Title 22, Maine Revised Statutes, chapter 103-A. Direct care and routine costs are limited by application of base year costs in the facility's fiscal year that ended in 2005 and by a limit of 87% of the median costs in the facility's peer group for the applicable region of the state.

Reimbursement to nursing facilities is designed to, and does, result in underpayment of allowable costs by MaineCare. Based on nursing facilities' 2011 "as filed" cost reports for their fiscal years

ending in 2011, the nursing facilities total allowable costs amounted to $300,571,792. MaineCare reimbursement totaled $271,457,438. The resulting underfunding of nursing facility care, comparing allowable costs to reimbursement, for 2011 was $29,114,354. The spreadsheet comparing allowable costs and MaineCare reimbursement prepared by the Department of Health and Human Services for the commission is included as Appendix G. Commission members noted that the $29,114,354 in underfunding is itself understated since $8,000,000 in administrative and management costs are subject to an internal cap in the routine cost component and thereby excluded in calculating underfunding. The total for underfunding for nursing facilities for 2011 then amounts to $37,114,354.

Commission members learned that delayed auditing by the Department of Health and Human Services of filed cost reports is a serious problem for nursing facilities and contributes to financial pressures. The department provided information to the commission that as of October 28, 2013, 174 cost reports for nursing facilities spanning facility fiscal years from 2010 through 2012 were awaiting auditing in the department. Payments to the providers whose cost reports await auditing are estimated to amount to $8,000,000. Timely auditing would accelerate payments to nursing facilities and reduce the gap between amounts paid and amounts owed.

Commission members reviewed MaineCare reimbursement information and discussed the mechanisms used in the Principles of Reimbursement, including the roles of the base year, the peer groups and the limitation to a percentage of median costs. Commission members learned that the base year of 2005 was established in 2010 and that since 2010 nursing facilities have received only one inflation adjustment, an increase in 2012 of 2%. Commission members learned that the chronic underfunding of nursing facilities causes a significant cost shift to private pay residents, undermines the ability of facilities to provide high quality care and places facilities at risk of financial disaster and closure.

Commission members proceeded to discuss the Department of Health and Human Services rules for nursing facility services, adopted as Chapter 101, MaineCare Benefits Manual, Chapter II, Section 67. Commission members focused in this discussion on staffing requirements. Commission members referred to the minimum staffing ratios, established pursuant to the Public Law 1999, Chapter 731, Section BBBB-11 and rules adopted in Chapter 110, Section 9.A.4 and the requirements for licensed staffing as adopted in Chapter 110, Section 9.A.3. Public Law 1999, Chapter 731 is included as Appendix H. Rule Chapter 110, Section 9 on resident care staffing is included as Appendix I. Chapter 110, Section 9.A.4 requires a minimum nursing staff to resident ratio on the day shift of one direct-care provider for every 5 residents; on the evening shift of one direct-care provider for every 10 residents; and on the night shift of one direct-care provider for every 15 residents. Chapter 110, Section 9.A.3 requires coverage by licensed nursing staff sufficient to meet the needs of the residents as determined by their levels of care. In addition, Section 9.A.3 sets a minimum standard that addresses licensed nurse staffing, allows in some circumstances the Director of Nursing to be counted, disallows counting private duty nurses and provides for variations in staffing depending on the number of beds in the nursing facility.

Nursing facilities must also comply with the federal requirement from the Department of Health and Human Services, Centers for Medicare and Medicaid Services for staffing adequate to care for the facility's residents. Specifically the federal regulation, 42 Code of Federal Regulations, section 483.30 requires that each facility "must have sufficient nursing staffing to provide nursing and related services to attain or maintain the highest practical physical, mental and psychological well-being of each resident, as determined by resident assessments and individual care plans." A copy of 42 C.F.R. section 483.30 is included as Appendix J.

In addition to the federal and state requirements for minimum staffing, nursing facilities are assessed for the number of hours of direct care provided to each resident per day by registered nurses, licensed nurses and nursing aides and assistants. A national study, "Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2005 through 2010," written by Charlene Harrington, Helen Carillo, Megan Dowdell, Paul Tang and Brandee Woleslagle Blank (published by the Department of Social and Behavioral Sciences at the University of California, San Francisco in 2011), cites the strong relationship between resident characteristics, nurse staffing time requirements and nursing costs in nursing homes and that relationship serving as the basis for the case mix reimbursement systems used in some states. In addition, the study cites reporting by the Centers for Medicare and Medicaid Services that facilities staffing below 4.1 hours per resident day for long stay residents may provide care that results in harm and jeopardy to the residents. The study also cites Institute of Medicine studies that conclude that there is a positive relationship between nursing staffing and the quality of nursing home care and the recommendation of an expert panel of minimum staffing levels that provide 4.55 hours resident day. Charlene Harrington, lead author on the "Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2005 through 2010," sent a letter to commission member Brenda Gallant dated October 8, 2013 stating that Maine's staffing requirements of 3.46 hours per resident per day are close to the recommended 4.1 level, that quality of care could decline if Maine eliminates its ratios or reduces its staffing standards and that such steps would be a serious step backward. Ms. Harrington's letter is included as Appendix K.

C. Third Meeting

The third meeting of the commission was held on November 8th. The commission heard a presentation by State Auditor Pola Buckley and Principal Auditor Amanda Spencer on the Auditor's review of cost of care amounts assessed to long-term care facility residents for the first nine months of State fiscal year 2013. The State Auditor's report on Cost of Care is included as Appendix L. For residents who receive assistance from the Department of Health and Human Services, cost of care acts as a co-payment that the residents pay directly from their own income to their facilities, both nursing facilities and private non-medical institutions. This leaves a balance that is payable by the department and this is where the State Auditor found inaccuracies estimated at over $29,000,000 in State Fiscal Year 2013.

One Department of Health and Human Services computer system, the Automated Client Eligibility System (ACES), completes eligibility determinations for persons who receive assistance from the department and calculates cost of care and the responsibilities of the department. Another department computer system, the Maine Integrated Management Solution

(MIHMS) acts as the claims processing system and actually causes the payments to the long-term care facilities to be made. The auditor's review found deficiencies in both systems and failures of communication between them. The deficiencies caused mistakes in income and expense information and the failures resulted in errors in deducting cost of care and in payment. At the completion of the review the auditors concluded that during the nine months reviewed the Department of Health and Human Services in paying long-term care facilities should have deducted $76,000,000 for cost of care paid by residents.

Applying an error rate of 29% to the proper annualized cost of care deduction of $89,000,000, the resulting overpayment amounts to $29,000,000 for State Fiscal Year 2013. The auditors noted that the department has some procedures in place to recover overpaid funds but believes that these procedures are far from adequate and do not address the root causes on a timely basis. Quoting from the State Auditor's report, the commission notes that this "overpay and recover procedure cannot mitigate the fact that at any given time about $27 million or more of State and federal money is not available for government use." The auditors conclude with recommendations that the department improve internal controls to ensure that cost of care amounts are computed correctly and implement additional controls and system corrections that allow cost of care to be properly deducted from the monthly payments that the department makes to long-term care facilities.

At the second and third meetings of the commission, members received information and discussed the challenges to access to nursing facility services in rural areas. Commission members learned that when the Atlantic Rehabilitation and Nursing Center in Calais closed in June, 2012, the disruption was felt both within and beyond the walls of the 52-bed facility. Ninety-two employees of the facility lost their jobs, all of the residents suffered through the disruption of locating nursing facility services outside of Calais and families and friends of residents faced increased travel to spend time with their loved ones.

At the third meeting the commission heard a presentation on the perspective of a rural nursing facility from owner Nathan Brown of the Oceanview Nursing Home in Lubec. Oceanview is a 31-bed facility that in July 2013 was operating at 87.10% occupancy. On that day, its Medicare census was 3.7%, its MaineCare census was 85.19%, and its "other payor" census was 11.11%. Mr. Brown spoke with passion of his commitment to Oceanview's residents and their dedicated staff and he stressed the precarious financial position that facilities are in that have high percentages of MaineCare residents and low percentages of Medicare residents. He argued for fair reimbursement from Medicaid so that costs are not shifted onto other payors and allowable costs are paid. In addition, Mr. Brown brought to the attention of the commission the financial stress caused by a resident whose medical eligibility for care changes from a residential level care to a nursing facility level of care. Because eligibility standards for the two types of care are not identical, a person can be financially and medically eligible for residential care and then become medically eligible for nursing facility care while failing to qualify financially. At the time of the third meeting, when Mr. Brown spoke with the commission, two of Oceanview's residents fell into this category.

The commission discussed LD 1092, An Act to Increase the Use of Long-term Care Insurance, a bill sponsored by Senator Craven and carried over to the Second Regular Session of the 126th Legislature for consideration by the Joint Standing Committee on Insurance and Financial Services. Christos Orestis, III, a principal in the business Life Care Funding, presented information to the commission on Medicaid life settlement policy conversion. This concept involves transferring ownership of a life insurance policy through a contract that guarantees a benefit of a stated amount through payment for long-term care, a death benefit and any remaining balance to the owner's estate. This policy option is already available but individuals are often unaware of the option. Through a Medicaid State Plan Amendment the arrangement could be tailored to benefit the owner and the MaineCare program. Mr. Orestis stressed that life settlement policy conversion enables a policy owner to continue coverage under a life insurance policy, provides benefits upon death and avoids disqualification by MaineCare because a life insurance policy is considered to be an asset and because some policy owners arrive at a point in which they are unable to continue to pay for premiums. Mr. Orestis stated that the amount of contractual benefits to the policy owner varies with the owner's life expectancy. The buyer of the life insurance policy makes a payment into an irrevocable trust that holds the owner's benefit. The exact terms and amounts are driven by the commercial market, averaging 45% and ranging from 25% to 65% of the face value of the life insurance policy. Mr. Orestis suggested that the Legislature, in considering LD 1092, review whether to exempt benefits from state taxes.

The commission reviewed information from Julie Fralich from the second meeting and information provided by Richard Erb and Holly Harmon from the Maine Health Care Association regarding pay for performance as an incentive to encourage high quality care. Materials provided by Mr. Erb and Ms. Harmon are included as Appendix M. Quality measures could include staffing levels and retention rates, consistent assignment of staff, consumer satisfaction, inspection performance, clinical quality indicators, quality of life measures, efficiency, access, employee satisfaction, family satisfaction and quality improvement that measures factors such as reported pain and use of anti-psychotic medications. Performance methods could include benchmarks, percentile rankings, annual improvements, structure versus process and risk adjustments. Administration could be complex or simple, could rely on data that is already collected or new data and could use a composite index or a simple approach. The payment method could be an addition to or a subtraction from the Principles of Reimbursement. Whatever the design of the pay for performance system, a successful system would require significant stakeholder involvement, phased-in implementation, flexibility in administration and a secure source of funding.

D. Fourth Meeting

The fourth meeting of the commission was held on November 15th. The commission received a written statement and an oral presentation from Leo Delicata from Legal Services for the Elderly and oral testimony from Lisa Harvey-McPherson from Eastern Maine Healthcare. Mr. Delicata spoke of the importance of looking at the whole continuum of long-term care and then at the individual parts of the continuum. He spoke of the importance of adequate reimbursement for long-term care facilities so that they can provide skilled staffing and ensure high quality care. A copy of Mr. Delicata's statement is included as Appendix N. Ms. Harvey-McPherson spoke of

the importance of quality staffing, strengthening every component of the provider market, impending cuts in reimbursement provided by Medicare, and shortages of nursing facility care that is specialized and serves ventilator-dependent residents, that provides geriatric, sub-acute nursing and psychiatric care and that serves rural areas.

Commission members discussed the duties of the commission and proposed preliminary recommendations. The commission also voted to request an additional meeting to finish its work.

E. Fifth Meeting

The fifth meeting of the commission was held on December 4th. At this meeting, the commission refined the recommendations that had been developed in previous meetings and took final votes on each recommendation.

The commission received information from the Department of Health and Human Services regarding the cost of proposals increase nursing facility reimbursement for high MaineCare utilization by 20 cents per patient per day for each 1% above 70% MaineCare census. The handout pricing reimbursement at 20 cents per patient per day for each 1% above 70% MaineCare census is included as Appendix O. In this discussion commission members noted that they favored a supplemental payment of 40 cents per patient per day for each 1% above 70% MaineCare census. The commission discussed the different reimbursement issues with respect to different types of nursing facilities (for example, facilities with a high MaineCare or those that are larger than 90 beds and higher acuity residents) resulting in the need for several different reimbursement recommendations in order to increase revenue for most nursing facilities. Richard Erb, Maine Health Care Association, also provided information quantifying changes to reimbursement mechanisms included as Appendix P. Mr. Brett Seekins, Baker, Newman and Noyes, presented information on the process that the Department of Health and Human Services follows in obtaining federal approval of a MaineCare State Plan Amendment. Mr. Brett Witham, Verrill Dana, L.L.P., assisted the commission with review of information on the MaineCare Principles of Reimbursement for Nursing Facilities. There was also considerable discussion about whether recommendations should reflect the large and growing gap between cost and reimbursement or be simple, incremental and affordable. The commission reviewed research information on pay-for-performance provided by Kristen Brawn of the Office of Policy and Legal Analysis. The research information is included as Appendix Q.

Commission members wish to publicly thank all those persons who provided assistance and information and who spoke from their expertise, experience and hearts to the commission. Specifically the commission thanks Ms. Fralich, Ms. Heath, Ms. Hanson, Mr. Gedat, Mr. O'Halloran, Ms. Rice, Ms. Buckley, Ms. Spencer, Mr. Brown, Mr. Orestis, Ms. Harmon, Mr. Seekins, Mr. Witham and Ms. Brawn.

The commission determined that there was still considerable work to be done regarding the duties set in Resolve 2013, Chapter 78, particularly with respect to ensuring access, providing adequate reimbursement for residents whose care is paid through the MaineCare program and

developing a state plan across the spectrum of long term care that includes home and community based services in addition to nursing facilities.

IV. RECOMMENDATIONS

The commission focused its work on long-term care facilities on adequate funding, staffing and regulatory requirements and access to nursing facility services in rural and urban areas. The 14 recommendations of the commission include recommendations: designed to assist facilities in achieving adequate reimbursement for the care of residents whose care is reimbursed by the MaineCare program; a recommendation that Maine retain the current nursing facility staffing requirements and ratios; a recommendation to address the use of consumer life insurance as a resource to pay for nursing facility care; recommendations relating to errors in Cost of Care overpayments to facilities; and recommendations for further study of long-term care. The recommendation for further study by a Blue Ribbon Commission on Long-term Care reflects an understanding that more work needs to be done to study and make recommendations on a state plan for long-term care services in the community and in facilities. The recommendation for further study by a Commission to Continue the Study of Long-term Care Facilities reflects an understanding that further review and recommendations are needed on adequate reimbursement for facilities, ensuring access in rural and urban areas and providing incentives for high quality care through the nursing facility principles of reimbursement of the MaineCare program. Specific recommendations, including the votes for each recommendation are below.

1. Rebase to 2011 and every two years. Direct the Department of Health and Human Services to amend the Principles of Reimbursement for Nursing Facilities, Chapter 101, MaineCare Benefits Manual, Chapter III, Section 67 in the direct care cost component for nursing facilities in subsection 80.3.3(1) to establish a facility's base year by reference to the facility's 2011 audited cost report, or if the 2011 audited report is not available by reference to the facility's 2011 as filed cost report, and rebase every two years thereafter. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in the routine cost component in subsection 80.4.5.1 in a similar manner to the direct care cost component. Vote: 9 for, 0 against, 1 abstain.

2. Increase peer group upper limit. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to increase the peer group upper limit on the base year case mix and regionally adjusted cost per day to 110% of the median in the direct care cost component in subsection 80.3.3.4(b) and in the routine cost component in subsection 80.5.4. Vote: 8 for, 2 against.

3. Repeal administrative and management ceiling. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 43.4.2(A) to repeal the administrative and management ceiling in the routine cost component. Vote: 7 for, 3 against.

4. Cost of living adjustment included in budget request. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 91.1 to require the Department of Health and Human Services to set the inflation adjustment cost of living percentage change in reimbursement on an annual basis and by reliance on a publicly available

index such as the Consumer Price Index Medical Care Services Index and to require that budget requests submitted by the Department of Health and Human Services include that annual adjustment. Vote: 9 for, 0 against.

5. Health insurance as fixed cost component. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to move health insurance costs for nursing facility personnel in subsection 41.1.7(3) from the direct care cost component and in subsection 43.4.1(16)(c) from the routine cost component to the fixed cost component in subsection 44. Vote: 6 for, 3 against.

6. Supplemental payment for high MaineCare census. Direct the Department of Health and Human Services to amend the Principles of Reimbursement to provide a supplemental payment, subject to cost settlement, to nursing facilities with a MaineCare census above 70%. The supplemental payment would provide additional reimbursement to those high MaineCare census facilities of 40 cents per resident per day for each 1% MaineCare census above 70%. The supplemental payment would be enacted on an emergency basis with payments beginning July 1, 2014. Vote: 7 for, 3 against. The minority favored a supplemental payment for nursing facilities with a Medicaid census above 70% that is identical to the majority proposal but that is not cost settled.

7. Increase acuity for dementia. Direct the Department of Health and Human Services to amend the Principles of Reimbursement in subsection 80.3.2 to increase the specific resident classification group case mix weight that is attributable to a resident who is diagnosed with dementia. Vote: 9 for, 0 against, 1 abstain.

8. Maintain current staffing ratios. Recommend that no changes be made to staffing ratios and requirements for licensed staff coverage adopted in Chapter 110, Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities, Chapter 9, subsection 9.A.3 and 9.A.4. Vote: 10 for, 0 against.

9. Support life settlement contract legislation. Recommend to the Insurance and Financial Services Committee that they consider, amend and report out favorably LD 1092, An Act to Increase the Use of Long-term Care Insurance, on life settlement policy conversion. The bill proposes to allow an owner of a life insurance policy to enter into a life settlement contract with a life care benefits company and to use the proceeds for long-term care expenses. The bill proposes amendments to the MaineCare program so that the policy and benefits under it do not disqualify the owner from eligibility for MaineCare long-term care services. Vote: 7 for, 0 against, 1 abstain.

10. Collect Cost of Care overpayments. Direct the Department of Health and Human Services to take all necessary actions to collect Cost of Care overpayments to nursing facilities and private non-medical institutions which were paid when the department's computer systems, when providing reimbursement owed by the department, failed to take into account the financial contributions paid by residents in the nursing facilities and private non-medical institutions. Vote: 10 for, 0 against.

11. Correct Cost of Care overpayments. Direct the Department of Health and Human Services to require that Molina make adjustments to the MIHMS computer system to correct and discontinue overpayments in the calculation and deduction of Cost of Care in the payment of nursing facilities and private non-medical institutions. Vote: 10 for, 0 against.

12. Cost of Care recoupment used for nursing facilities. Recommend that the first $10 million collected from Cost of Care overpayment recoupments collected under recommendation 10 be appropriated to pay for initiatives recommended by the commission. Vote: 10 for, 0 against.

13. Continue the commission. Recommend establishing a Commission to Continue the Study of Long-term Care Facilities, based on the 2013 commission, with added duties of reporting to the Blue Ribbon Commission on Long-term Care and reviewing payment methodologies and removing the duties completed in 2013. The recommendation includes the duty to report to Legislature and to the Blue Ribbon Commission on Long-term Care by October 15th, 2014. Vote: 10 for, 0 against.

14. Establish Blue Ribbon Commission on Long-term care spectrum. Recommend establishing a Blue Ribbon Commission on Long-term Care to review the State's plan for long-term care and the provision of services in the community and in nursing and residential care facilities. The recommendation includes broad representation on the commission, funding for contracted staffing and consultant services and the duty to draft a plan for long-term care for presentation to Legislature and the Department of Health and Human Services. The recommendation also includes the duty to receive and consider recommendations from the Commission to Continue the Study of Long-term Care Facilities. The Blue Ribbon Commission must submit the report to the Legislature by November 4th, 2014. Vote: 10 for, 0 against.

V. DRAFT LEGISLATION

DRAFT
An Act to Implement the Recommendations of the Commission to Study Long-term Care Facilities (Emergency Legislation)

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

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

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

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

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

1. Facility base year. The Principles of Reimbursement must be amended, in order to establish a nursing facility's base year and increase rates beginning July 1, 2014 and every 2 years thereafter, as follows:

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

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

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

A. In the direct care cost component in subsection 80.3.3.4(b) the peer group upper limit must be increased to 110% of the median; and

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

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

4. Health insurance costs. The Principles of Reimbursement must be amended to include the costs of health insurance for nursing facility personnel beginning July 1, 2014 as follows:

A. The costs of health insurance for those personnel currently included in the direct care cost component in subsection 41.1.7(3) must be included in the fixed cost component in subsection 44 and removed from the direct care cost component for the purposes of rebasing and future cost settlements; and

B. The costs of health insurance for those personnel currently included in the routine cost component in subsection 43.4.1(16)(c) must be included in the fixed cost component in subsection 44 and removed from the routine cost component for the purpose of rebasing and future cost settlements.

5. Cost of living adjustment. The Principles of Reimbursement must be amended in subsection 91.1 to set the inflation adjustment cost of living percentage change in nursing facility reimbursement on an annual basis and by reliance on the Consumer Price Index Medical Care Services Index. Beginning with the biennial budget for state fiscal year 2015 in submitting budget proposals to the Governor and the Legislature the department shall include in the budget for nursing facilities funding sufficient to cover the cost of annual inflation as calculated by reference to the Consumer Price Index Medical Care Services index.

6. Supplemental payment for high MaineCare census. The Principles of Reimbursement must be amended to provide a supplemental payment, subject to cost settlement, to nursing facilities with a MaineCare census above 70% beginning July 1, 2014.. The supplemental payment must provide additional reimbursement to those high MaineCare census facilities of 40 cents per resident per day for each 1% MaineCare census above 70%.

7. Increase acuity for dementia. The Principles of Reimbursement must be amended in subsection 80.3.2 to increase the specific resident classification group case mix weight that is attributable to a nursing facility resident who is diagnosed with dementia.

Sec. 2. Cost of care overpayment recoupment. The Department of Health and Human Services shall immediately take all necessary actions to collect cost of care overpayments to nursing facilities and private non-medical institutions which were paid when the department's computer systems, when providing reimbursement owed by the department, failed to take into account the financial contributions paid by residents in the nursing facilities and private non-medical institutions and miscalculated the amounts payable under the MaineCare program. The first $10,000,000 of revenue collected under this section in each year of the 2014-2015 biennium must be used to provide funding for section 6 of this Act.

Sec. 3. Cost of care overpayment correction. The Department of Health and Human Services shall immediately require that the department's contractor Molina Medicaid Solutions make adjustments to the Maine Integrated Health Management Solution computer system to correct and discontinue overpayments in the calculation and deduction of cost of care in the payment of nursing facilities and private non-medical institutions.

Sec. 4. Commission to Continue the Study of Long-term Care Facilities. The Commission to Continue the Study of Long-term Care Facilities, referred to herein as "the commission," is established notwithstanding Joint Rule 353. The membership, duties and functioning of the commission are subject to the following requirements.

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

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

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

(3) Six members appointed by the Governor who possess expertise in the subject matter of the study, as follows:

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

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

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

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

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

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

C. All appointments must be made no later than 30 days following the effective date of this Act. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members and after adjournment of the 126th Legislature, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative

Council may grant authority for the commission to meet and conduct its business.

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

(1) Funding for long-term care facilities, payment methodologies and the development of a pay-for-performance program to encourage and reward strong performance by nursing;

(2) Regulatory requirements other than staffing requirements and ratios;

(3) Collaborative agreements with critical access hospitals for the purpose of sharing resources;

(4) The viability of privately owned facilities in rural communities;

(5) The impact on rural populations of nursing home closures; and

(6) Access to nursing facility services statewide.

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

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

G. No later than October 15, 2014, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the Blue Ribbon Commission on Long-term Care and to the First Regular Session of the 127th Legislature.

Sec. 5. Blue Ribbon Commission on Long-term Care. The Blue Ribbon Commission on Long-term Care, referred to herein as "the commission," is established to review the State's plan for long-term care and the provision of services in the community and in facilities.

1. Commission membership. The commission consists of 13 members appointed as follows:

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

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

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

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

(3) A representative of a statewide organization representing consumer directed long term care services;

(4) A representative of a statewide association representing area agencies on aging;

(5) A representative of a statewide association providing legal services for the elderly; and

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

2. Chairs. The first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission.

3. Appointments; convening of commission. All appointments must be made no later than 30 days following the effective date of this legislation. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

4. Duties. The commission shall study the following issues and the feasibility of developing or amending a state plan for the provision of long-term care in the community and in facilities:

A. Review the existing plans and programs that exist within the Department of Health and Human Services for providing long-term care services in home-based and community care settings and in nursing and residential care facilities;

B. Develop a state plan for providing long-term care services across the spectrum in a manner that provides dignity for clients and residents and is financially sustainable for individuals and the MaineCare program;

C. Receive and consider recommendations from the Commission to Continue the Study of Long-Term Care Facilities.

5. Staff assistance. The commission shall be staffed by the Legislative Council with assistance from contracted staff and expert consultant services pursuant to section 7.

6. Report. No later than November 5, 2014, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the First Regular Session of the 127th Legislature.

7. Funding. The commission shall seek funding contributions to fully fund the costs of contracted staff and expert consultant services. All funding is subject to approval by the

Legislative Council in accordance with its policies. The commission may not meet unless outside funding has been obtained and approval has been granted by the Legislative Council.

Sec. 6. Appropriations and allocations

Department of Health and Human Services
Nursing Facilities 0148
Provides funding to pay for nursing facilities services

GENERAL FUND		**2013-2014**	**2014-2015**
			$10,000,000
OTHER SPECIAL REVENUE FUNDS	(To be determined)		_____
FEDERAL EXPENDITURES FUND	(To be determined)		_____
Total	(To be determined)		_____

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

SUMMARY

This bill implements the recommendations of the Commission to Study Long-term Care Facilities. The bill includes amendments to the MaineCare Principles of Reimbursement for Nursing Facilities with regard to facility base year, peer group upper limit, administrative and management ceiling, health insurance costs, cost of living adjustment, supplemental payment for high MaineCare census and increased acuity for dementia. The bill includes a directive to the Department of Health and Human Services to collect amounts overpaid to nursing facilities and private non-medical institutions under the category of cost of care and a directive to the department to correct the computer problems that are leading to the overpayments. The bill provides funding for nursing facilities to fund the amendments to the MaineCare Principles of Reimbursement in the bill, the new funding being provided by the revenues from collection of MaineCare overpayments made because of cost of care miscalculations. The bill also includes the establishment of two study commissions: the Commission to Continue the Study of Long-term Care Facilities and the Blue Ribbon Commission on Long-term Care. No later than October 15, 2014, the Commission to Continue the Study of Long-term Care Facilities is required to submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the Blue Ribbon Commission on Long-term Care and to the First Regular Session of the 127th Legislature. No later than November 5, 2014, the Blue Ribbon Commission on Long-term Care is required to submit a report that includes its findings and recommendations, including suggested legislation, to the First Regular Session of the 127th Legislature.

APPENDIX A

Authorizing Legislation, Resolve 2013, Chapter 78

APPROVED | CHAPTER
JULY 16, 2013 | 78
BY GOVERNOR | RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND THIRTEEN

S.P. 331 - L.D. 986

Resolve, To Establish the Commission To Study Long-term Care Facilities

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

Whereas, it is necessary that this legislation take effect immediately in order to allow sufficient time for the Commission To Study Long-term Care Facilities to conduct its work; and

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

Sec. 1. Commission To Study Long-term Care Facilities established. Resolved: That, notwithstanding Joint Rule 353, the Commission To Study Long-term Care Facilities, referred to in this resolve as "the commission," is established; and be it further

Sec. 2. Commission membership. Resolved: That the commission consists of 11 members appointed as follows:

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

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

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

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

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

C. A person who serves as a city manager of a municipality in the State;

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

E. A representative of the Governor's office or the Governor's administration; and be it further

Sec. 3. Chairs; subcommittees. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission. The chairs of the commission are authorized to establish subcommittees to work on the duties listed in section 5 and to assist the commission. The subcommittees must be composed of members of the commission and interested persons who are not members of the commission and who volunteer to serve on the subcommittees without reimbursement. Interested persons may include representatives of nursing facilities with a high percentage of residents whose care is reimbursed through the MaineCare program, individuals with specialized knowledge in implementing an acuity-based staffing system, individuals with expertise in acuity-based reimbursement systems, a representative of an agency that provides services to the elderly and any other persons with experience in nursing facility care; and be it further

Sec. 4. Appointments; convening of commission. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business; and be it further

Sec. 5. Duties. Resolved: That the commission shall study the following issues and the feasibility of making policy changes to the long-term care system:

1. Funding for long-term care facilities, including the development of an acuity-based reimbursement system as proposed in Legislative Document 1245 of the 126th Legislature, "Resolve, Directing the Department of Health and Human Services To Create a More Equitable, Transparent Resource Allocation System for Nursing Facilities Based on Residents' Needs," and the development of a pay-for-performance program to encourage and reward strong performance by nursing facilities as proposed in Legislative Document 928 of the 126th Legislature, "An Act To Improve MaineCare Nursing Home Reimbursement To Preserve Access and Promote Quality";

2. Staffing and regulatory requirements, including the development of minimum staffing requirements based on a 24-hour time period as proposed in Legislative Document 1246 of the 126th Legislature, "An Act To Promote Greater Staffing Flexibility without Compromising Safety or Quality in Nursing Facilities";

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

4. Reimbursement mechanisms to reimburse facilities for which the MaineCare program is the payor for a high percentage of the residents as proposed in Legislative Document 928 of the 126th Legislature, "An Act To Improve MaineCare Nursing Home Reimbursement To Preserve Access and Promote Quality";

5. The viability of privately owned facilities in rural communities; and

6. The impact on rural populations of nursing home closures.

In performing the study the commission shall review the final report of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities established by Resolve 1997, chapter 81; and be it further

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the commission; and be it further

Sec. 7. Information and assistance. Resolved: That the Commissioner of Health and Human Services, the State Auditor and the State Budget Officer shall provide information and assistance to the commission as required for its duties; and be it further

Sec. 8. Report. Resolved: That, no later than December 4, 2013, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the Second Regular Session of the 126th Legislature.

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

APPENDIX B

Membership list, Commission to Study Long-Term Care Facilities

Commission to Study Long-term Care Facilities

Resolve 2013, Ch. 78

Thursday, October 17, 2013

Appointment(s) by the Governor

Kenneth J. Albert III DHHS 41 Anthony Ave. Augusta, ME 04333 207 287-6664	Representative of Governor's Office
Diane M. Barnes P.O. Box 1273 Calais, ME 04619 207 454-2512	City Manager
Philip A. Cyr 435 Washburn Street Caribou, ME 04736 207 498-3102	Nursing facility director, owner, or administrator
Richard A. Erb 35 Melden Drive Brunswick, ME 04011 207 623-1146	Director of a statewide association representing long-term care facilities
Brenda Gallant 196 Beechnut Hill Road Wiscasset, ME 04578 207 621-1079	Director of a long-term care ombudsman program
S. John Watson Jr. 41 Craige Street Portland, ME 04102 207 221-7000	Representative of a statewide association of long-term care facility owners

Appointment(s) by the President

Sen. Margaret M. Craven - Chair 41 Russell St Lewiston, ME 04240 207 783-1897	Senate Member
Sen. David C. Burns 159 Dodge Road Whiting, ME 04691 207 733-8856	Senate Member

Appointment(s) by the Speaker

Rep. Peter C. Stuckey - Chair 20 Vaill Street Portland, ME 04103 207 773-3345	House Member
Rep. Richard R. Farnsworth 55 Old Mast Road Portland, ME 04102 207 878-9663	House Members
Rep. Beth P. Turner 74 Main Road Burlington, ME 04417 207 732-4625	House Member

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Staff:

Jane Orbeton 287-1670
OPLA

Anna Broome 287-1670
OPLA

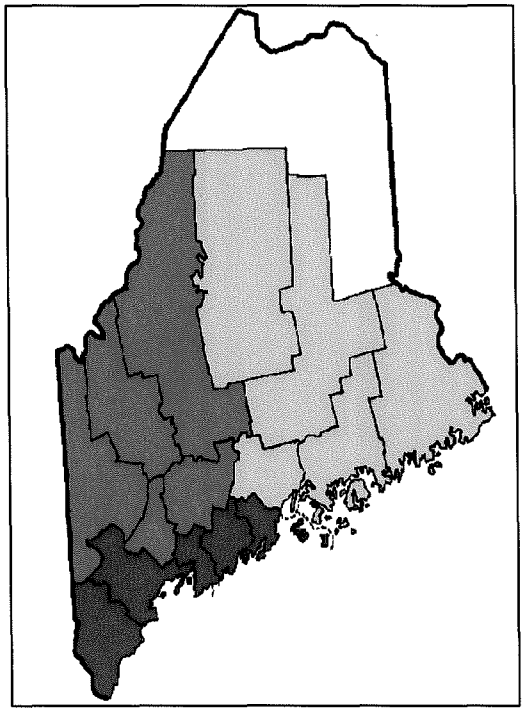
APPENDIX C

Berry, Dunn, McNeil and Parker Background on Shortfall

REGIONAL MAP

Following this document, you will find information regarding cost report data by region for the State of Maine. We have subdivided Maine into four regions organized by county. Below are listed the breakdowns by region and county so that when looking at any of our regional reports you will have a complete understanding of which facilities belong to a particular region.

Color	County	Region
Red	Lincoln	1
Red	Cumberland	1
Red	Knox	1
Red	York	1
Red	Sagadahoc	1
Green	Somerset	2
Green	Androscoggin	2
Green	Kennebec	2
Green	Franklin	2
Green	Oxford	2
Blue	Piscataquis	3
Blue	Penobscot	3
Blue	Waldo	3
Blue	Hancock	3
Blue	Washington	3
Yellow	Aroostook	4



BerryDunn

MaineCare NF Shortfall
BerryDunn's Industry Cost Data

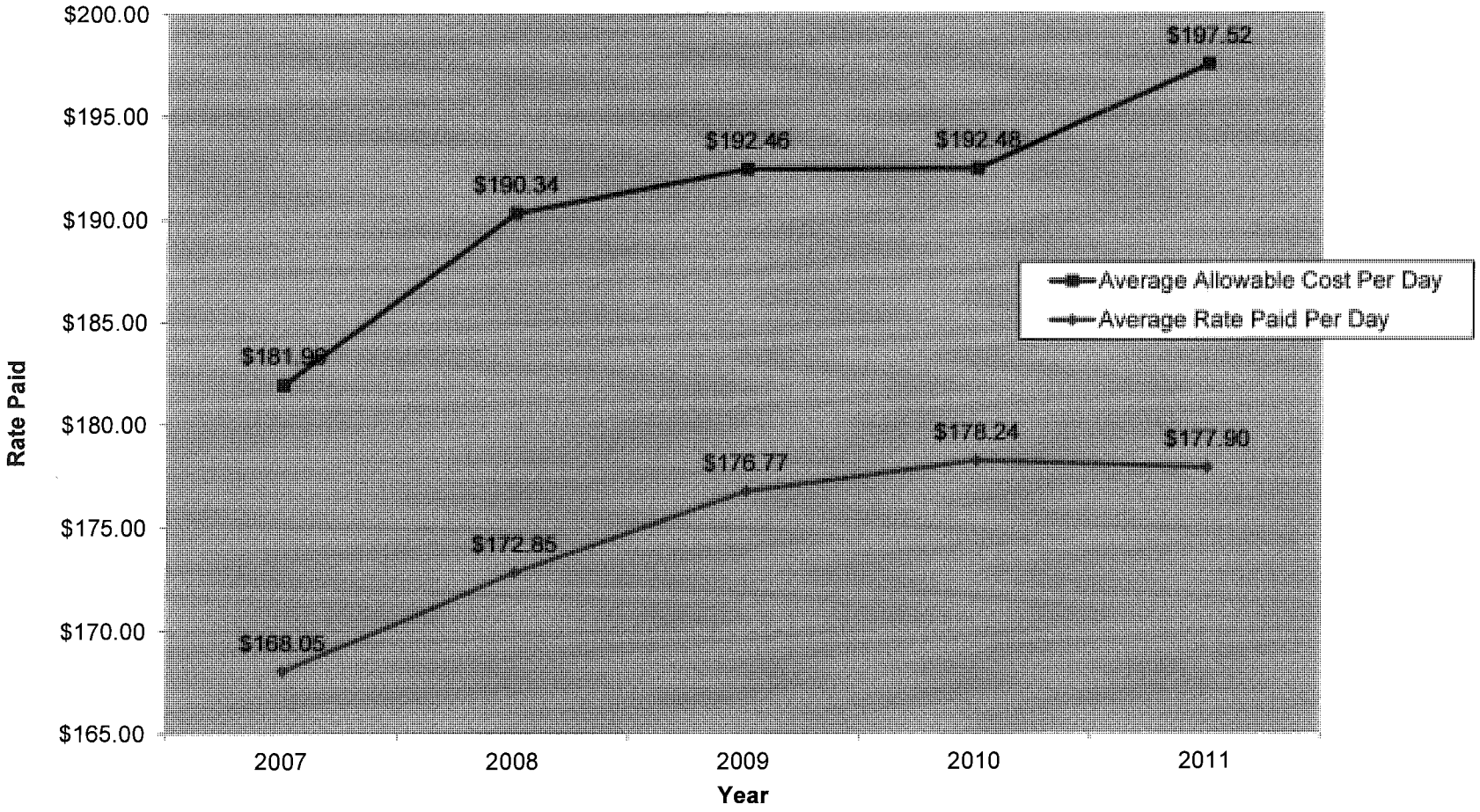
	2009		2010		2011	
	Total	Average Per Facility	Total	Average Per Facility	Total	Average Per Facility
Region 1	$ (11,432,294)	$ (326,637)	$ (9,826,386)	$ (280,754)	$ (12,734,002)	$ (363,829)
Region 2	(7,063,101)	(220,722)	(7,767,642)	(242,739)	(9,065,383)	(283,293)
Region 3	(3,366,872)	(124,699)	(3,303,672)	(122,358)	(5,398,985)	(199,962)
Region 4	(2,294,609)	(208,601)	(1,588,868)	(144,443)	(2,211,407)	(201,037)
Total	$ (24,156,876)		$ (22,486,568)		$ (29,409,777)	

Note: Based on 2009, 2010 and 2011 cost data. Shortfall represents difference between allowable costs per day and reimbursement per day.

Data includes all non hospital-based facilities and was compiled by BerryDunn utilizing "as-filed" cost reports for each reporting period.

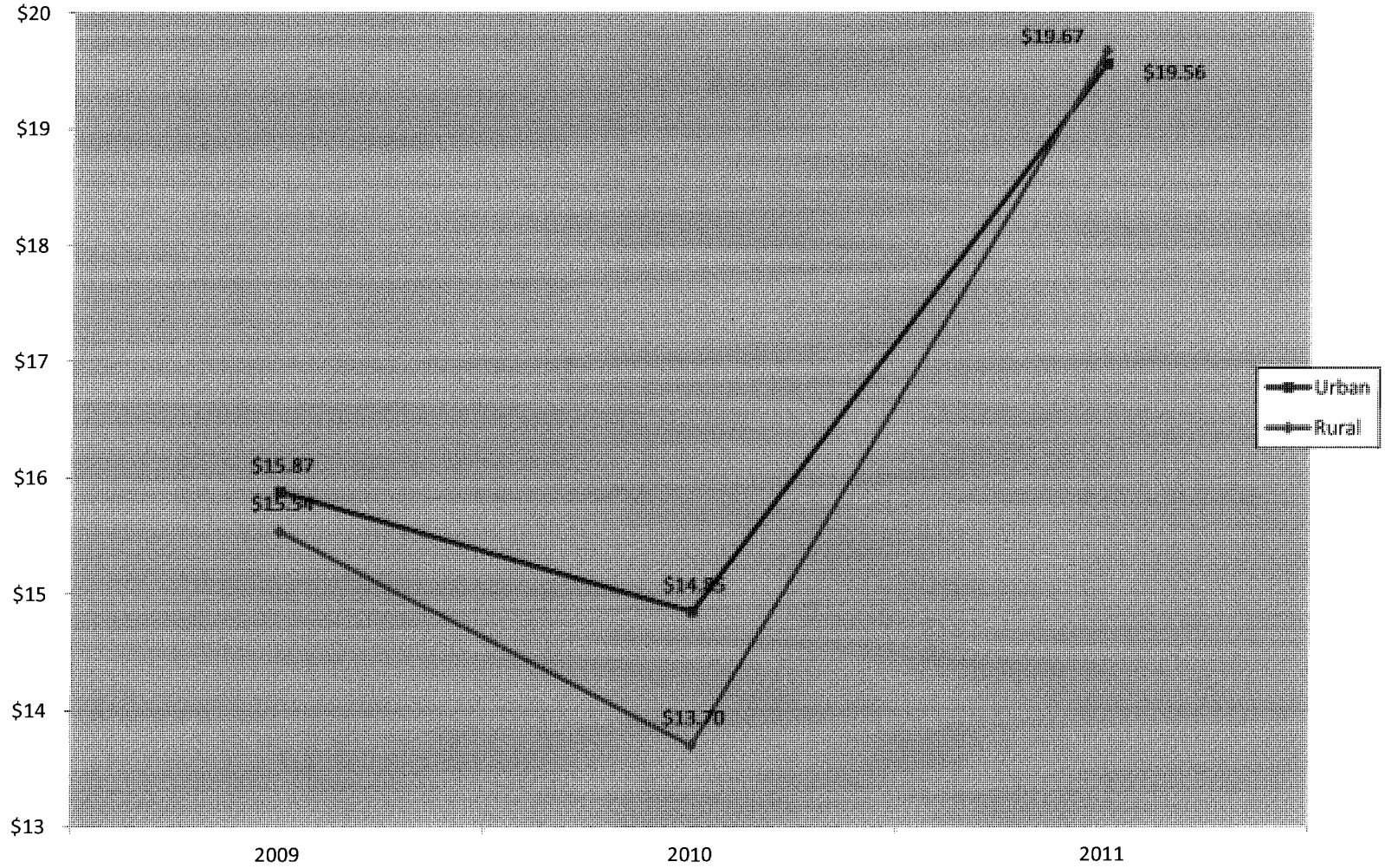
BerryDunn

Five Year Comparison of Average Medicaid Allowable Cost Per Day to Average Rate Paid to Nursing Facilities



Data includes all non hospital-based facilities and was compiled by BerryDunn utilizing "as-filed" cost reports for each reporting period.

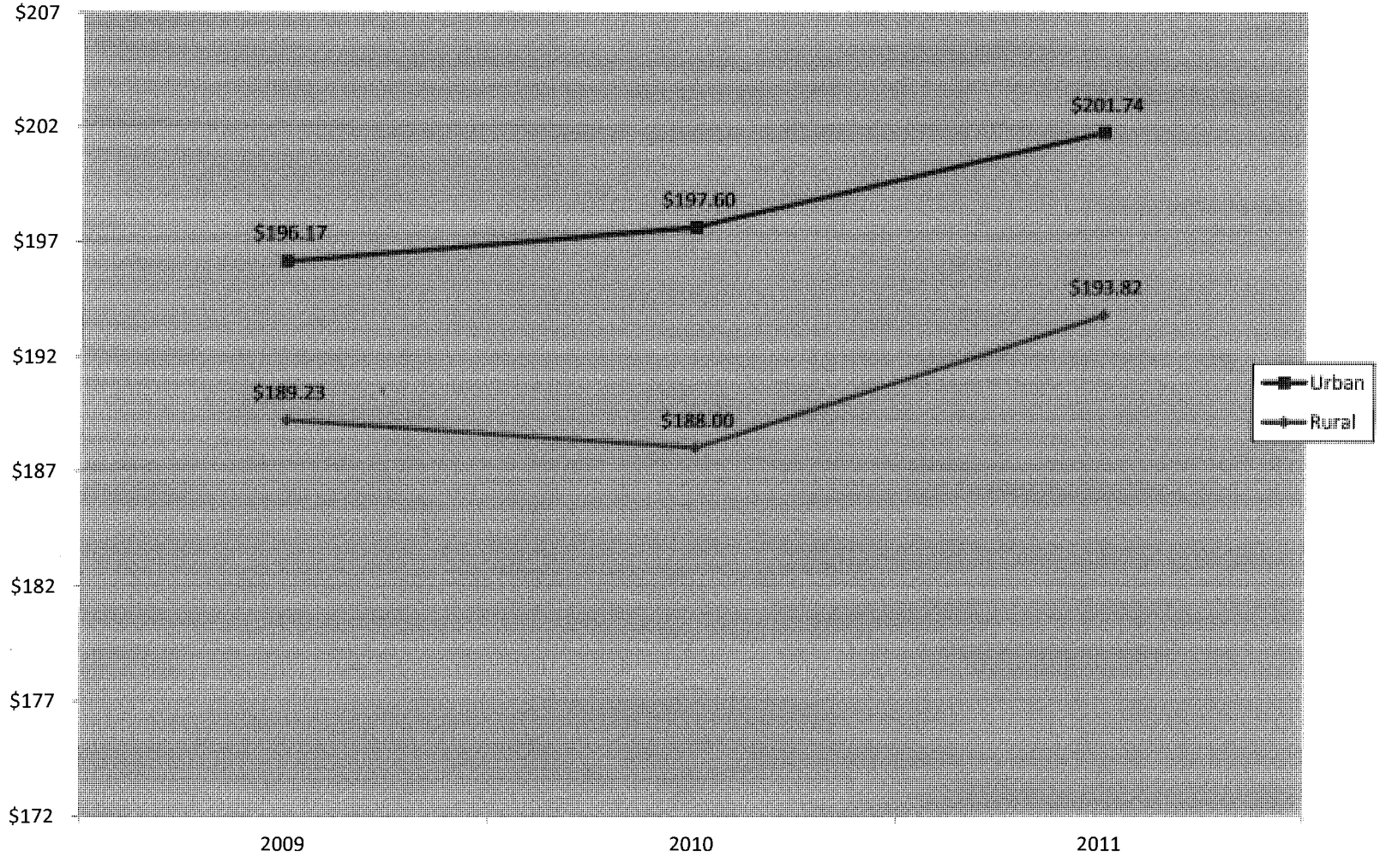
Average Medicaid Shortfall Per Day



Data includes all non hospital-based facilities and was compiled by BerryDunn utilizing "as-filed" cost reports for each reporting period.
Urban - includes providers located in Core Based Statistical Areas (CBSA's) of Penobscot County (#12620), Androscoggin Country (#30340) and Cumberland, Sagadahoc and York Counties (#38860) as defined by CMS.
Rural - includes providers located in Core Based Statistical Area (CBSA's) of Aroostook, Piscataquis, Somerset, Franklin, Oxford, Kennebec, Lincoln, Knox, Waldo, Hancock and Washington Counties (#99920) as defined by CMS.

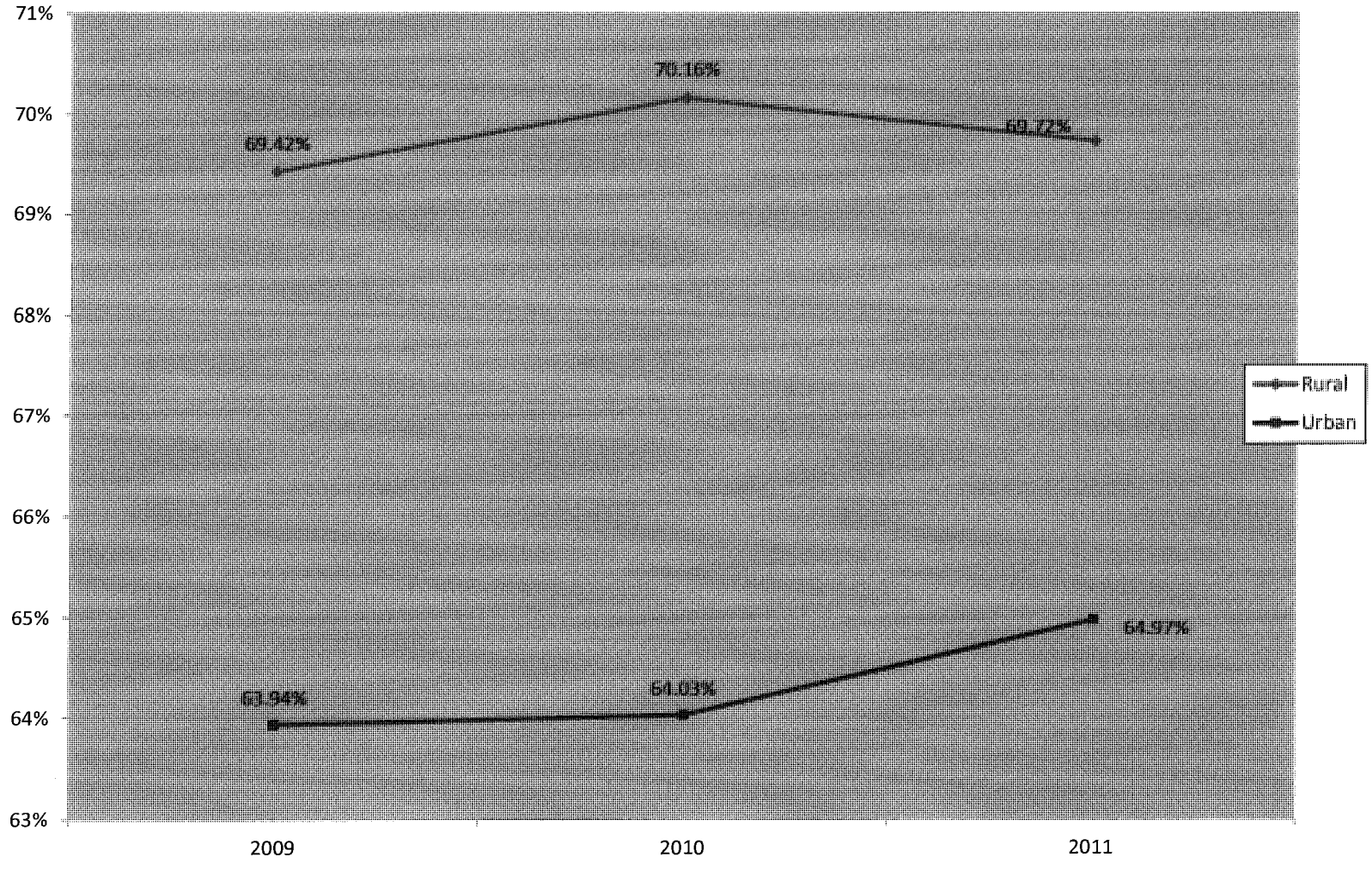
BerryDunn

Average Medicaid Cost Per Day



Data includes all non hospital-based facilities and was compiled by BerryDunn utilizing "as-filed" cost reports for each reporting period.
Urban - includes providers located in Core Based Statistical Areas (CBSA's) of Penobscot County (#12620), Androscoggin Country (#30340) and Cumberland, Sagadahoc and York Counties (#38860) as defined by CMS.
Rural - includes providers located in Core Based Statistical Area (CBSA's) of Aroostook, Piscataquis, Somerset, Franklin, Oxford, Kennebec, Lincoln, Knox, Waldo, Hancock and Washington Counties (#99920) as defined by CMS.

MaineCare Payor Percentage



Data includes all non hospital-based facilities and was compiled by BerryDunn utilizing "as-filed" cost reports for each reporting period.
Urban - includes providers located in Core Based Statistical Areas (CBSA's) of Penobscot County (#12620), Androscoggin Country (#30340) and Cumberland, Sagadahoc and York Counties (#38860) as defined by CMS.
Rural - includes providers located in Core Based Statistical Area (CBSA's) of Aroostook, Piscataquis, Somerset, Franklin, Oxford, Kennebec, Lincoln, Knox, Waldo, Hancock and Washington Counties (#99920) as defined by CMS.

APPENDIX D

Presentation by Julie Fralich, Muskie School of Public Service Report

Commission to Study Long-Term Care Facilities

Julie Fralich
Muskie School of Public Service
October 25, 2013
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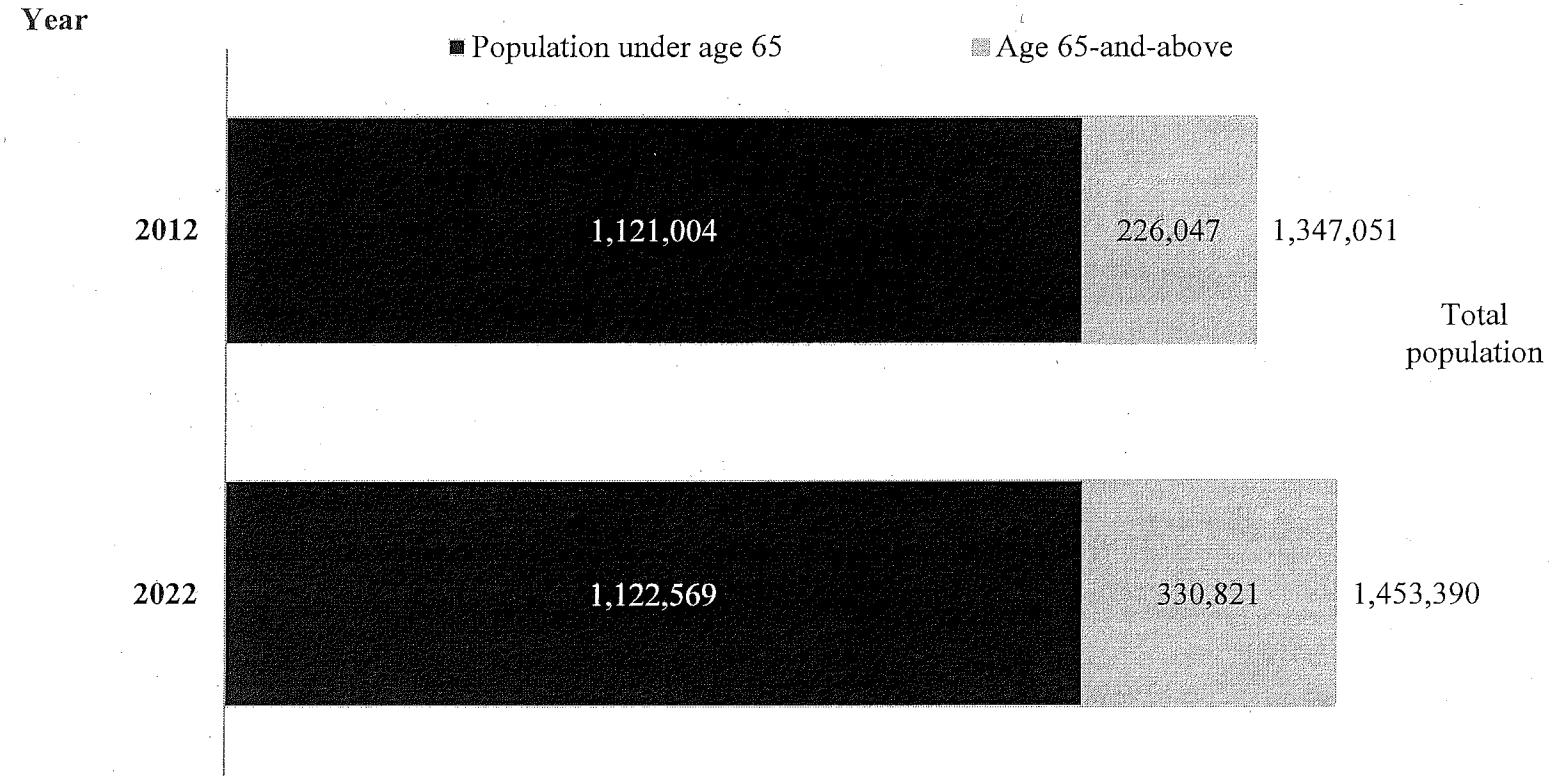
Overview of Presentation

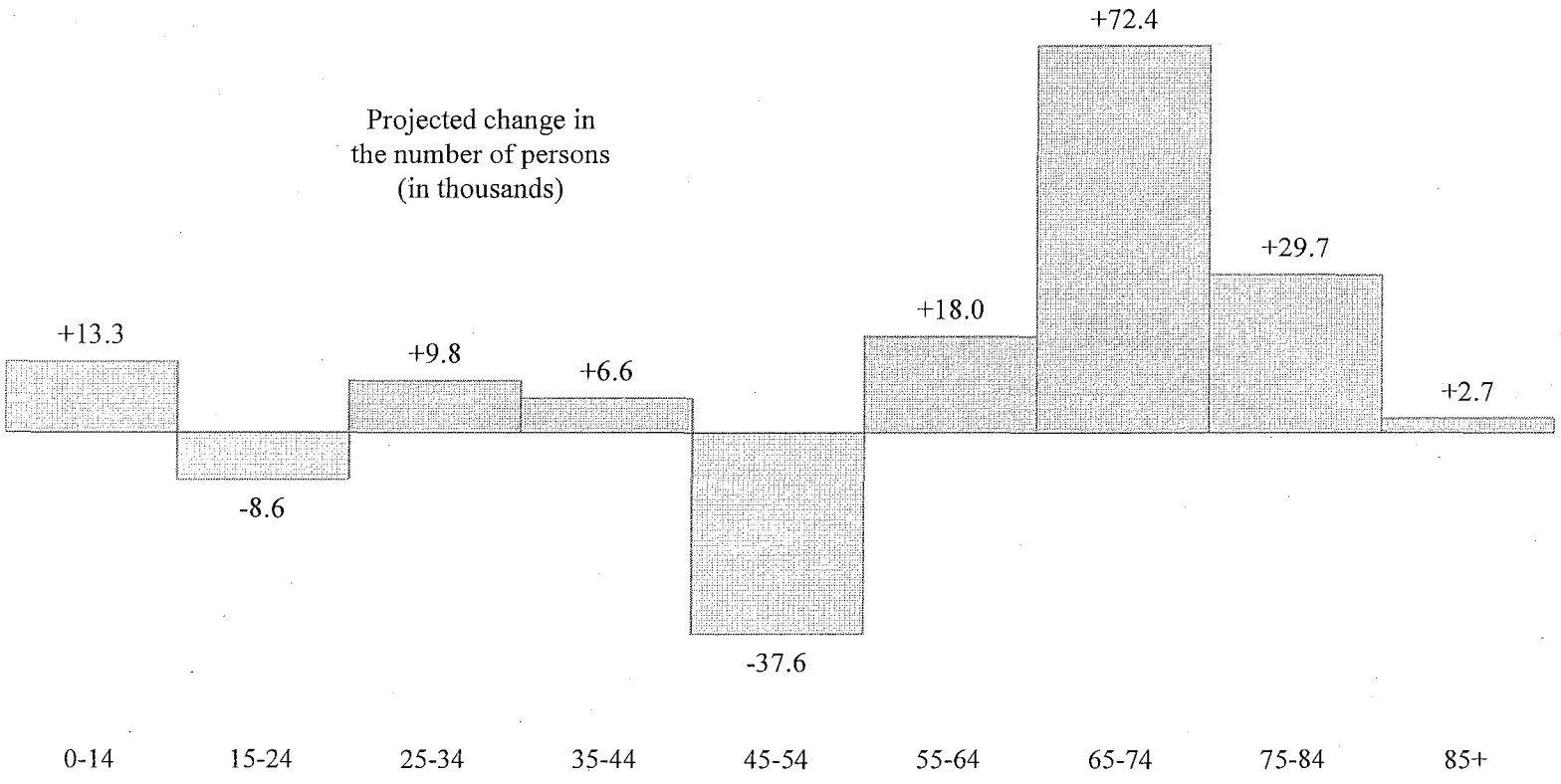
- Some Demographics for Maine
- Overview of Long Term Care System
  - Maine versus U.S.
- Nursing Facility and Residential Care Use and Supply in Maine
- Trends Across LTSS Settings in Maine
- Nursing Facility Pay for Performance and other Incentives
- Other LTSS Initiatives (Maine and US)

The number of people in Maine who are over age 65 will increase by 105,000 in 10 years.



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The greatest increase in the next 10 years is among those who are 65-74. Maine is also seeing a decline in the number of people in the age 45-54 age group.



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Comparison of Maine and U.S.

	Maine	U.S.	Rank (High to Low)
NF beds per 1000/65+, 2010	34	42	38
NF Occupancy Rate, 2008	90%	83%	9
Residents w/low care needs, 2010	2%	17%	49
Residents w/dementia, 2010	55%	46%	1
Residents with Medicare as primary payer, 2010	16%	14%	12
Percent change in NF residents (2005 to 2010)	-5%	-4%	30
Medicaid payment per day for nursing facility care, 2011	$178	$178	20

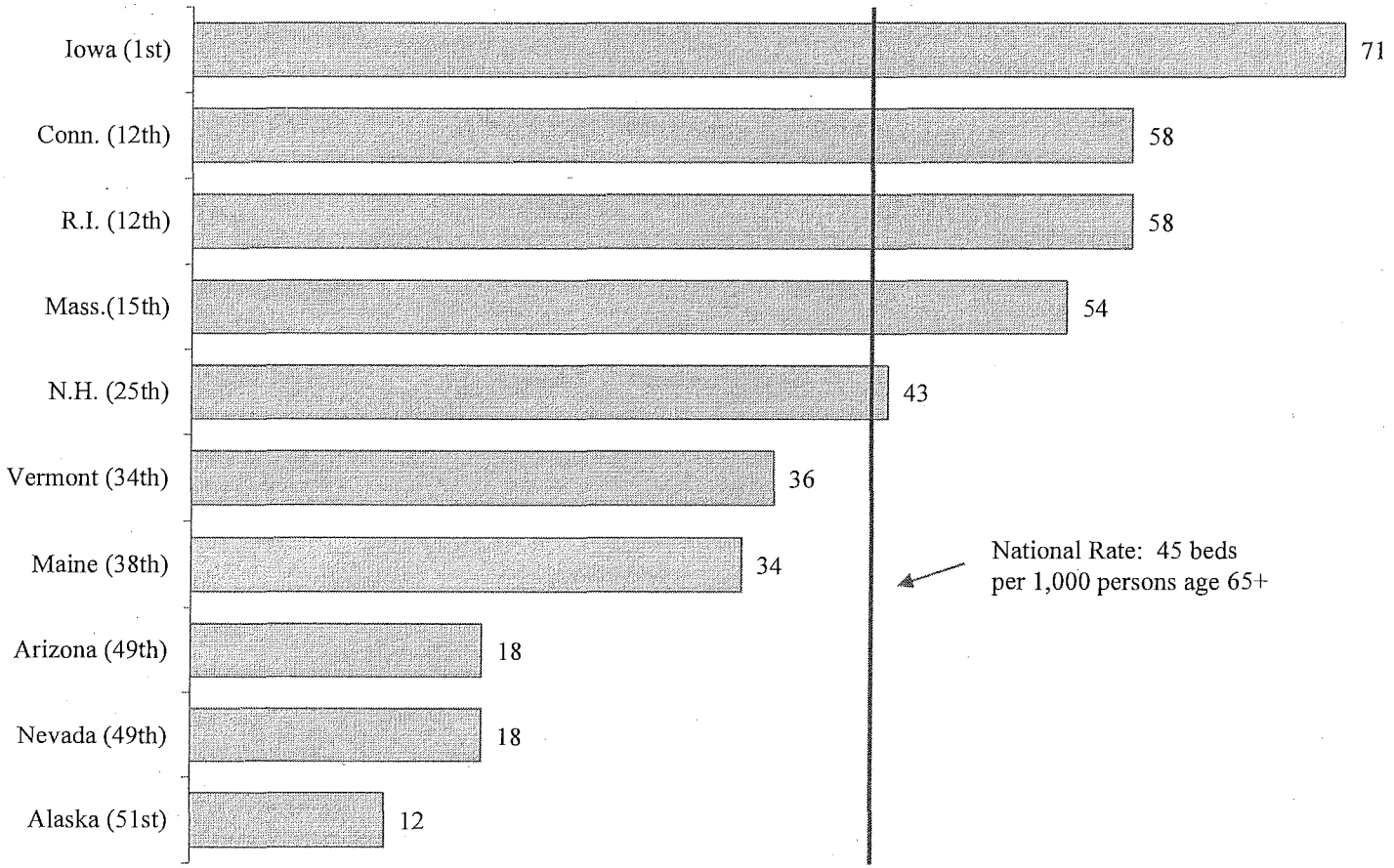
Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Comparison of LTSS Expenditures for Maine and US

	Maine	US	Rank (High To Low)
Medicaid Nursing Facility Expenditures per person served, 2008	$23,988	$29,533	44
Medicaid Aged/Disabled Waiver Expenditures per person served, 2008	$14,163	$10,710	11
ICF-MR Expenditures per person, 2008	$137,218	$123,053	19
MR/DD Waiver Services Expenditures per person served, 2008	$77,736	$42,896	3

Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Number of nursing facility beds per 1,000 persons age 65-and-above



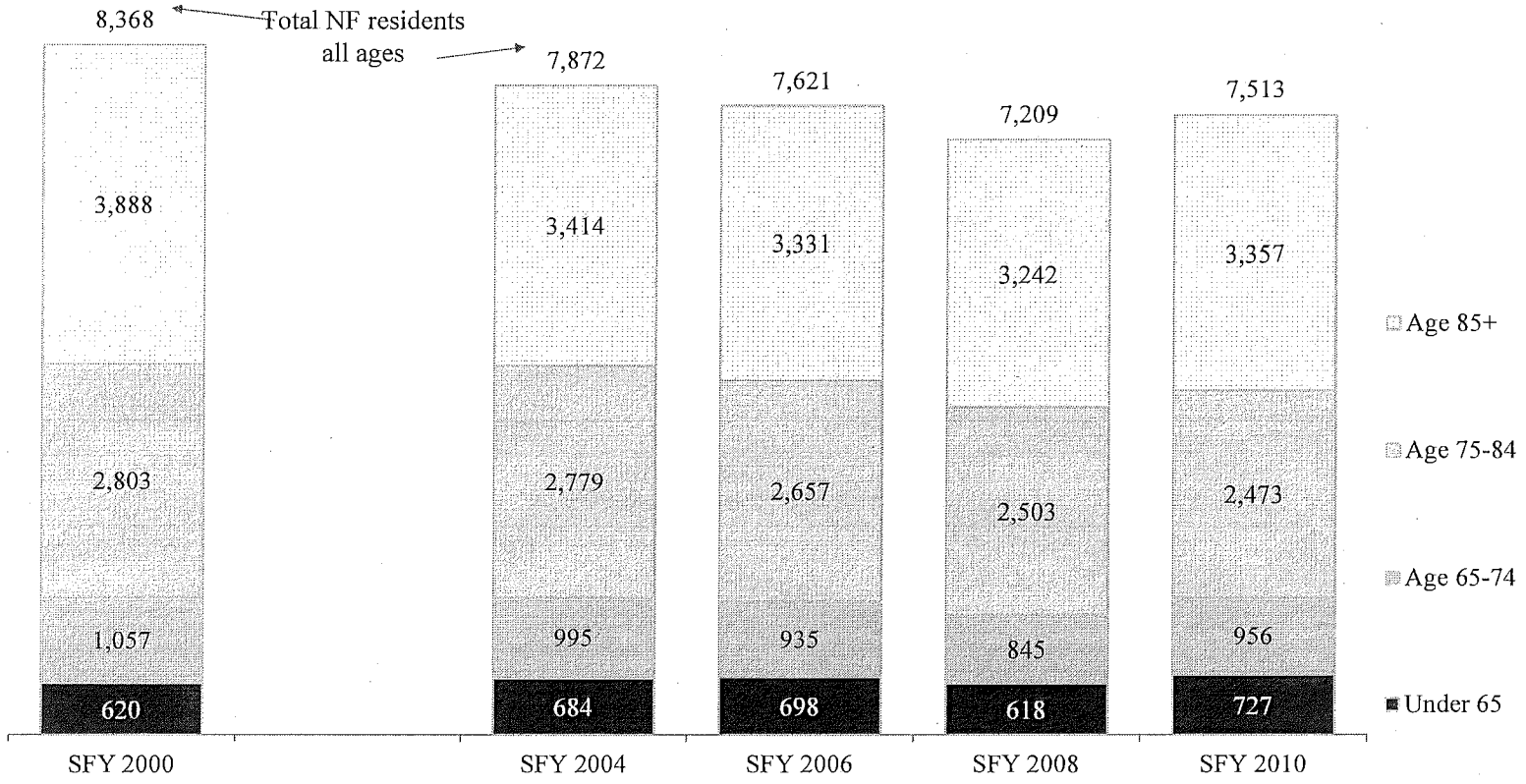
Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Change in LTSS Spending, 2004- 2009, by Service

	Maine	% Change	
		Maine	US
Nursing Facilities	+$8 million	+3%	+12%
Aged/Disabled Waivers	-$1 million	-5%	+77%
Personal Care Services and other HCBS	+$7 million	+15%	+67%
ICF/MR	+$4 million	+7%	+8%
MR/DD Waivers	+$173million	+88%	+54%

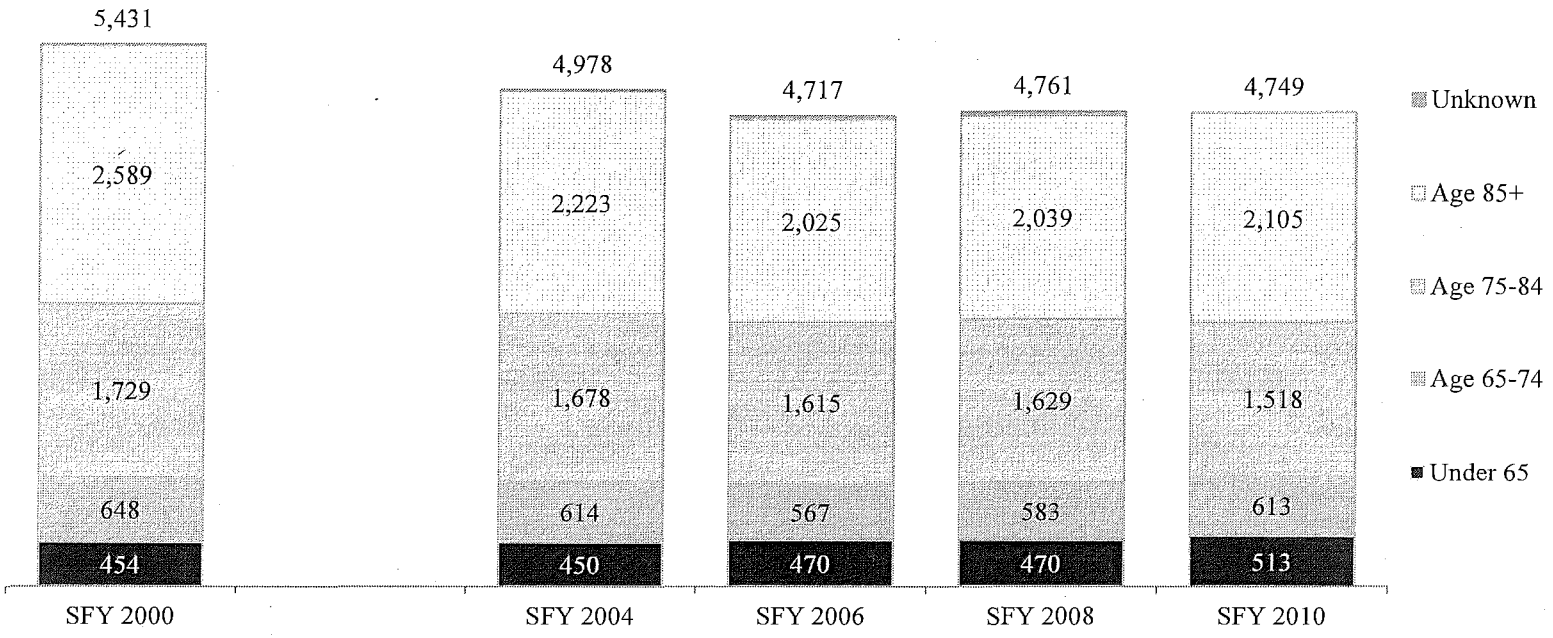
Source: AARP Across the States: Profiles of Long-Term Services and Supports, 2012

Maine's average monthly number of nursing facility residents declined from 2000 to 2008, then increased



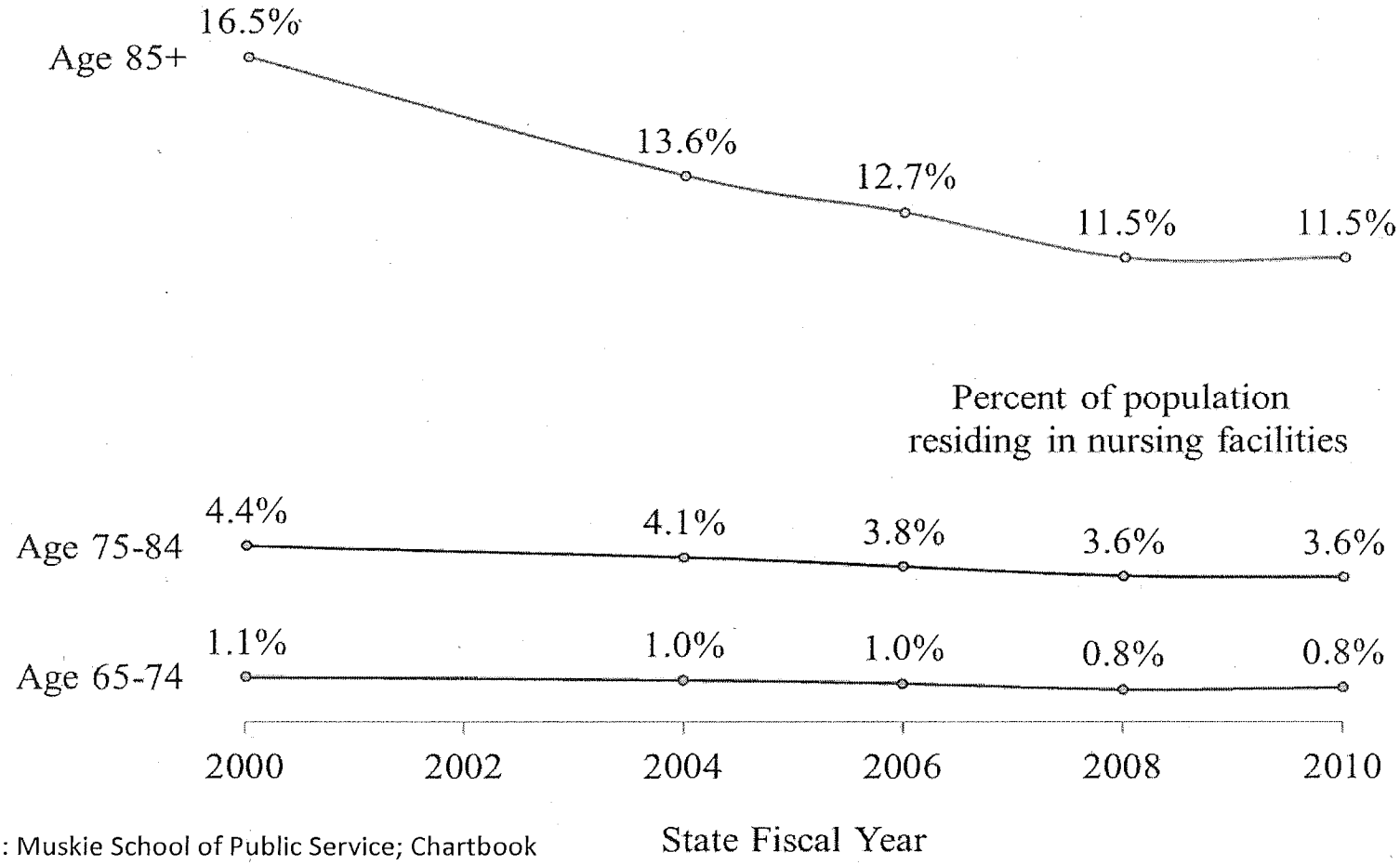
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The average monthly number of MaineCare members in nursing facilities declined from 2000 to 2010



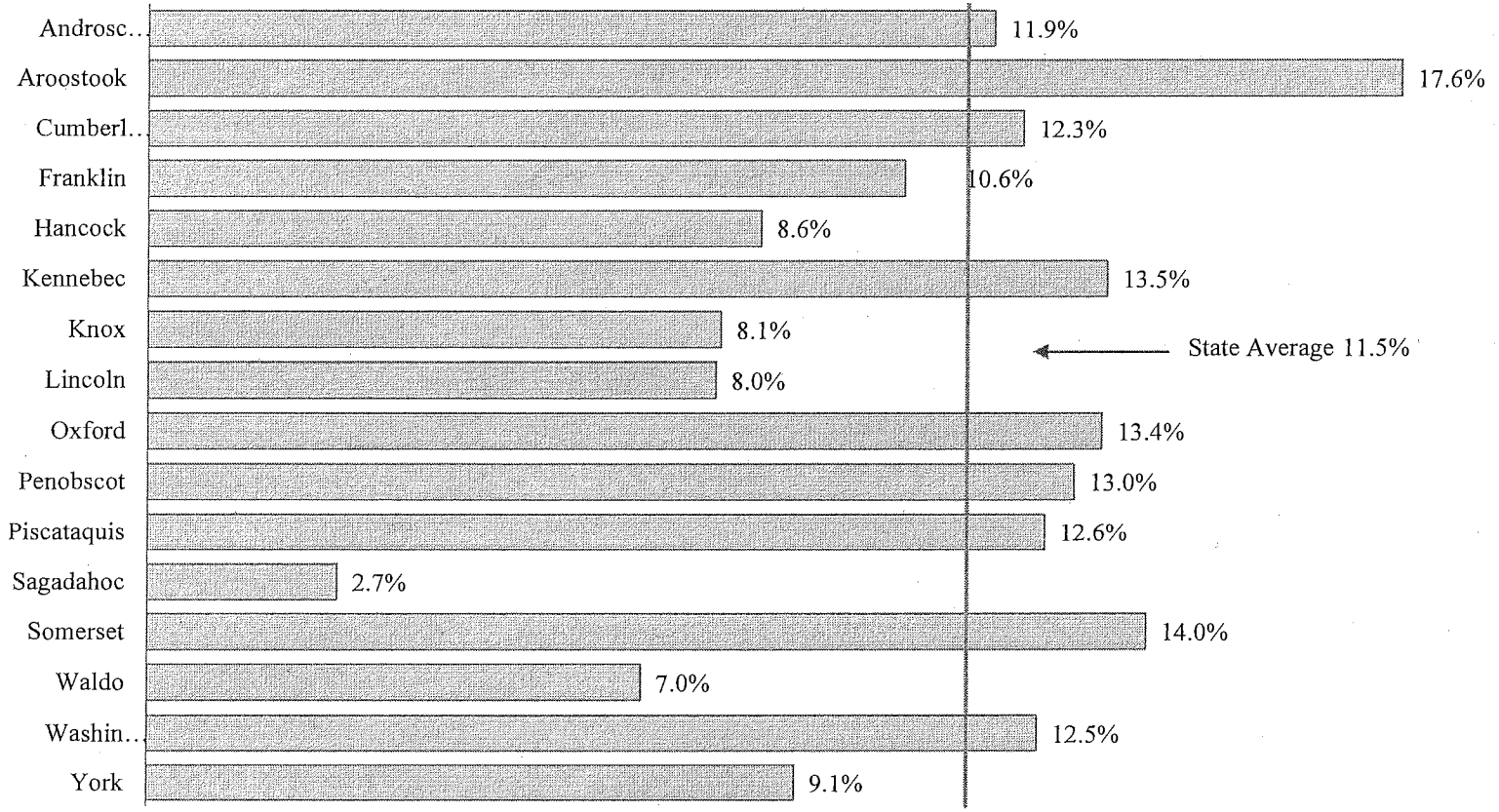
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The percent of Maine's population residing in nursing facilities (all payers) declined steadily across all age groups from 2000 to 2008, and then leveled off in 2010.



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Percent of population age 85 and above who resided in nursing facilities in 2010



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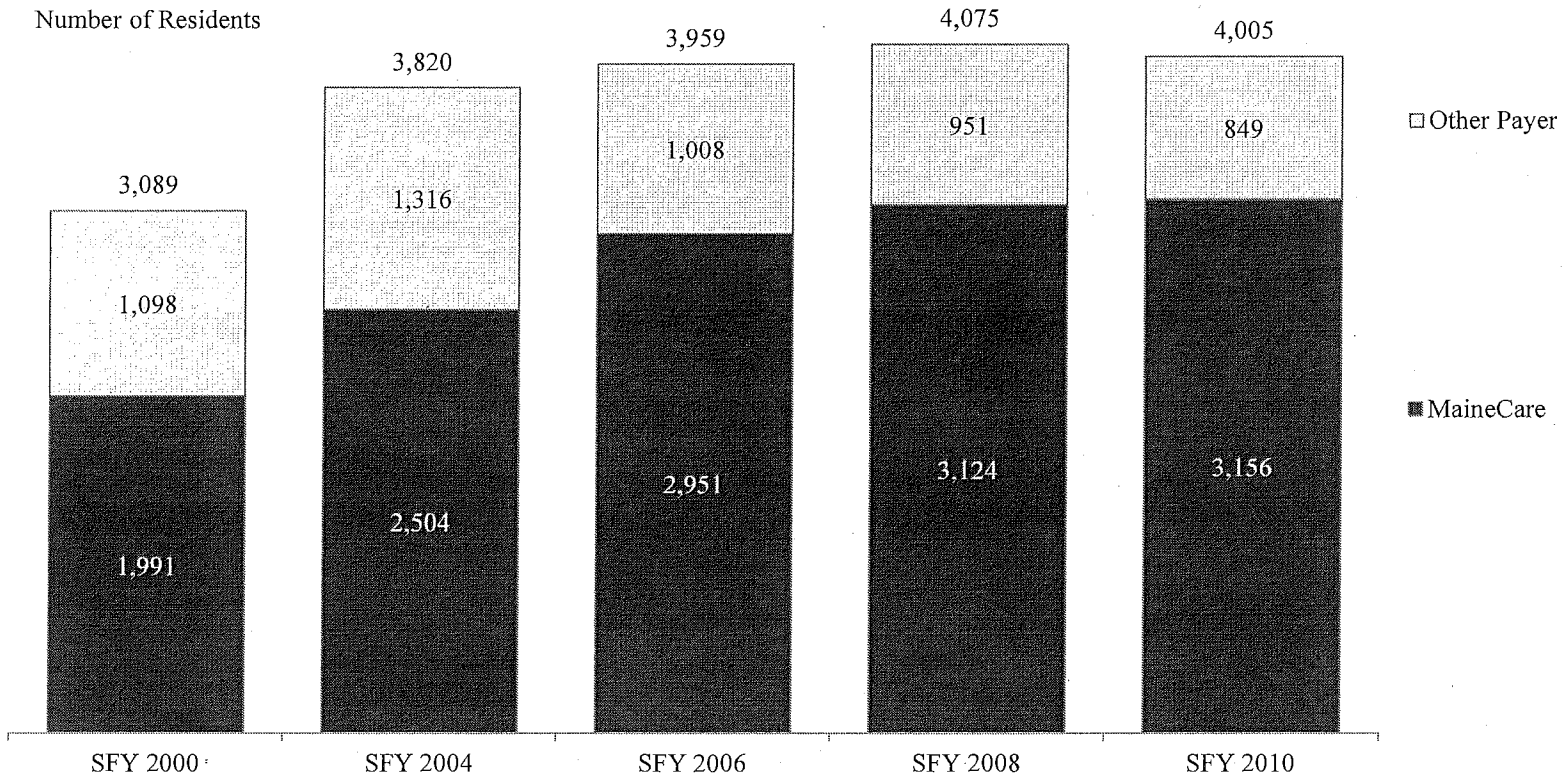
Average number of residential care residents grew 30% between SFY 2000 and SFY 2010



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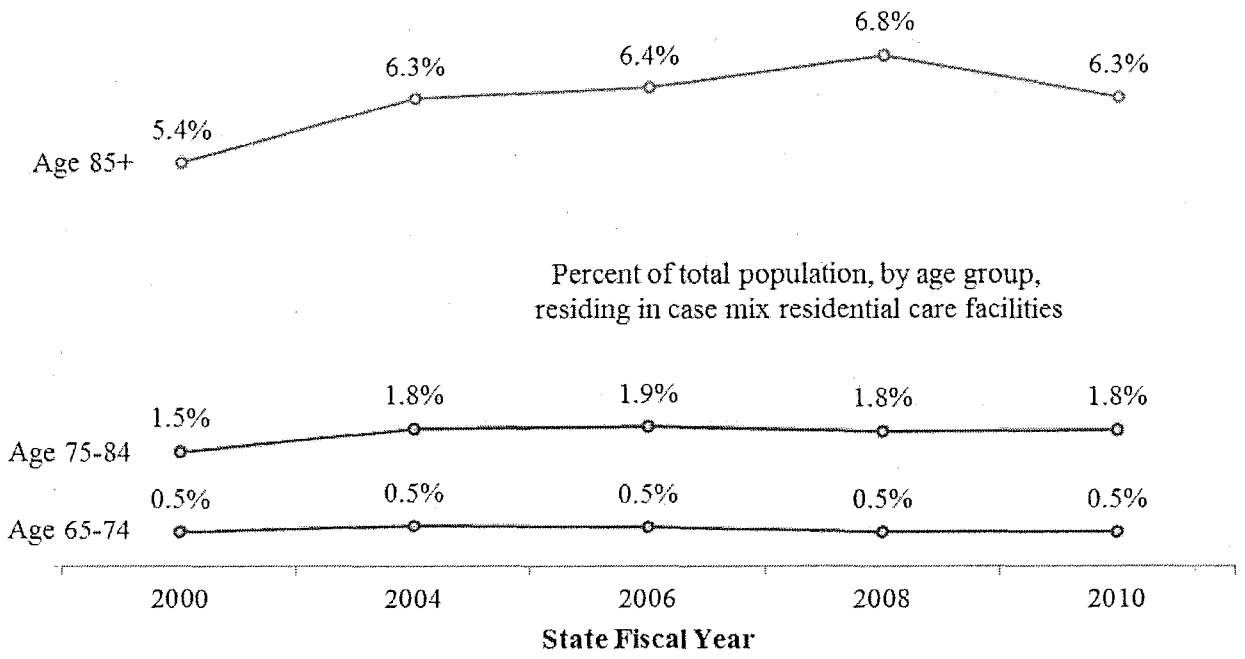
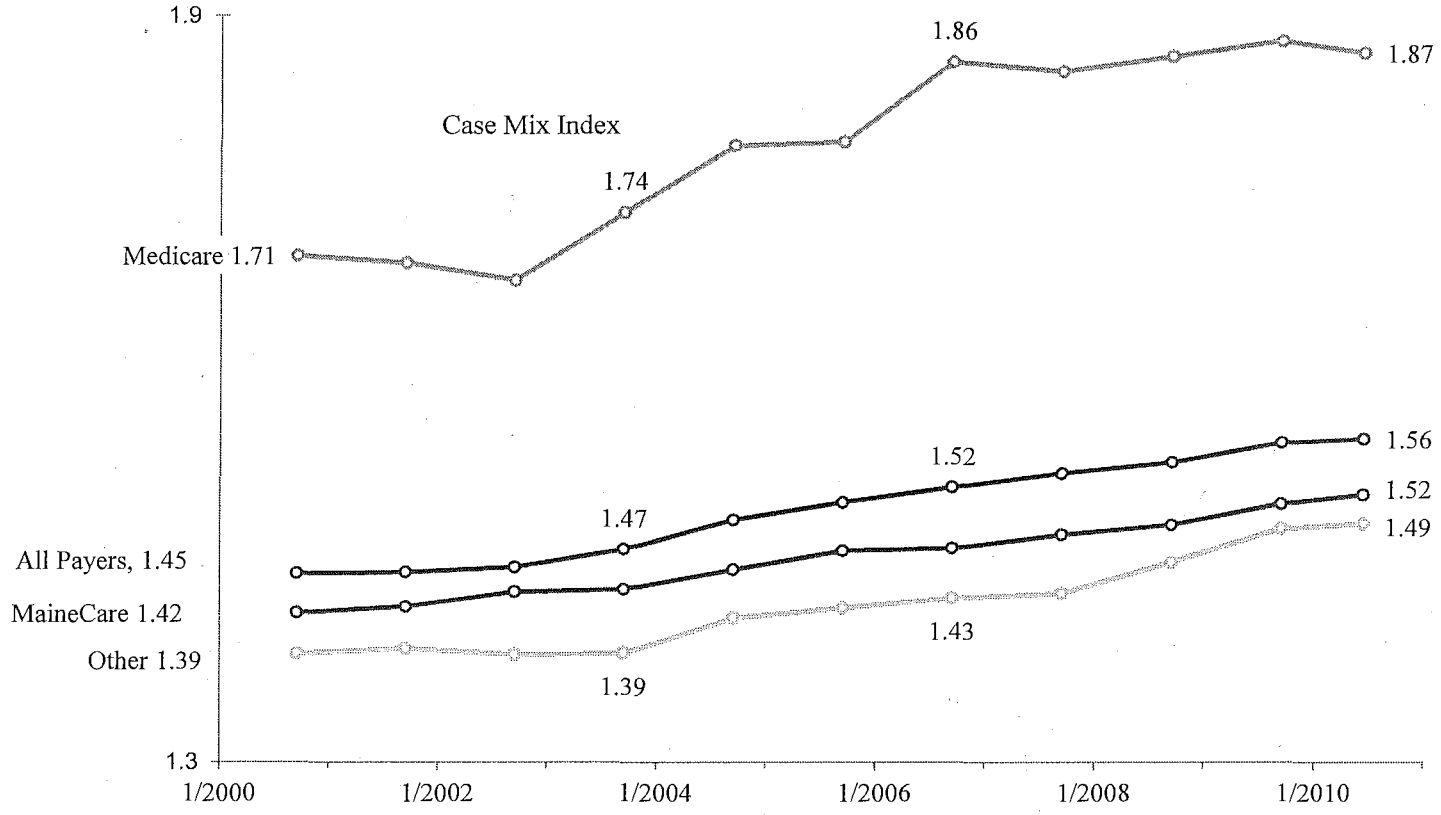
The percent of Maine's population residing in residential care facilities by age group, 2000 to 2012



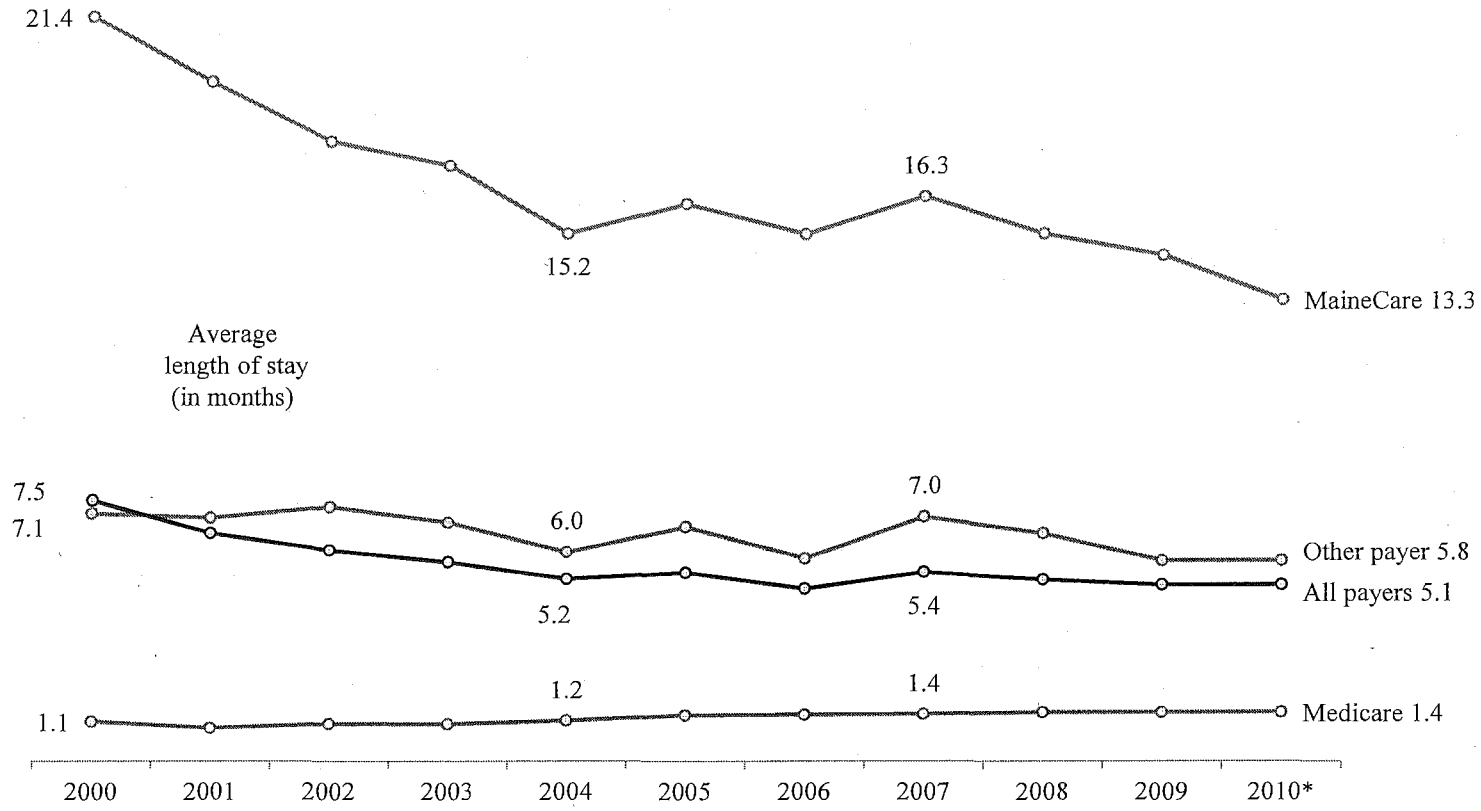
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The case mix (acuity) of nursing home residents increased from 2000 to 2010



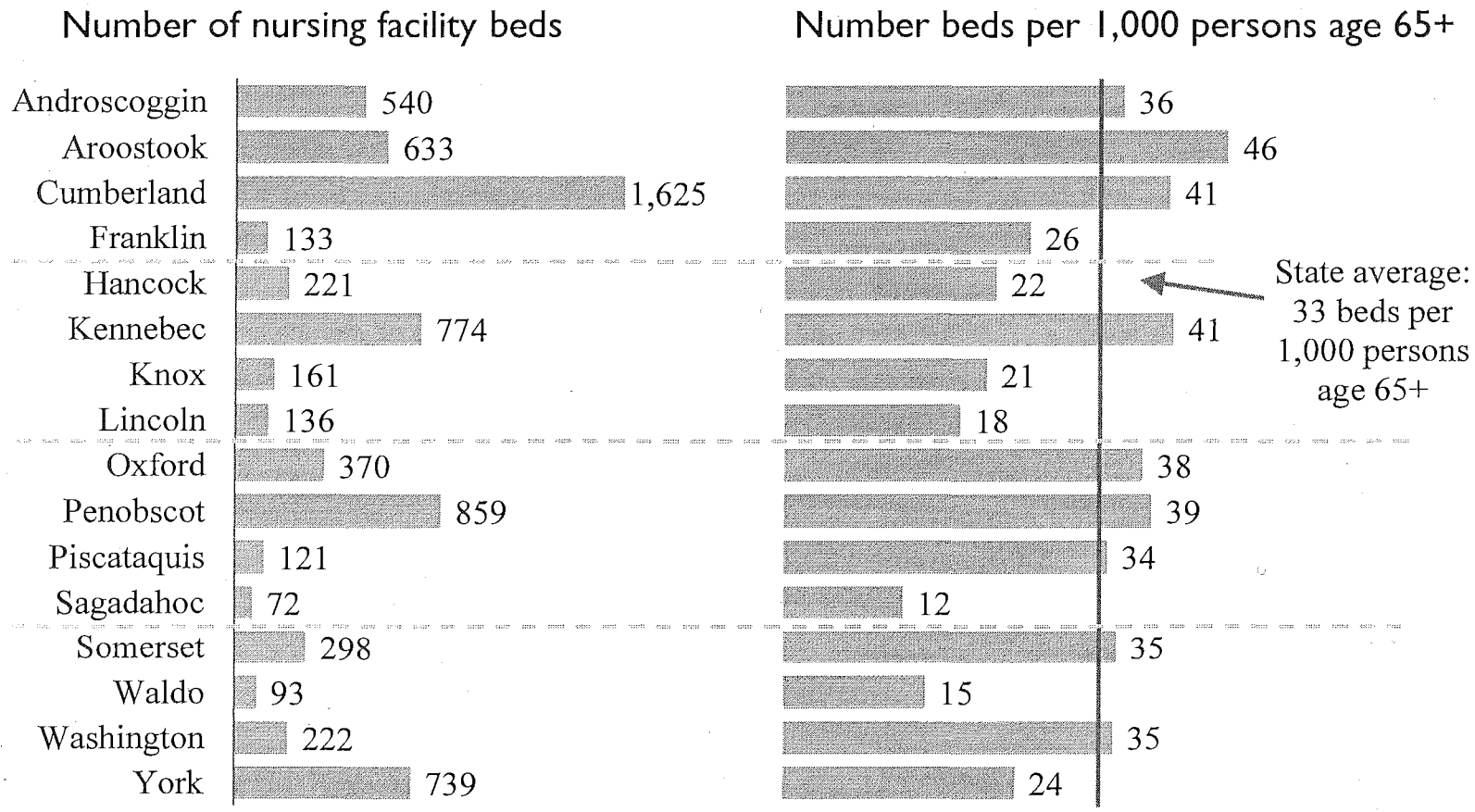
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Average length of stay in nursing facilities for MaineCare residents declined from 2000 to 2014



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

The distribution of nursing facility beds by Maine County and number of beds per 1,000 persons, age 65-or-above, SFY 2010



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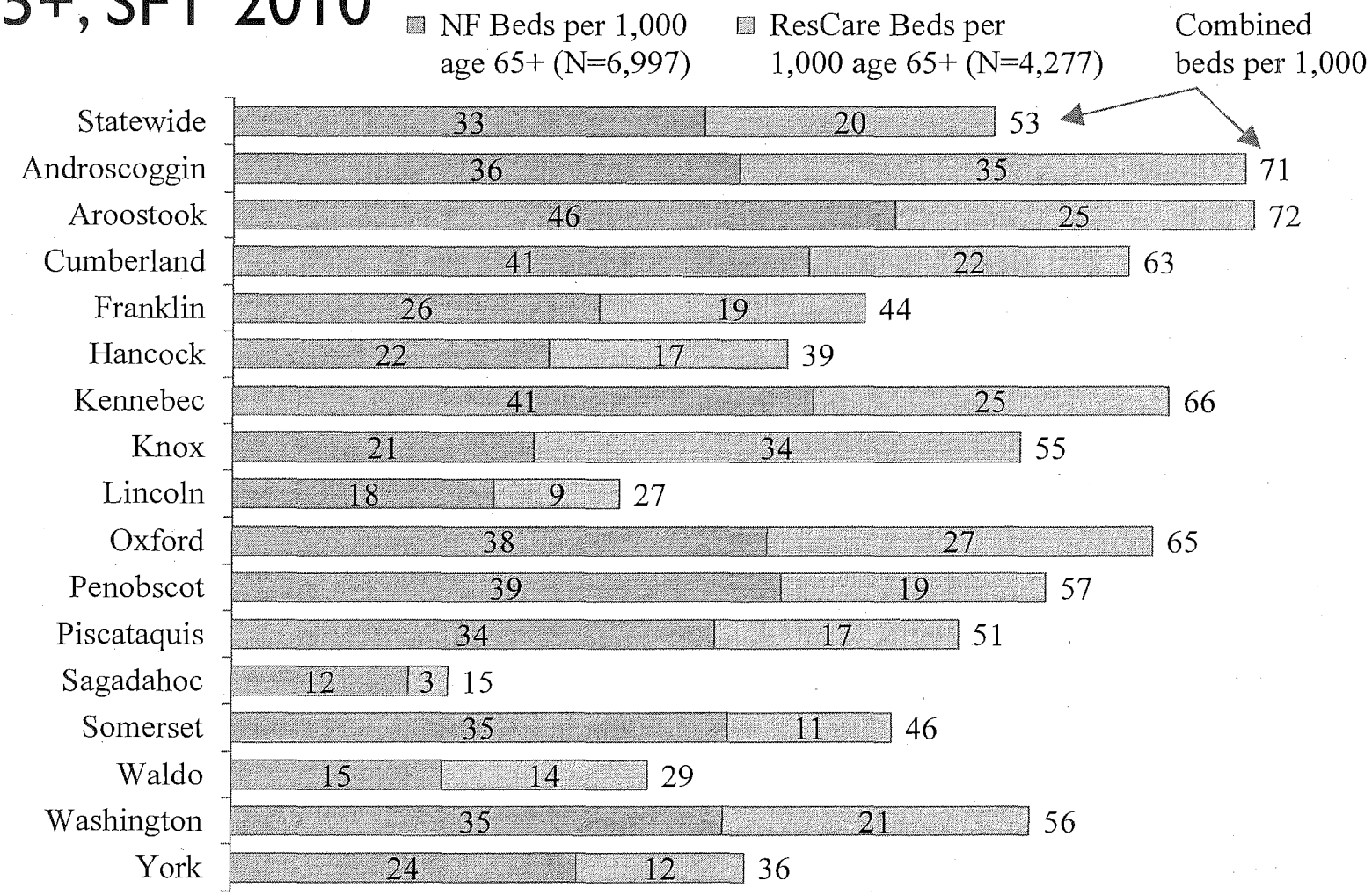
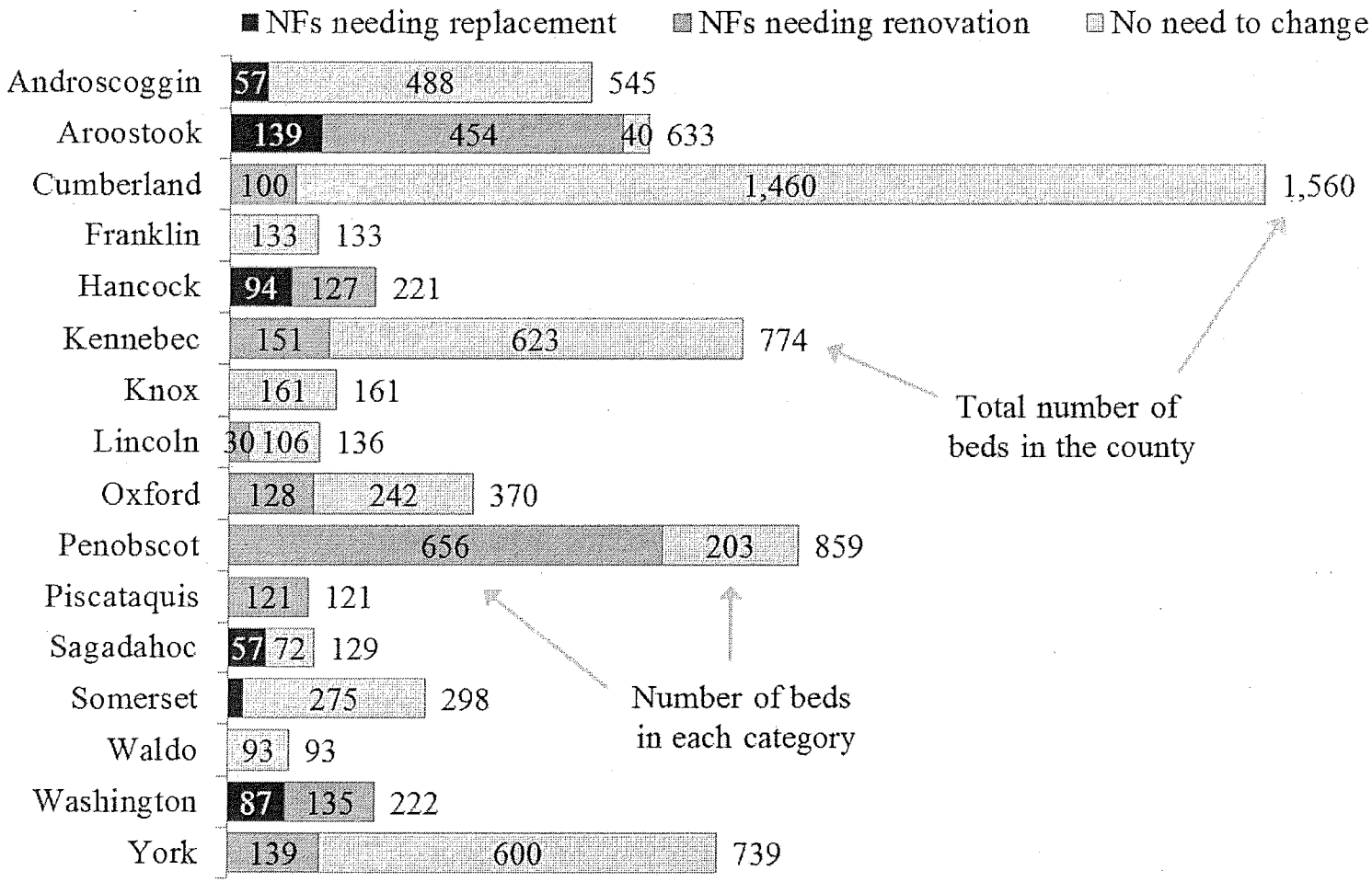
The number of nursing facility and case-mix residential care beds per 1,000 persons age 65+, SFY 2010



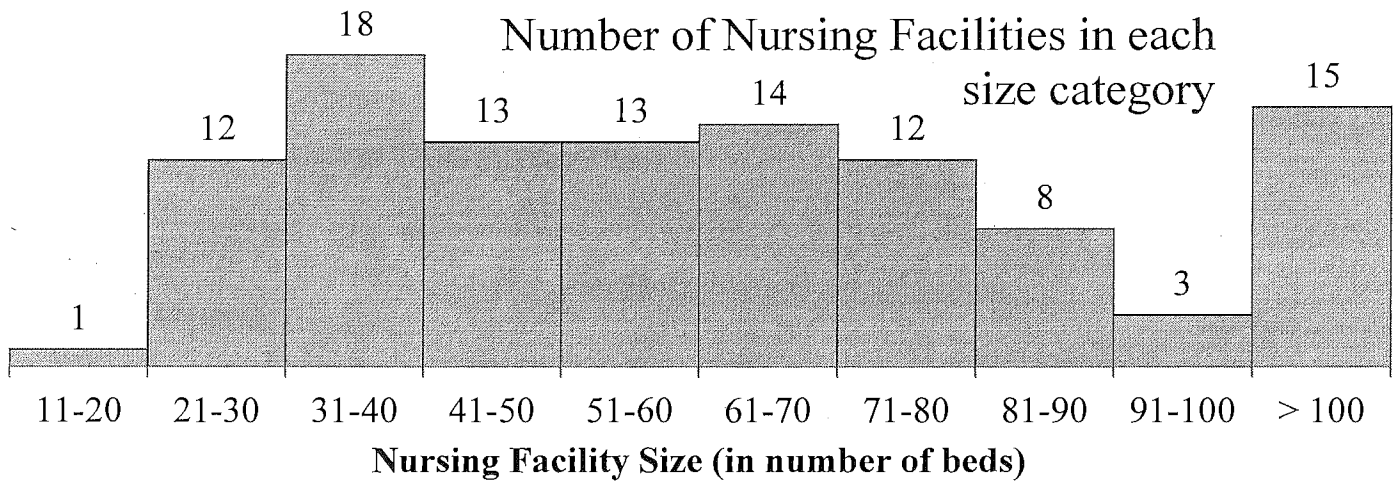
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

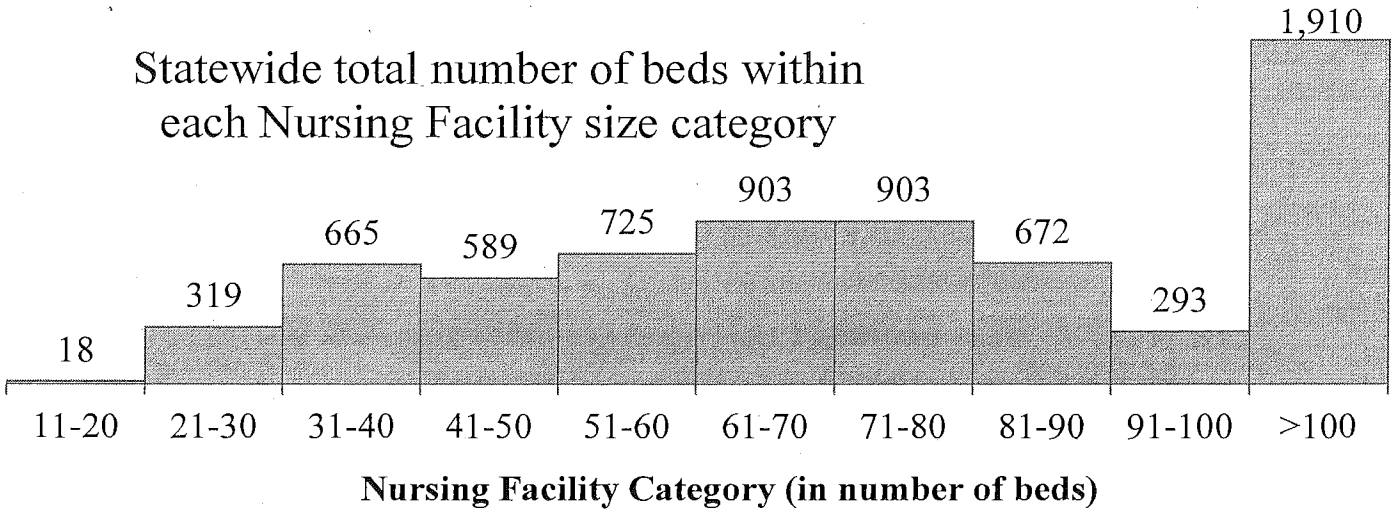
In 2009, nearly 3-out-of-10 Maine Nursing Facility beds were in buildings needing renovation and 7% of beds were in buildings in need of replacement.



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

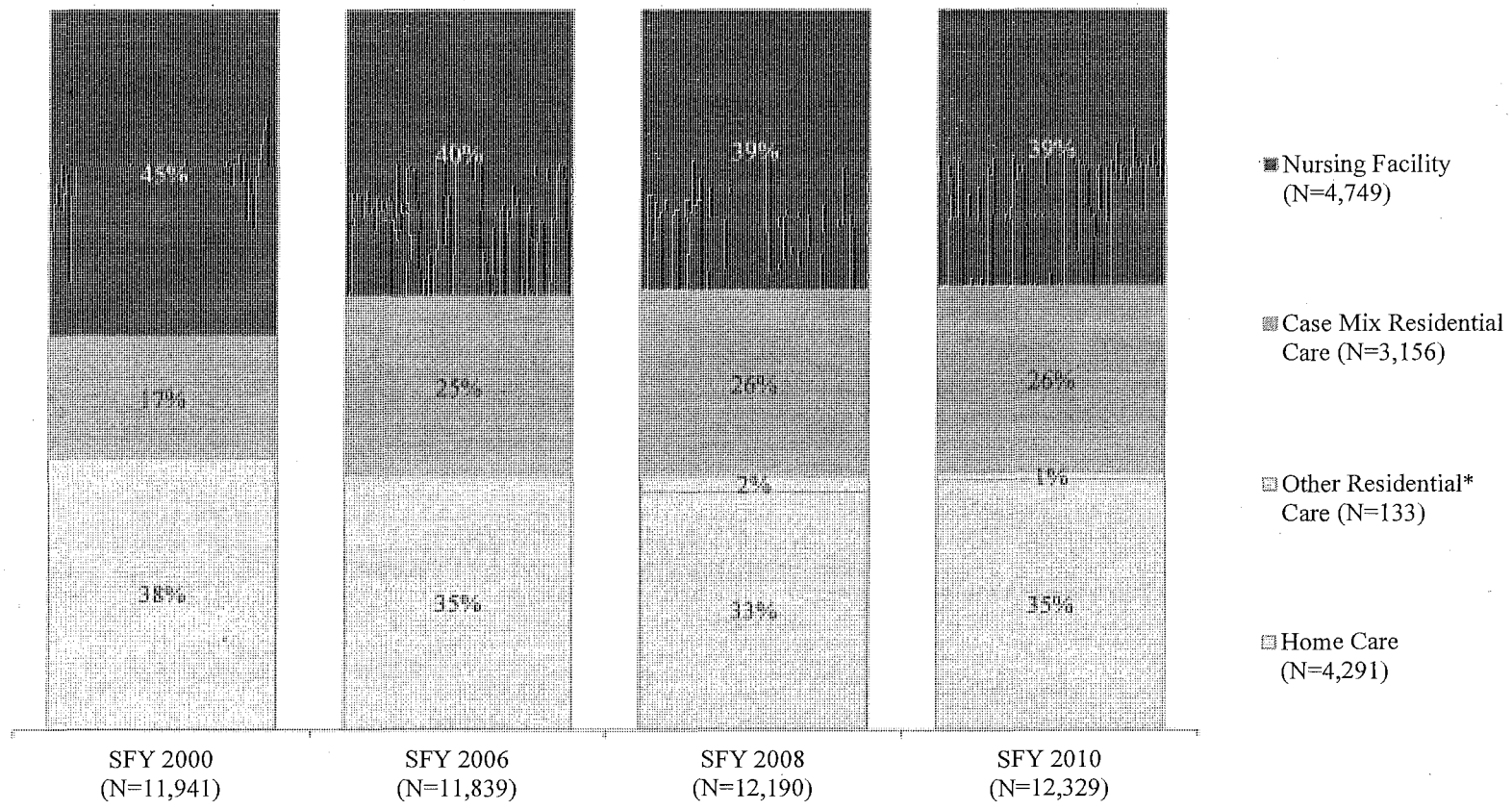
In 2010, nearly half of Maine's nursing facilities (48%) were larger than 60 beds (N=109)





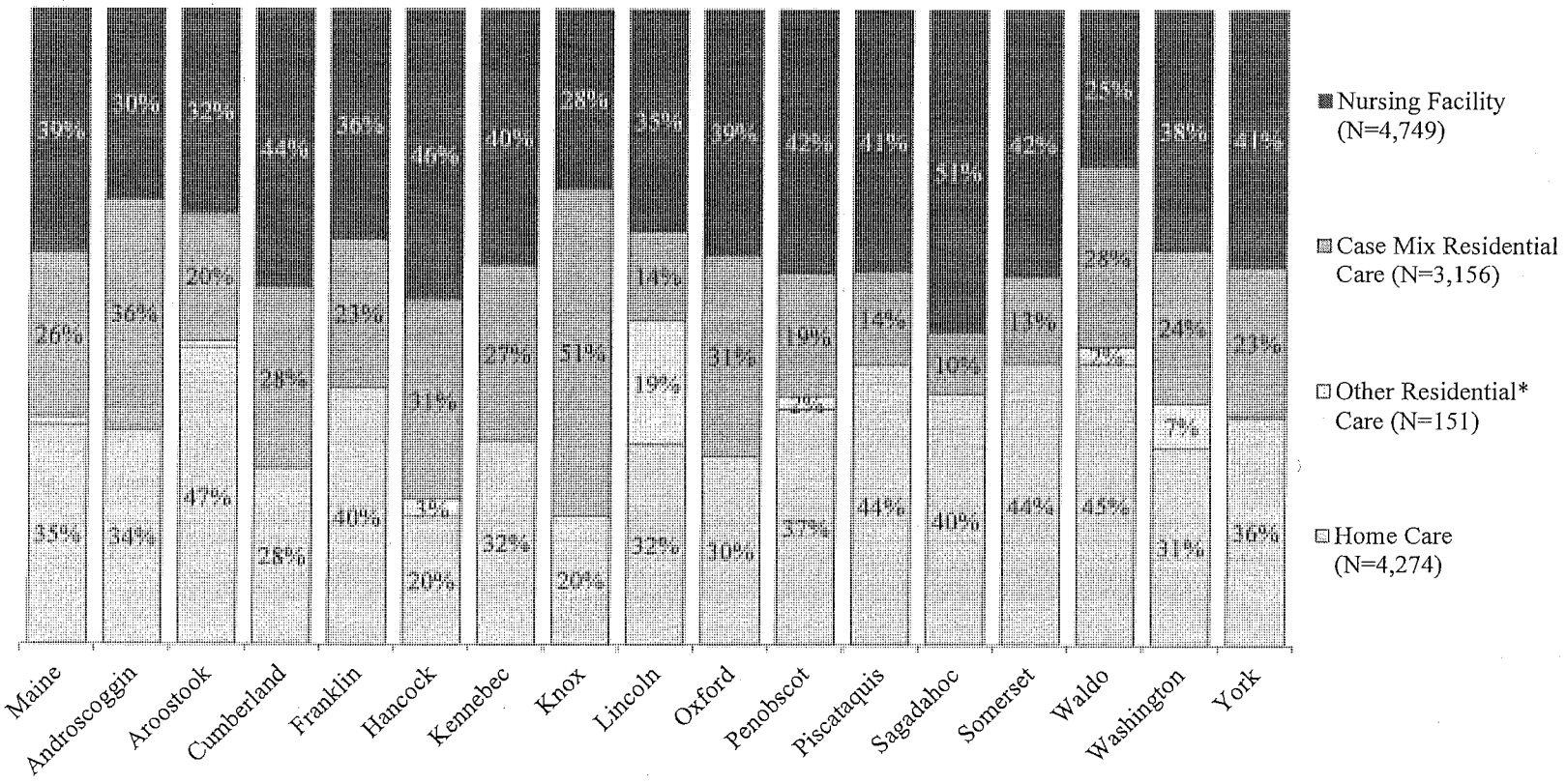
Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Distribution of average monthly MaineCare LTC users by setting



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Distribution of average monthly number of MaineCare LTC users by setting by county



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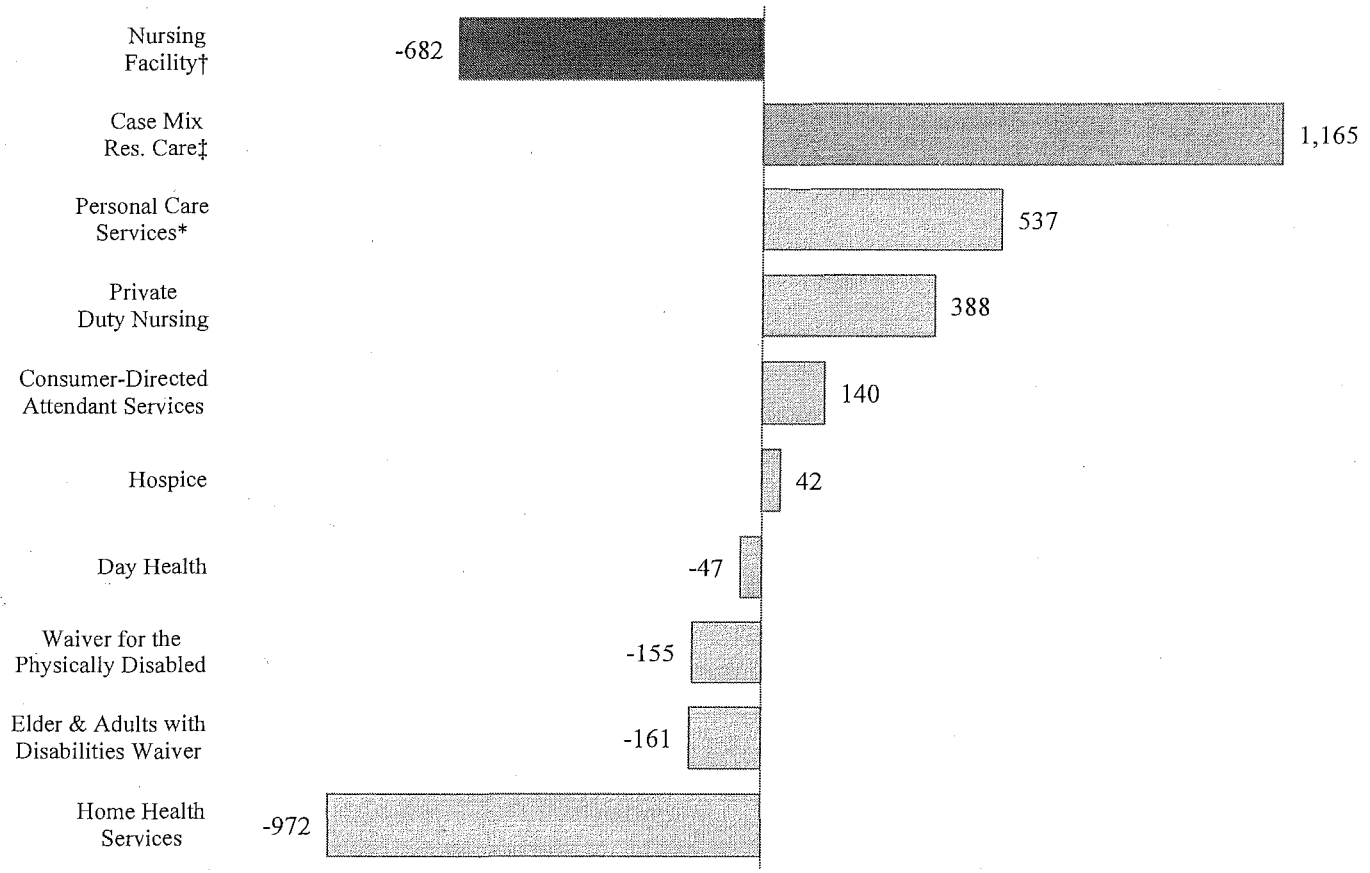
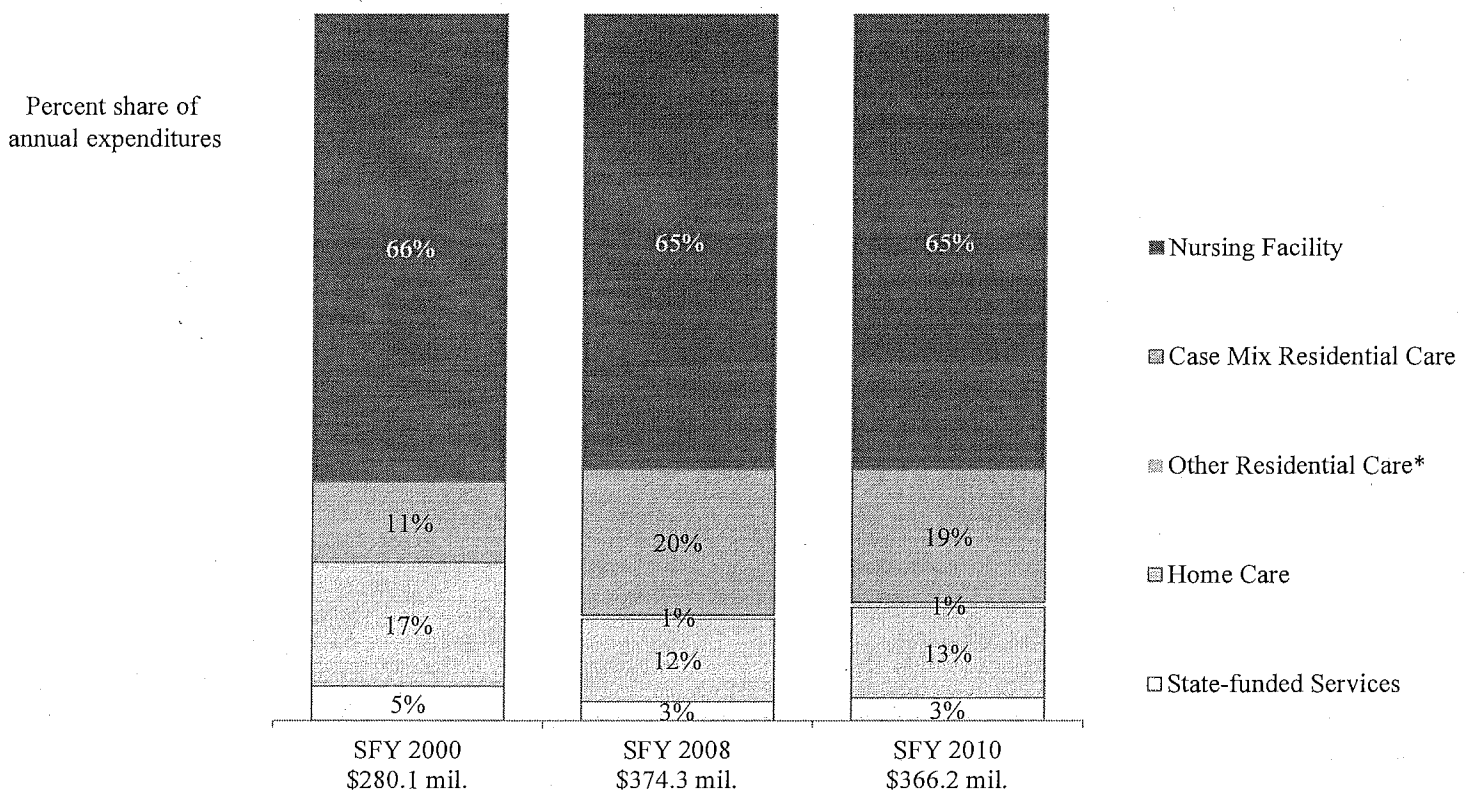
Change in average monthly number of MaineCare members using MaineCare LTSS, 2000-2010



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Annual MaineCare LTC expenditures by setting, SFY 2010



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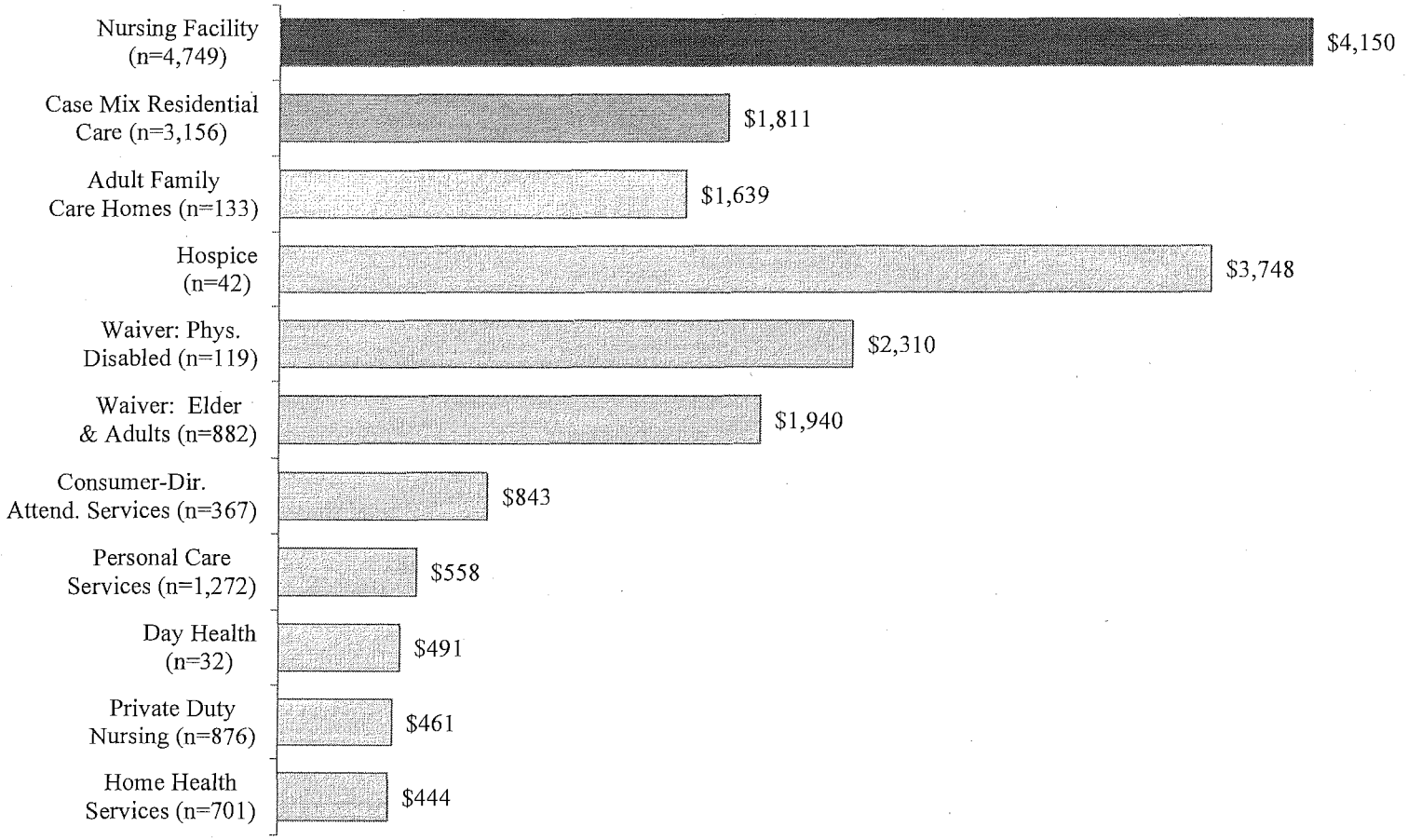
Average MaineCare LTSS expenditures per service user per month, SFY 2010



Source: Muskie School of Public Service; Chartbook Older Adults and Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition

Nursing Home Pay for Performance Systems

Types of Quality Measures

- Staffing
- Consumer satisfaction
- Inspection performance
- Clinical quality indicators
- Person-centered/quality of life
- Efficiency
- Access
- Employee satisfaction
- Quality improvement

Performance Methods

- Benchmarks
- Percentile ranking
- Year to year improvements
- Structure versus process
- Risk adjustments

(Source: Performance in 5 states: Lessons for the Nursing Home Sector. States included Iowa, Minnesota, Oklahoma, Utah and Vermont)

Nursing Home Pay for Performance Systems (cont)

Administration

- Complex versus Simple
- Relies on existing data and/or additional data (e.g. consumer surveys)
- Composite index versus simple approach

Payment method

- Added to per diem
- Funds allocated competitively

Findings

Need to incentivize engagement

- Secure funding
- Design systems that are perceived as fair and workable
- Minimize administrative burden on facilities
- Address different aspects of quality
- Encourage improvement among low-middle tier performers

- Slow Phase-in
- Availability of funding
- Provider participation is key
- Flexibility

Results

- Indiana study found that nursing home quality improved in 3 areas (falls, quality of life and rehospitalizations)
- Study of 8 states (2001 to 2009) found 3 quality measures improved (people in restraints, with pain, with pressure sores); other measures did not change or worsened
- Study in Minnesota found that facilities that participated in the program had greater gains in targeted areas of improvement and overall quality.

Other Nursing Home Incentives

Access Incentives

- Add-ons for serving people with certain conditions (e.g. ventilator dependent; brain injury; dementia); for serving Medicaid recipients; encourage higher occupancy

Efficiency Incentives

- Facility paid a state-wide rate; median; or peer group rate
- Facility receive bonuses for keeping costs below a ceiling

Other LTSS Initiatives

- Money Follows the Person
- Health Homes/Medical Homes and Nursing Homes
- Long Term Care Managed Care
- Rebalancing Services

Money Follows the Person

- Provides opportunities for people living in nursing homes to return to the community
- Maine participates in this program

Health Homes/Medical Homes

- People with hi costs/multiple chronic conditions assigned to "health home" to coordinate care and identify gaps in care
- Some states implementing health homes with nursing home and residential care residents
- Maine has a Health Home initiative for people with multiple chronic conditions and behavioral health conditions

Managed Long Term Care

- Managed long term care increasing

- States are including home and community based services and nursing facility services within managed long term care

Rebalancing Programs

- Focus on increasing access to home and community based services
- Less reliance on nursing home services

Conclusions

- Demographics will drive economic and other policy decisions in next 10 years
- It is helpful to look at long term care system as a whole – to develop a balanced system
- Pay for performance provides opportunity to implement value based purchasing within the long term care system

Other Resources

- Chartbook: Older Adults and Adults with Physical Disabilities – Population and Service Use Trends in Maine. http://muskie.usm.maine.edu/Publications/DA/Adults-Disabilities-Maine-Service-Use-Trends-chartbook-2012.pdf
- AARP Across the States Profiles of Long-Term Services and Supports 2012 http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html

APPENDIX E

Testimony from direct care workers

ROY G. GEDAT

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October 25, 2013

Statement of Concern to the Long term Care Commission to Study Nursing Facilities

Please do not dilute the staffing standards in nursing homes.

I am Roy Gedat from Norway Maine and I am here today as a volunteer to make this plea.

For 7 years I worked for advocacy organizations focused on improving the jobs of direct care staff. Those are the people who change the bedpans, give the baths, provide personal care and do much of the actual staffing of patients in residential facilities and homes. This advocacy usually focused on improving pay and health benefits as well as strengthening professional standards and insuring that the workforce is granted the respect and status they earn every day. This work put me in regular contact with direct care workers in Maine and across the country. I have also worked as a direct care worker. Currently I run a private duty "non-medical" home care business and serve as the elected Treasurer of Oxford County.

Never have I heard a direct care staff person request more flexibility and less staffing in a residential facility. In fact, people who work in those positions report quite the opposite!

Inadequate staffing puts personal care workers in unsafe and stressful positions every day resulting in compromised care to the patients and residents they are there to assist. Low wages coupled with difficult (at best) working conditions result in a discouraged workforce, difficult retention and high turnover. I can report that providing high quality care without enough staffing is simply not possible!

Maine's current staffing ratios really only set a low bar to insure quality care. While our state is better than many in this regard there is no doubt we could AND SHOULD do better. Many

experts advocate for a staffing ratio minimum of better than 4.5 hours per resident day, the national average is 4.1 (hprd) and Maine only requires 3.49.

Don't we owe it to the frail and compromised residents of our nursing homes to keep that in mind?

Finally, let me remind you why these standards exist in the first place. We have a sad and well documented history of NOT caring for human beings in nursing homes and other institutions. It took years of shocking stories of abuse, indifferent care and cover-ups for the government to step in and insure a level of quality care. In some states this is still going on. Now we have standards, inspections, a state ombudsman to field complaints and movements to empower self-advocacy. Even with those measures in place we still have to be vigilant to insure that we don't slip back too those dark days in the name of saving money or granting administrative flexibility.

Maine's network of residential care facilities are a vital and important part of our safety net. They are also an important economic driver proving important and needed jobs.

Yes, changes to need to be made to our long term care system. We need to make sure we have a quality workforce. We need to provide more staffing and better quality care. There is simply no reason to lower staffing requirements in nursing homes and every reason to increase the staffing standards.

Thank you for your attention.

My name is Michele Heath. I am a Certified Nursing Assistant who works in a local nursing facility. I have worked as a CNA since the summer of 2010 in two different nursing facilities.

I got into direct care because I enjoy helping people. The first facility I worked per diem at $10 an hour, but had left because I needed a job with a set amount of hours a week and health insurance. I currently work at another facility with a guaranteed 32 hours a week, health insurance and make $9.97 an hour.

I work the evening shift, 3 in the afternoon until 11 at night, where the minimum staffing ratio is one 'direct care provider' for every 10 residents. I realize that 'direct care providers' include nurses, med-techs and CNAs on the floor, however, when using the minimum staffing ratio where I work I can have up to 13 residents to take care. This includes transfers (which may take two people), assisting them with ambulation, dressing, bathing and toileting. Passing meals, feeding, changing soiled bedding, turning residents who stay in bed every two hours to prevent pressure ulcers (bedsores), and charting on everything that takes place on my shift. Some of my residents are total assists, which means that I must do everything listed above for them. Almost all of my residents are two assists, meaning it takes two people to help them and take two CNAs off the floor until we have completed the task.

I try and get to my residents as soon as I can to provide the care they need but there are times that they do have to wait and they do know when we are working short because it takes a while before we can get to them to help them into bed. The facility I work for strives for quality, patient centered care and so do I. However, I ask myself "how can I deliver that when I got thirteen people to take care of?" The answer is that I can't do it. No matter how hard I try to

provide quality care for a resident when I am helping them, all I have is time to provide the basics and move on to the next resident.

The stress of working at the state minimum is frustrating for both the residents and myself. I have had residents ring there call bells during the busiest part of the evening, getting everyone into bed, and ask for something to drink and then apologize to me for taking me away from whatever it was I was doing or going to do because they know how busy the other aids and I are. These facilities are their homes and they shouldn't have to feel like they are taking us away from other people to ask for a simple request like something to drink. I will admit that this upsets me and makes me wonder 'how many of my residents need or want something but don't tell the other aids or me because we always appear to be busy with something?'

I know that I am a good CNA. My residents are constantly thanking me for everything I do for them, telling me that I am patient with them and a hard worker. I appreciate hearing this from my residents because it lets me know that I am doing a good job and that they appreciate everything I do for them. This is my reason why I got into this type of work because I enjoy helping people and want to see them stay as healthy as they can.

With the state considering changing the hours form 3.49 hours in a 24 hour period to 3 hours in a 24 hour period that is time being taking away from these residents for their care, and to allow nursing facilities to staff according to need is not going to help anymore. I do not see how the changes the state is considering to the hours of direct care is any benefit for these residents or even the workers. I believe that the staffing ratios need to remain in place, even be enhanced so that there is more staff for a lower number of residents and consider taking the med-techs and nurses out of the ratio because even though they help they have their meds to pass and their own work to do.

Greetings members of this committee considering staffing changes in Maine's nursing homes:

I am Helen Hanson. I am a Certified Nurse Aide who works in a local nursing facility. I have done this type of work for ten years now, in the home and in a nursing facility.

I got my start in home care as a homemaker and then a Personal Support Specialist. I helped and supported many elders and those with physical disabilities in their homes with everything from grocery shopping and housekeeping to assistance with bathing, dressing, toileting, catheter care, eating, and changing batteries in a motorized wheelchair. Let me tell you, those batteries are like those found in a car and just has heavy.

I left home care because the hours of work are not stable, there is no guarantee of working the number of hours you need to make a living and pay your bills, and just as important, there is no access to employer-sponsored health insurance. When I left my home care job, I made $10.01 per hour.

I obtained my Nurse Aide certificate in 2009 because at that time, I worked with a quadriplegic in her home. She had many health issues beyond her physical disability and by becoming a CNA, it was a way for me to be better able to support her and understand her medical needs. I was also better able to communicate with her visiting nurse and take instruction and direction from this nurse.

I enjoy people and helping them, and this is why I got into direct care. I prefer to work in the home, one-to-one with the person I am caring for, and taking a little time to get to know them and what their preferences for care are, but because of the reasons mentioned above, I had to leave it. I now work per diem in a nursing facility, after working there full time for quite some time.

Working in a nursing facility offers a set amount of hours to work and access to health insurance. It does not offer a better, livable wage. My base pay is currently $10.05 per hour, just four cents more than I made working in home care. Yes, when I worked a regular schedule I had a guaranteed amount of hours and yes I had access to health insurance, but at what cost to me?

I work second shift, the evening shift, where the minimum staffing ratio is one "direct-care provider" for every 10 residents. When we use the minimum staffing ratio where I work, it equals one CNA being responsible for 12 or 13 residents on my shift. I understand that "direct-care provider" includes the nurses, med-techs, and CNAs on the floor, but the nurses and med-techs are responsible for their medication passes, and the nurses are responsible for bandage changes, tube feedings, IV medication administration, monitoring blood sugars, admissions and documentation, to name just a few of what it is they do. That leaves little time for the nurses and med-techs to jump in and help the CNAs with all that we need to do: transferring residents from chair to bed or bed to chair, most times with a mechanical lift that takes two aides off the floor for a bit; assist with ambulation; assist with toileting; dressing; passing meal

trays; feeding; monitoring and emptying foleys and ostomies; taking and recording weights and vital signs; changing soiled bed linen; turning bed-bound residents every two hours to prevent bed sores (this can take two aides off the floor if the bed-bound person is big and heavy and has limited bed mobility); bathing a resident in the shower or whirlpool tub; charting everything that occurred during the shift; unclogging toilets when they plug up; and taking the trash out. CNAs also handle their portion of an admission; we inventory a new resident's cloths and belongings, orientate them to their room and the bathroom, explain the meal services and times, and get their weight and vital signs as a baseline.

We are supposed to be providing quality, resident-centered care, based upon their preferences, but how can quality, resident-centered care be delivered when there is one CNA to 12 or 13 people? I cannot provide it. Being responsible for that many people allows me to provide the basics at a rushed rate. They all demand something at the same time and it is impossible to meet all their needs. It is hard to not get frustrated when you have 12 or 13 people demanding something of you all at the same time. Some of these 12 or 13 people need more assistance than others. The term is that they are a two-assist, meaning it takes two aides to help them ambulate or to transfer them. I try to assist all of them as quickly as I can, but inevitably, some have to wait. They do not like having to wait and are very vocal about it. I try to apologize when this happens. They ask me if we are working short. They know because it takes so long for someone to answer their call bell or help them get ready for bed.

The stress level and frustration from working at the state minimums is incredible. While at work I find myself saying "I'm doing all this for just $10 an hour!" I honestly do not see it getting better for CNAs working in nursing facilities and more importantly I do not see it getting better for the residents in these facilities.

I am a good CNA. I get feedback from my residents, telling me how compassionate and caring I am; how gentle I am. I try to be because I do not want to cause anyone more pain than what they are in. They tell me how patient I am. I have to be; most of these people cannot easily move on their own. The feedback I get from the people in my care means a lot. It lets me know I am doing a good job and that these folks are comfortable with me. I like that. This is why I got into direct care; I like people, I like helping them, and I want them to stay as healthy as possible.

With the State considering changing the hours of direct care from 3.49 hours in a 24-hour period to 3 hours in a 24-hour period and allowing the nursing homes themselves to staff according to need, without minimum staffing ratios, the changes recommended are NOT a good thing. Not good for the residents and not good for the already over-worked and extremely stressed staff. If anything, staffing ratios need to stay in place and need to be enhanced. A reasonable level is 1 CNA to 4 residents during the day, 1 CNA to six residents for the evening, and 1 CNA to 10 people overnight. Taking the RNs and med-techs out of the ratio equation should be considered too.

I am getting out of direct care. I struggle with my finances; not being able to set aside money for those emergencies that come up. I struggle with the frustration and stress of the job. I am tired of it. I am making a change and am in school at Husson University. I do not mind working hard, but I cannot continue to work so hard for so little and survive financially and mentally. I do not like the negativity I feel because of my job.

Good CNAs like me leave the profession. The turnover of nursing staff at my facility is extremely high. All the nurses that started when I did have moved on to other positions. Most of the CNAs I started working with have moved on to other jobs. The recurring theme is the stress and frustration we all deal with. What does this say about working in a nursing home? Who wants to do this work when there are not enough hands on the floor, when the pay barely allows you to pay your bills? Not me. The profession is losing one good CNA, one of many that leave to find work that is not so stressful and frustrating for $10 an hour.

APPENDIX F

Minimum Data Set, Resident Assessment and Care Screening

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home Comprehensive (NC) Item Set

Section A | Identification Information

A0050. Type of Record

Enter Code

1. **Add new record** → Continue to A0100, Facility Provider Numbers
2. **Modify existing record** → Continue to A0100, Facility Provider Numbers
3. **Inactivate existing record** → Skip to X0150, Type of Provider

A0100. Facility Provider Numbers

A. **National Provider Identifier (NPI):**

B. **CMS Certification Number (CCN):**

C. **State Provider Number:**

A0200. Type of Provider

Enter Code

Type of provider

1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310. Type of Assessment

Enter Code

A. **Federal OBRA Reason for Assessment**

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

CATs | RUG IV

Enter Code

B. **PPS Assessment**

PPS Scheduled Assessments for a Medicare Part A Stay

01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment

99. **None of the above**

RUG IV

Enter Code

C. **PPS Other Medicare Required Assessment - OMRA**

0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment

RUG IV

Enter Code

D. **Is this a Swing Bed clinical change assessment?** Complete only if A0200 = 2

0. **No**
1. **Yes**

RUG IV

A0310 continued on next page

Section A | Identification Information

A0310. Type of Assessment - Continued

Enter Code ☐

E. **Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?**
0. **No**
1. **Yes**

Enter Code ☐☐

F. **Entry/discharge reporting**
01. **Entry** tracking record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

Enter Code ☐

G. **Type of discharge** - Complete only if A0310F = 10 or 11
1. **Planned**
2. **Unplanned**

A0410. Submission Requirement

Enter Code ☐

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. **First name:** ☐☐☐☐☐☐☐☐☐☐☐☐

B. **Middle initial:** ☐

C. **Last name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. **Suffix:** ☐☐☐

A0600. Social Security and Medicare Numbers

A. **Social Security Number:** ☐☐☐ – ☐☐ – ☐☐☐☐

B. **Medicare number** (or comparable railroad insurance number): ☐☐☐☐☐☐☐☐☐☐☐☐

A0700. Medicaid Number - Enter "-" if pending, "N" if not a Medicaid recipient

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0800. Gender

Enter Code ☐

1. **Male**
2. **Female**

A0900. Birth Date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A1000. Race/Ethnicity

↓ **Check all that apply**

☐ A. **American Indian or Alaska Native**

☐ B. **Asian**

☐ C. **Black or African American**

☐ D. **Hispanic or Latino**

☐ E. **Native Hawaiian or Other Pacific Islander**

☐ F. **White**

Section A | Identification Information

A1100. Language

Enter Code ☐

A. **Does the resident need or want an interpreter to communicate with a doctor or health care staff?**
0. **No**
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine**

B. **Preferred language:**

A1200. Marital Status

Enter Code ☐

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

A1300. Optional Resident Items

A. **Medical record number:**

B. **Room number:**

C. **Name by which resident prefers to be addressed:**

D. **Lifetime occupation(s)** - put "/" between two occupations:

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01, 03, 04, or 05

Enter Code ☐

Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?
0. **No** → Skip to A1550, Conditions Related to ID/DD Status
1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions
9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status

A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions

Complete only if A0310A = 01, 03, 04, or 05

↓ **Check all that apply**

☐ A. **Serious mental illness**

☐ B. **Intellectual Disability ("mental retardation" in federal regulation)**

☐ C. **Other related conditions**

Section A Identification Information

A1550. Conditions Related to ID/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ **Check all conditions that are related to ID/DD status** that were manifested before age 22, and are likely to continue indefinitely

ID/DD With Organic Condition

- ☐ **A. Down syndrome**
- ☐ **B. Autism**
- ☐ **C. Epilepsy**
- ☐ **D. Other organic condition related to ID/DD**

ID/DD Without Organic Condition

- ☐ **E. ID/DD with no organic condition**

No ID/DD

- ☐ **Z. None of the above**

A1600. Entry Date (date of this admission/entry or reentry into the facility)

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A1700. Type of Entry

Enter Code ☐

1. **Admission**
2. **Reentry**

A1800. Entered From

Enter Code ☐☐

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
09. **Long Term Care Hospital** (LTCH)
99. **Other**

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code ☐☐

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
08. **Deceased**
09. **Long Term Care Hospital** (LTCH)
99. **Other**

Section A Identification Information

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

Month – Day – Year

A2300. Assessment Reference Date

Observation end date:

Month – Day – Year

CATs | RUG IV | RUG III

A2400. Medicare Stay

Enter Code

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

Month – Day – Year

RUG-IV

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

Month – Day – Year

RUG IV

Look back period for all items is 7 days unless another time frame is indicated

Section B | Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness

0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

RUG IV | RUG III

B0200. Hearing

Enter Code ☐

Ability to hear (with hearing aid or hearing appliances if normally used)

0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

CATs

B0300. Hearing Aid

Enter Code ☐

Hearing aid or other hearing appliance used in completing B0200, Hearing

0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code ☐

Select best description of speech pattern

0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression

0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

CATs | RUG IV | RUG III

B0800. Ability To Understand Others

Enter Code ☐

Understanding verbal content, however able (with hearing aid or device if used)

0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

CATs

B1000. Vision

Enter Code ☐

Ability to see in adequate light (with glasses or other visual appliances)

0. **Adequate** - sees fine detail, such as regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

CATs

B1200. Corrective Lenses

Enter Code ☐

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision

0. **No**
1. **Yes**

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?

Attempt to conduct interview with all residents

Enter Code

0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

RUG IV | RUG III

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code

Ask resident: "*Please tell me what year it is right now.*"

A. Able to report correct year

0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

RUG IV | RUG III

Enter Code

Ask resident: "*What month are we in right now?*"

B. Able to report correct month

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

RUG IV | RUG III

Enter Code

Ask resident: "*What day of the week is today?*"

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

RUG IV | RUG III

C0400. Recall

Enter Code

Ask resident: "*Let's go back to an earlier question. What were those three words that I asked you to repeat?*"

If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"

0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

RUG IV | RUG III

Enter Code

B. Able to recall "blue"

0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

RUG IV | RUG III

Enter Code

C. Able to recall "bed"

0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

RUG IV | RUG III

C0500. Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

CATs | RUG IV | RUG III

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code ☐

0. **No** (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes

0. **Memory OK**
1. **Memory problem**

CATs | RUG IV | RUG III

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past

0. **Memory OK**
1. **Memory problem**

CATs

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

- ☐ **A. Current season**
- ☐ **B. Location of own room**
- ☐ **C. Staff names and faces**
- ☐ **D. That he or she is in a nursing home**
- ☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life

0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

CATs | RUG IV | RUG III

Delirium

C1300. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

- ☐ **A. Inattention** - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)? CATs
- ☐ **B. Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? CATs
- ☐ **C. Altered level of consciousness** - Did the resident have altered level of consciousness (e.g., **vigilant** - startled easily to any sound or touch; **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch; **stuporous** - very difficult to arouse and keep aroused for the interview; **comatose** - could not be aroused)? CATs
- ☐ **D. Psychomotor retardation**- Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly? CATs

C1600. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the resident's baseline?

0. **No**
1. **Yes**

CATs

Section D Mood

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	CATs ☐	RUG IV ☐ RUG III
B. *Feeling down, depressed, or hopeless*	☐	RUG IV ☐ RUG III
C. *Trouble falling or staying asleep, or sleeping too much*	☐	RUG IV ☐ RUG III
D. *Feeling tired or having little energy*	☐	RUG IV ☐ RUG III
E. *Poor appetite or overeating*	☐	RUG IV ☐ RUG III
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	RUG IV ☐ RUG III
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	RUG IV ☐ RUG III
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	RUG IV ☐ RUG III
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	CATs ☐	RUG IV ☐ RUG III

D0300. Total Severity Score

Enter Score ☐☐

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

CATs ☐ RUG IV ☐ RUG III ☐

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

Section D Mood

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	CATs	RUG IV / RUG III
B. Feeling or appearing down, depressed, or hopeless		RUG IV / RUG III
C. Trouble falling or staying asleep, or sleeping too much		RUG IV / RUG III
D. Feeling tired or having little energy		RUG IV / RUG III
E. Poor appetite or overeating		RUG IV / RUG III
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down		RUG IV / RUG III
G. Trouble concentrating on things, such as reading the newspaper or watching television		RUG IV / RUG III
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual		RUG IV / RUG III
I. States that life isn't worth living, wishes for death, or attempts to harm self	CATs	RUG IV / RUG III
J. Being short-tempered, easily annoyed		RUG IV / RUG III

D0600. Total Severity Score

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. CATs | RUG IV | RUG III

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

Section E Behavior

E0100. Potential Indicators of Psychosis

↓ Check all that apply

- ☐ A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli) RUG IV RUG III
- ☐ B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality) RUG IV RUG III
- ☐ Z. **None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

↓ Enter Codes in Boxes

- ☐ A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) CATs RUG IV RUG III
- ☐ B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others) CATs RUG IV RUG III
- ☐ C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) CATs RUG IV RUG III

E0300. Overall Presence of Behavioral Symptoms

Enter Code ☐

Were any behavioral symptoms in questions E0200 coded 1, 2, or 3? CATs
0. **No** → Skip to E0800, Rejection of Care
1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

E0500. Impact on Resident

Did any of the identified symptom(s):

Enter Code ☐ **A. Put the resident at significant risk for physical illness or injury?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly interfere with the resident's care?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly interfere with the resident's participation in activities or social interactions?**
0. **No**
1. **Yes**

E0600. Impact on Others

Did any of the identified symptom(s):

Enter Code ☐ **A. Put others at significant risk for physical injury?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly intrude on the privacy or activity of others?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly disrupt care or living environment?**
0. **No**
1. **Yes**

E0800. Rejection of Care - Presence & Frequency

Enter Code ☐

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

CATs RUG IV RUG III

Section E Behavior

E0900. Wandering - Presence & Frequency

Enter Code ☐

Has the resident wandered?

0. **Behavior not exhibited** → Skip to E1100, Change in Behavioral or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

CATs | RUG IV | RUG III

E1000. Wandering - Impact

Enter Code ☐

A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?

0. **No**
1. **Yes**

Enter Code ☐

B. Does the wandering significantly intrude on the privacy or activities of others?

0. **No**
1. **Yes**

E1100. Change in Behavior or Other Symptoms

Consider all of the symptoms assessed in items E0100 through E1000

Enter Code ☐

How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or Scheduled PPS)?**

0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior MDS assessment

CATs

Section F | Preferences for Customary Routine and Activities

F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code ☐

0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

↓ **Enter Codes in Boxes**

☐	**A.** *how important is it to you to* ***choose what clothes to wear?***
☐	**B.** *how important is it to you to* ***take care of your personal belongings or things?***
☐	**C.** *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***
☐	**D.** *how important is it to you to* ***have snacks available between meals?***
☐	**E.** *how important is it to you to* ***choose your own bedtime?***
☐	**F.** *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***
☐	**G.** *how important is it to you to* ***be able to use the phone in private?***
☐	**H.** *how important is it to you to* ***have a place to lock your things to keep them safe?***

F0500. Interview for Activity Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

↓ **Enter Codes in Boxes**

☐	**A.** *how important is it to you to* ***have books, newspapers, and magazines to read?*** CATs
☐	**B.** *how important is it to you to* ***listen to music you like?*** CATs
☐	**C.** *how important is it to you to* ***be around animals such as pets?*** CATs
☐	**D.** *how important is it to you to* ***keep up with the news?*** CATs
☐	**E.** *how important is it to you to* ***do things with groups of people?*** CATs
☐	**F.** *how important is it to you to* ***do your favorite activities?*** CATs
☐	**G.** *how important is it to you to* ***go outside to get fresh air when the weather is good?*** CATs
☐	**H.** *how important is it to you to* ***participate in religious services or practices?*** CATs

F0600. Daily and Activity Preferences Primary Respondent

Enter Code ☐

Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500) CATs

1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No response" to 3 or more items")

Section F Preferences for Customary Routine and Activities

F0700. Should the Staff Assessment of Daily and Activity Preferences be Conducted?

Enter Code ☐

0. **No** (because Interview for Daily and Activity Preferences (F0400 and F0500) was completed by resident or family/significant other) → Skip to and complete G0110, Activities of Daily Living (ADL) Assistance
1. **Yes** (because 3 or more items in Interview for Daily and Activity Preferences (F0400 and F0500) were not completed by resident or family/significant other) → Continue to F0800, Staff Assessment of Daily and Activity Preferences

F0800. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F0400-F0500) was completed

Resident Prefers:

↓ Check all that apply		
☐	A. Choosing clothes to wear	
☐	B. Caring for personal belongings	
☐	C. Receiving tub bath	
☐	D. Receiving shower	
☐	E. Receiving bed bath	
☐	F. Receiving sponge bath	
☐	G. Snacks between meals	
☐	H. Staying up past 8:00 p.m.	
☐	I. Family or significant other involvement in care discussions	
☐	J. Use of phone in private	
☐	K. Place to lock personal belongings	
☐	L. Reading books, newspapers, or magazines	CATs
☐	M. Listening to music	CATs
☐	N. Being around animals such as pets	CATs
☐	O. Keeping up with the news	CATs
☐	P. Doing things with groups of people	CATs
☐	Q. Participating in favorite activities	CATs
☐	R. Spending time away from the nursing home	CATs
☐	S. Spending time outdoors	CATs
☐	T. Participating in religious activities or practices	CATs
☐	Z. None of the above	

Section G Functional Status

G0110. Activities of Daily Living (ADL) Assistance

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance

Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided

Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	CATs / RUG IV / RUG III	RUG IV / RUG III
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	CATs / RUG IV / RUG III	RUG IV / RUG III
C. **Walk in room** - how resident walks between locations in his/her room	CATs	
D. **Walk in corridor** - how resident walks in corridor on unit	CATs	
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	CATs	
F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	CATs	
G. **Dressing** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	CATs	
H. **Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	CATs / RUG IV / RUG III	RUG IV
I. **Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	CATs / RUG IV / RUG III	RUG IV / RUG III
J. **Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	CATs	

Section G Functional Status

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support.

Enter Code ☐

A. Self-performance
0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

CATs

Enter Code ☐

B. Support provided
(Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

G0300. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent**

Coding:
0. **Steady at all times**
1. **Not steady, but able to stabilize without staff assistance**
2. **Not steady, only able to stabilize with staff assistance**
8. **Activity did not occur**

↓ **Enter Codes in Boxes**

☐	**A. Moving from seated to standing position**	CATs
☐	**B. Walking** (with assistive device if used)	CATs
☐	**C. Turning around** and facing the opposite direction while walking	CATs
☐	**D. Moving on and off toilet**	CATs
☐	**E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)	CATs

G0400. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury

Coding:
0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

↓ **Enter Codes in Boxes**

☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
☐	**B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ **Check all that were normally used**

☐	**A. Cane/crutch**
☐	**B. Walker**
☐	**C. Wheelchair** (manual or electric)
☐	**D. Limb prosthesis**
☐	**Z. None of the above** were used

G0900. Functional Rehabilitation Potential

Complete only if A0310A = 01

Enter Code ☐

A. Resident believes he or she is capable of increased independence in at least some ADLs
0. **No**
1. **Yes**
9. **Unable to determine**

CATs

Enter Code ☐

B. Direct care staff believe resident is capable of increased independence in at least some ADLs
0. **No**
1. **Yes**

CATs

Section H Bladder and Bowel

H0100. Appliances

Check all that apply

- ☐ A. **Indwelling catheter** (including suprapubic catheter and nephrostomy tube) CATs
- ☐ B. **External catheter** CATs
- ☐ C. **Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ D. **Intermittent catheterization** CATs
- ☐ Z. **None of the above**

H0200. Urinary Toileting Program

Enter Code ☐

A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?

0. **No** → Skip to H0300, Urinary Continence
1. **Yes** → Continue to H0200B, Response
9. **Unable to determine** → Skip to H0200C, Current toileting program or trial

Enter Code ☐

B. Response - What was the resident's response to the trial program?

0. **No improvement**
1. **Decreased wetness**
2. **Completely dry** (continent)
9. **Unable to determine** or trial in progress

Enter Code ☐

C. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence? RUG IV RUG III

0. **No**
1. **Yes**

H0300. Urinary Continence

Enter Code ☐

Urinary continence - Select the one category that best describes the resident CATs

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐

Bowel continence - Select the one category that best describes the resident CATs

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

H0500. Bowel Toileting Program

Enter Code ☐

Is a toileting program currently being used to manage the resident's bowel continence? RUG IV RUG III

0. **No**
1. **Yes**

H0600. Bowel Patterns

Enter Code ☐

Constipation present?

0. **No**
1. **Yes**

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists.

Cancer

- ☐ I0100. **Cancer** (with or without metastasis)

Heart/Circulation

- ☐ I0200. **Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ I0300. **Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
- ☐ I0400. **Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
- ☐ I0500. **Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
- ☐ I0600. **Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- ☐ I0700. **Hypertension**
- ☐ I0800. **Orthostatic Hypotension**
- ☐ I0900. **Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

Gastrointestinal

- ☐ I1100. **Cirrhosis**
- ☐ I1200. **Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
- ☐ I1300. **Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Genitourinary

- ☐ I1400. **Benign Prostatic Hyperplasia (BPH)**
- ☐ I1500. **Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**
- ☐ I1550. **Neurogenic Bladder**
- ☐ I1650. **Obstructive Uropathy**

Infections

- ☐ I1700. **Multidrug-Resistant Organism (MDRO)** CATs
- ☐ I2000. **Pneumonia** CATs | RUG IV | RUG III
- ☐ I2100. **Septicemia** CATs | RUG IV | RUG III
- ☐ I2200. **Tuberculosis** CATs
- ☐ I2300. **Urinary Tract Infection (UTI) (LAST 30 DAYS)** CATs
- ☐ I2400. **Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E) CATs
- ☐ I2500. **Wound Infection** (other than foot) CATs

Metabolic

- ☐ I2900. **Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy) RUG IV | RUG III
- ☐ I3100. **Hyponatremia**
- ☐ I3200. **Hyperkalemia**
- ☐ I3300. **Hyperlipidemia** (e.g., hypercholesterolemia)
- ☐ I3400. **Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal

- ☐ I3700. **Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
- ☐ I3800. **Osteoporosis**
- ☐ I3900. **Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ I4000. **Other Fracture**

Neurological

- ☐ I4200. **Alzheimer's Disease** CATs
- ☐ I4300. **Aphasia** RUG III
- ☐ I4400. **Cerebral Palsy** RUG IV | RUG III
- ☐ I4500. **Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ I4800. **Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases) CATs

Neurological Diagnoses continued on next page

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Neurological - Continued

- ☐ I4900. **Hemiplegia or Hemiparesis** RUG IV | RUG III
- ☐ I5000. **Paraplegia**
- ☐ I5100. **Quadriplegia** RUG IV | RUG III
- ☐ I5200. **Multiple Sclerosis (MS)** RUG IV | RUG III
- ☐ I5250. **Huntington's Disease**
- ☐ I5300. **Parkinson's Disease** RUG IV
- ☐ I5350. **Tourette's Syndrome**
- ☐ I5400. **Seizure Disorder or Epilepsy**
- ☐ I5500. **Traumatic Brain Injury (TBI)** RUG III

Nutritional

- ☐ I5600. **Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- ☐ I5700. **Anxiety Disorder**
- ☐ I5800. **Depression** (other than bipolar)
- ☐ I5900. **Manic Depression** (bipolar disease)
- ☐ I5950. **Psychotic Disorder** (other than schizophrenia)
- ☐ I6000. **Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ I6100. **Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ I6200. **Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis) RUG IV
- ☐ I6300. **Respiratory Failure** RUG IV

Vision

- ☐ I6500. **Cataracts, Glaucoma, or Macular Degeneration** CATs

None of Above

- ☐ I7900. **None of the above active diagnoses** within the last 7 days

Other

I8000. **Additional active diagnoses**

Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____ | | | | | | | | |

B. _____ | | | | | | | | |

C. _____ | | | | | | | | |

D. _____ | | | | | | | | |

E. _____ | | | | | | | | |

F. _____ | | | | | | | | |

G. _____ | | | | | | | | |

H. _____ | | | | | | | | |

I. _____ | | | | | | | | |

J. _____ | | | | | | | | |

Section J Health Conditions

J0100. Pain Management - Complete for all residents, regardless of current pain level

At any time in the last 5 days, has the resident:

Enter Code ☐ **A. Received scheduled pain medication regimen?**
0. No
1. Yes

Enter Code ☐ **B. Received PRN pain medications OR was offered and declined?**
0. No
1. Yes

Enter Code ☐ **C. Received non-medication intervention for pain?**
0. No
1. Yes

J0200. Should Pain Assessment Interview be Conducted?

Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code ☐
0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
1. **Yes** → Continue to J0300, Pain Presence

Pain Assessment Interview

J0300. Pain Presence

Enter Code ☐ Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"
0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0400, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain Frequency

Enter Code ☐ Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"
1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

CATs

J0500. Pain Effect on Function

Enter Code ☐ **A.** Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night?***"
0. **No**
1. **Yes**
9. **Unable to answer**

CATs

Enter Code ☐ **B.** Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain?***"
0. **No**
1. **Yes**
9. **Unable to answer**

CATs

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating ☐☐ **A. Numeric Rating Scale (00-10)**
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -10 pain scale)
Enter two-digit response. Enter 99 if unable to answer.

CATs

Enter Code ☐ **B. Verbal Descriptor Scale**
Ask resident: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show resident verbal scale)
1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

CATs

Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

0. **No** (J0400 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0400 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Staff Assessment for Pain

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓ Check all that apply

☐	A. **Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)	CATs
☐	B. **Vocal complaints of pain** (e.g., that hurts, ouch, stop)	CATs
☐	C. **Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)	CATs
☐	D. **Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)	CATs
☐	Z. **None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)	

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code ☐

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ Check all that apply

☐	A. **Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)	
☐	B. **Shortness of breath** or trouble breathing **when sitting at rest**	
☐	C. **Shortness of breath** or trouble breathing **when lying flat**	RUG IV
☐	Z. **None of the above**	

J1300. Current Tobacco Use

Enter Code ☐

Tobacco use

0. **No**
1. **Yes**

J1400. Prognosis

Enter Code ☐

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)

0. **No**
1. **Yes**

J1550. Problem Conditions

↓ Check all that apply

☐	A. **Fever**	CATs	RUG IV	RUG III
☐	B. **Vomiting**	CATs	RUG IV	RUG III
☐	C. **Dehydrated**	CATs		RUG III
☐	D. **Internal bleeding**	CATs		RUG III
☐	Z. **None of the above**			

Section J Health Conditions

J1700. Fall History on Admission/Entry or Reentry

Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐

A. Did the resident have a fall any time in the **last month** prior to admission/entry or reentry?
0. **No**
1. **Yes**
9. **Unable to determine**

CATs

Enter Code ☐

B. Did the resident have a fall any time in the **last 2-6 months** prior to admission/entry or reentry?
0. **No**
1. **Yes**
9. **Unable to determine**

CATs

Enter Code ☐

C. Did the resident have any **fracture related to a fall in the 6 months** prior to admission/entry or reentry?
0. **No**
1. **Yes**
9. **Unable to determine**

J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Enter Code ☐

Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?
0. **No** → Skip to K0100, Swallowing Disorder
1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

CATs

J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Coding:
0. **None**
1. **One**
2. **Two or more**

↓ **Enter Codes in Boxes**

☐ **A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

☐ **B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

☐ **C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section K | Swallowing/Nutritional Status

K0100. Swallowing Disorder

Signs and symptoms of possible swallowing disorder

↓ Check all that apply

- ☐ A. Loss of liquids/solids from mouth when eating or drinking
- ☐ B. Holding food in mouth/cheeks or residual food in mouth after meals
- ☐ C. Coughing or choking during meals or when swallowing medications
- ☐ D. Complaints of difficulty or pain with swallowing
- ☐ Z. None of the above

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

inches ☐☐

A. **Height** (in inches). Record most recent height measure since the most recent admission/entry or reentry CATs

pounds ☐☐☐

B. **Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.) CATs

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

CATs | RUG IV | RUG III

K0310. Weight Gain

Enter Code ☐

Gain of 5% or more in the last month or gain of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-gain regimen
2. **Yes, not on** physician-prescribed weight-gain regimen

CATs

K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last 7 **days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
A. **Parenteral/IV feeding**	CATs | RUG IV | RUG III ☐	CATs | RUG IV | RUG III ☐
B. **Feeding tube** - nasogastric or abdominal (PEG)	CATs | RUG IV | RUG III ☐	CATs | RUG IV | RUG III ☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	CATs ☐	CATs ☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	CATs ☐	CATs ☐
Z. **None of the above**	☐	☐

Section K | Swallowing/Nutritional Status

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
3. **During Entire 7 Days**
   Performed during the entire ***last 7 days***

	1. While NOT a Resident	2. While a Resident	3. During Entire 7 Days
	↓ Enter Codes		↓
A. **Proportion of total calories the resident received through parenteral or tube feeding** 1. **25% or less** 2. **26-50%** 3. **51% or more**	☐	☐ RUG IV RUG III	☐
B. **Average fluid intake per day by IV or tube feeding** 1. **500 cc/day or less** 2. **501 cc/day or more**	☐	☐ RUG IV RUG III	☐

Section L | Oral/Dental Status

L0200. Dental

↓ **Check all that apply**

☐	A. **Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)	CATs
☐	B. **No natural teeth or tooth fragment(s)** (edentulous)	CATs
☐	C. **Abnormal mouth tissue** (ulcers, masses, oral lesions, including under denture or partial if one is worn)	CATs
☐	D. **Obvious or likely cavity or broken natural teeth**	CATs
☐	E. **Inflamed or bleeding gums or loose natural teeth**	CATs
☐	F. **Mouth or facial pain, discomfort or difficulty with chewing**	CATs
☐	G. **Unable to examine**	
☐	Z. **None of the above were present**	

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer Risk

Check all that apply

- ☐ A. **Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- ☐ B. **Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ C. **Clinical assessment**
- ☐ Z. **None of the above**

M0150. Risk of Pressure Ulcers

Enter Code ☐

Is this resident at risk of developing pressure ulcers?

0. **No**
1. **Yes**

CATs

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐

Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?

0. **No** → Skip to M0900, Healed Pressure Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number ☐

A. **Number of Stage 1 pressure ulcers** CATs | RUG III

Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Enter Number ☐

B. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3 CATs | RUG IV | RUG III

Enter Number ☐

2. **Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Number ☐

C. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4 CATs | RUG IV | RUG III

Enter Number ☐

2. **Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

Enter Number ☐

D. **Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable: Non-removable dressing CATs | RUG IV | RUG III

Enter Number ☐

2. **Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0300 continued on next page

Section M Skin Conditions

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - Continued

E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device

Enter Number ☐

1. **Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar CATs

Enter Number ☐

2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number ☐

1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable: Deep tissue CATs RUG-IV RUG-III

Enter Number ☐

2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution CATs

Enter Number ☐

1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number ☐

2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

☐☐.☐ cm **A. Pressure ulcer length:** Longest length from head to toe

☐☐.☐ cm **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

☐☐.☐ cm **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code ☐

Select the best description of the most severe type of tissue present in any pressure ulcer bed

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Eschar** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

9. **None of the Above**

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry

Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.

Enter Number ☐ **A. Stage 2** CATs

Enter Number ☐ **B. Stage 3** CATs

Enter Number ☐ **C. Stage 4** CATs

Section M Skin Conditions

M0900. Healed Pressure Ulcers

Complete only if A0310E = 0

Enter Code ☐

A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0900B, Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.

Enter Number ☐ **B. Stage 2**

Enter Number ☐ **C. Stage 3**

Enter Number ☐ **D. Stage 4**

M1030. Number of Venous and Arterial Ulcers

Enter Number ☐ **Enter the total number of venous and arterial ulcers present** RUG IV | RUG III

M1040. Other Ulcers, Wounds and Skin Problems

Check all that apply

Foot Problems

☐ **A. Infection of the foot** (e.g., cellulitis, purulent drainage) CATs | RUG IV | RUG III

☐ **B. Diabetic foot ulcer(s)** RUG IV | RUG III

☐ **C. Other open lesion(s) on the foot** RUG IV | RUG III

Other Problems

☐ **D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion) RUG IV | RUG III

☐ **E. Surgical wound(s)** RUG IV | RUG III

☐ **F. Burn(s)** (second or third degree) RUG IV | RUG III

☐ **G. Skin tear(s)**

☐ **H. Moisture Associated Skin Damage (MASD)** (i.e. incontinence (IAD), perspiration, drainage) CATs

None of the Above

☐ **Z. None of the above** were present

M1200. Skin and Ulcer Treatments

Check all that apply

☐ **A. Pressure reducing device for chair** RUG IV | RUG III

☐ **B. Pressure reducing device for bed** RUG IV | RUG III

☐ **C. Turning/repositioning program** RUG IV | RUG III

☐ **D. Nutrition or hydration intervention** to manage skin problems RUG IV | RUG III

☐ **E. Pressure ulcer care** RUG IV | RUG III

☐ **F. Surgical wound care** RUG IV | RUG III

☐ **G. Application of nonsurgical dressings** (with or without topical medications) other than to feet RUG IV | RUG III

☐ **H. Applications of ointments/medications** other than to feet RUG IV | RUG III

☐ **I. Application of dressings to feet** (with or without topical medications) RUG IV | RUG III

☐ **Z. None of the above** were provided

Section N | Medications

N0300. Injections

Enter Days ☐

Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0410, Medications Received

RUG III

N0350. Insulin

Enter Days ☐

A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days

RUG IV

Enter Days ☐

B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days

RUG IV

N0410. Medications Received

Indicate the number of DAYS the resident received the following medications during the last 7 days or since admission/entry or reentry if less than 7 days. Enter "0" if medication was not received by the resident during the last 7 days

Enter Days ☐ **A. Antipsychotic** CATs

Enter Days ☐ **B. Antianxiety** CATs

Enter Days ☐ **C. Antidepressant** CATs

Enter Days ☐ **D. Hypnotic** CATs

Enter Days ☐ **E. Anticoagulant** (warfarin, heparin, or low-molecular weight heparin)

Enter Days ☐ **F. Antibiotic**

Enter Days ☐ **G. Diuretic**

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	RUG III ☐	RUG III ☐ RUG IV
B. Radiation	RUG III ☐	RUG III ☐ RUG IV
Respiratory Treatments		
C. Oxygen therapy	RUG III ☐	RUG III ☐ RUG IV
D. Suctioning	RUG III ☐	RUG III ☐
E. Tracheostomy care	RUG III ☐	RUG III ☐ RUG IV
F. Ventilator or respirator	RUG III ☐	RUG III ☐ RUG IV
G. BiPAP/CPAP	☐	☐
Other		
H. IV medications	RUG III ☐	RUG III ☐ RUG IV
I. Transfusions	RUG III ☐	RUG III ☐ RUG IV
J. Dialysis	RUG III ☐	RUG III ☐ RUG IV
K. Hospice care	☐	☐
L. Respite care		☐
M. **Isolation or quarantine for active infectious disease** (does not include standard body/fluid precautions)	☐	☐ RUG IV
None of the Above		
Z. None of the above	☐	☐

O0250. Influenza Vaccine - Refer to current version of RAI manual for current flu season and reporting period

Enter Code ☐

A. Did the **resident receive the Influenza vaccine in this facility** for this year's Influenza season?

0. **No** → Skip to O0250C, If Influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date vaccine received

B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If Influenza vaccine not received, state reason:

1. **Resident not in facility** during this year's flu season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain vaccine** due to a declared shortage
9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

A. Is the resident's Pneumococcal vaccination up to date?

0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0400, Therapies

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:

1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

Section O | Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days RUG IV | RUG III

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days RUG IV | RUG III

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days RUG IV | RUG III

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date

Enter Number of Minutes

3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days RUG IV | RUG III

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month ___ Day ___ Year ___ RUG IV

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month ___ Day ___ Year ___ RUG IV

B. Occupational Therapy

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days RUG IV | RUG III

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days RUG IV | RUG III

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days RUG IV | RUG III

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date

Enter Number of Minutes

3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days RUG IV | RUG III

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month ___ Day ___ Year ___ RUG IV

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month ___ Day ___ Year ___ RUG IV

O0400 continued on next page

Section O | Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

C. Physical Therapy

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days RUG IV RUG III

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days RUG IV RUG III

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days RUG IV RUG III

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date

Enter Number of Minutes

3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days RUG IV RUG III

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month _____ Day _____ Year _____ RUG IV

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month _____ Day _____ Year _____ RUG IV

D. Respiratory Therapy

Enter Number of Minutes

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days

If zero, → skip to O0400E, Psychological Therapy

Enter Number of Days

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days RUG IV RUG III

E. Psychological Therapy (by any licensed mental health professional)

Enter Number of Minutes

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days

If zero, → skip to O0400F, Recreational Therapy

Enter Number of Days

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days

If zero, → skip to O0420, Distinct Calendar Days of Therapy

Enter Number of Days

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

O0420. Distinct Calendar Days of Therapy

Enter Number of Days

Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days. RUG IV

O0450. Resumption of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99

Enter Code

A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?

0. **No** → Skip to O0500, Restorative Nursing Programs
1. **Yes**

B. Date on which therapy regimen resumed: RUG IV

Month _____ Day _____ Year _____

Section O | Special Treatments, Procedures, and Programs

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique	
	A. Range of motion (passive)	RUG III RUG IV
	B. Range of motion (active)	RUG III RUG IV
	C. Splint or brace assistance	RUG III RUG IV
Number of Days	**Training and Skill Practice In:**	
	D. Bed mobility	RUG III RUG IV
	E. Transfer	RUG III RUG IV
	F. Walking	RUG III RUG IV
	G. Dressing and/or grooming	RUG III RUG IV
	H. Eating and/or swallowing	RUG III RUG IV
	I. Amputation/prostheses care	RUG III RUG IV
	J. Communication	RUG III RUG IV

O0600. Physician Examinations

Enter Days: ☐☐

Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?** RUG III

O0700. Physician Orders

Enter Days: ☐☐

Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?** RUG III

Section P Restraints

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Coding:
0. Not used
1. Used less than daily
2. Used daily

↓ Enter Codes in Boxes

	Used in Bed	
	A. Bed rail	CATs
	B. Trunk restraint	CATs
	C. Limb restraint	CATs
	D. Other	CATs
	Used in Chair or Out of Bed	
	E. Trunk restraint	CATs
	F. Limb restraint	CATs
	G. Chair prevents rising	CATs
	H. Other	CATs

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐
A. Resident participated in assessment
0. No
1. Yes

Enter Code ☐
B. Family or significant other participated in assessment
0. No
1. Yes
9. Resident has no family or significant other

Enter Code ☐
C. Guardian or legally authorized representative participated in assessment
0. No
1. Yes
9. Resident has no guardian or legally authorized representative

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code ☐
A. Select one for resident's overall goal established during assessment process
1. Expects to be **discharged to the community**
2. Expects to **remain in this facility**
3. Expects to be **discharged to another facility/institution**
9. **Unknown or uncertain**

Enter Code ☐
B. Indicate information source for Q0300A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **Unknown or uncertain**

Q0400. Discharge Plan

Enter Code ☐
A. Is active discharge planning already occurring for the resident to return to the community?
0. No
1. Yes → Skip to Q0600, Referral

Section Q Participation in Assessment and Goal Setting

Q0490. Resident's Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, or 99

Enter Code ☐

Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?

0. **No**
1. **Yes** → Skip to Q0600, Referral
8. **Information not available**

Q0500. Return to Community

Enter Code ☐

B. Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"**

0. **No**
1. **Yes**
9. **Unknown or uncertain**

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again

Enter Code ☐

A. Does the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) **want to be asked about returning to the community on <u>all</u> assessments?** (Rather than only on comprehensive assessments.)

0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment
1. **Yes**
8. **Information not available**

Enter Code ☐

B. Indicate information source for Q0550A

1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family or significant other, then **guardian or legally authorized representative**
8. **No information source available**

Q0600. Referral

Enter Code ☐

Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)

0. **No** - referral not needed
1. **No** - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20)
2. **Yes** - referral made

CATs

Section V Care Area Assessment (CAA) Summary

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment

Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01-06 or A0310B = 01-06

Enter Code

A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment)

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. None of the above

Enter Code

B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)

01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
99. None of the above

C. Prior Assessment Reference Date (A2300 value from prior assessment)

Month – Day – Year

Enter Score

D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment) CATs

Enter Score

E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment) CATs

Enter Score

F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment) CATs

Section V Care Area Assessment (CAA) Summary

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature

2. Date ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

C. Signature of Person Completing Care Plan Decision and Date Signed

1. Signature

2. Date ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

Section X Correction Request

Complete Section X only if A0050 = 2 or 3

Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider

Enter Code ☐

Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

X0200. Name of Resident on existing record to be modified/inactivated

A. **First name:**

C. **Last name:**

X0300. Gender on existing record to be modified/inactivated

Enter Code ☐

1. **Male**
2. **Female**

X0400. Birth Date on existing record to be modified/inactivated

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

X0500. Social Security Number on existing record to be modified/inactivated

☐☐☐ – ☐☐ – ☐☐☐☐

X0600. Type of Assessment on existing record to be modified/inactivated

Enter Code ☐☐

A. **Federal OBRA Reason for Assessment**
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code ☐☐

B. **PPS Assessment**
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **None of the above**

Enter Code ☐

C. **PPS Other Medicare Required Assessment - OMRA**
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment

X0600 continued on next page

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code ☐

D. **Is this a Swing Bed clinical change assessment?** Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code ☐☐

F. **Entry/discharge reporting**
01. **Entry** tracking record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

X0700. Date on existing record to be modified/inactivated - Complete one only

A. **Assessment Reference Date** - Complete only if X0600F = 99

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

B. **Discharge Date** - Complete only if X0600F = 10, 11, or 12

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. **Entry Date** - Complete only if X0600F = 01

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number ☐☐

Enter the number of correction requests to modify/inactivate the existing record, including the present one

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2)

↓ **Check all that apply**

☐ A. **Transcription error**
☐ B. **Data entry error**
☐ C. **Software product error**
☐ D. **Item coding error**
☐ E. **End of Therapy - Resumption (EOT-R) date**
☐ Z. **Other error requiring modification**
If "Other" checked, please specify: _____

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3)

↓ **Check all that apply**

☐ A. **Event did not occur**
☐ Z. **Other error requiring inactivation**
If "Other" checked, please specify: _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. **Attesting individual's first name:**

B. **Attesting individual's last name:**

C. **Attesting individual's title:**

D. **Signature**

E. **Attestation date**

Month – Day – Year

Section Z Assessment Administration

Z0100. Medicare Part A Billing

A. **Medicare Part A HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

Enter Code

C. **Is this a Medicare Short Stay assessment?**
0. No
1. Yes

Z0150. Medicare Part A Non-Therapy Billing

A. **Medicare Part A non-therapy HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

Z0200. State Medicaid Billing (if required by the state)

A. **RUG Case Mix group:**

B. **RUG version code:**

Z0250. Alternate State Medicaid Billing (if required by the state)

A. **RUG Case Mix group:**

B. **RUG version code:**

Z0300. Insurance Billing

A. **RUG billing code:**

B. **RUG billing version:**

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature	Title	Sections	Date Section Completed
A.				
B.				
C.				
D.				
E.				
F.				
G.				
H.				
I.				
J.				
K.				
L.				

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature:

B. Date RN Assessment Coordinator signed assessment as complete:

		–			–				
Month			Day			Year			

APPENDIX G

Department of Health and Human Services, Nursing Facilities Comparison of Funding & Costs

Nursing Facilities
Comparison of MaineCare Funding & Costs
Based on Provider's 2011 "As Filed" Cost Reports
for the Fiscal Years Ending in 2011

(1) # of Beds	(2) Facility	County	Town	Fiscal Year Begin	(3) Fiscal Year Ending in 2011	(4) State Days	(5) Total Resident Days	(6) Sch A Direct Care Rate	(7) Sch G Direct Care Costs	(8) Sch G Direct Care Cost per Day (col 7 / col 5)	(9) Direct Care MaineCare Funding (col 4 x col 6)	(10) Pre-Cap Allowable Direct Care Cost (col 4 x col 8)	(11) Variance between DC Funding & Pre-Cap Cost (col 9 - col 10)	(12) a) % of Pre-Cap Direct Care Costs Funded (col 9 / col 10)	(13) Sch A Routine Rate	(14) Sch G Routine Costs	(15) Sch G Routine Cost per Day (col 14 / col 5)	(16) Routine MaineCare Funding (col 4 x col 13)	(17) Pre-Cap Allowable Routine Cost (col 4 x col 15)	(18) Variance between Routine Funding & Pre-Cap Cost (col 16 - col 17)	(19) b) % of Pre-Cap Routine Costs Funded (col 16 / col 17)	(20) Total days net of DWP	(21) Sch A Fixed costs rate	(22) Schedule G Fixed costs	(23) Schedule G Fixed costs per day	(24) Fixed Costs MaineCare Reimbursement	(25) Per-Cap Fixed Allowable Fixed costs	(26) Variance between FC funding & Pre-Cap costs	(27) Total Net Variance DC & Routine (col 11 + col 18)	Total MaineCare Reimbursement	Total Pre-Cap Allowable Costs	Variance between total funding & total Pre-Cap costs
57	Amenity Manor (Closed-See Horizons)	Sagadahoc	Topsham	01/01/11	06/15/11	6,679	9,007	86.06	838,168	93.06	588,153	621,548	(33,395)	94.63%	58.21	581,771	64.59	388,765	431,397	(42,612)	90.12%	9,007	27.91	251,397	27.91	186,411	186,411	-	(76,007)	1,163,349	1,239,356	(76,007)
72	Aroostook Medical Center The - Health Cent	Aroostook	Mars Hill	09/26/10	09/24/11	17,750	21,538	91.28	2,311,075	107.30	1,620,220	1,904,575	(284,355)	85.07%	55.86	1,366,881	63.46	991,515	1,126,415	(134,900)	88.02%	21,538	15.49	346,321	16.08	274,948	285,420	(10,472)	(429,727)	2,886,683	3,316,410	(429,727)
52	Atlantic Rehab - Barnard	Washington	Calais	01/01/11	12/31/11	13,787	17,013	82.32	1,643,111	96.58	1,134,946	1,331,548	(196,602)	85.24%	58.21	1,123,662	66.05	802,541	910,631	(108,090)	88.13%	17,013	18.78	319,548	18.78	258,920	258,920	-	(304,692)	2,196,407	2,501,099	(304,692)
72	Augusta Rehab. Center (Augusta CC)	Kennebec	Augusta	01/01/11	12/31/11	13,920	24,900	80.19	2,125,077	85.34	1,116,245	1,167,933	(71,688)	93.97%	55.86	1,488,450	59.78	777,571	832,138	(54,567)	93.44%	24,859	25.71	639,153	25.71	357,883	357,883	-	(126,255)	2,251,699	2,377,954	(126,255)
60	Bangor Nursing Facility	Penobscot	Bangor	07/01/10	06/30/11	10,102	19,400	91.23	2,311,596	119.15	921,605	1,203,653	(282,048)	76.57%	58.21	1,609,692	82.97	588,037	838,163	(250,126)	70.16%	19,400	31.66	614,161	31.96	319,829	319,829	-	(532,174)	1,829,471	2,361,645	(532,174)
219	Barron Center	Cumberland	Portland	07/01/10	06/30/11	58,585	75,900	95.64	9,183,096	120.99	5,603,069	7,088,199	(1,485,130)	79.05%	55.86	5,029,669	66.27	3,272,558	3,882,428	(609,870)	84.29%	75,522	36.85	2,782,973	36.85	2,158,857	2,158,857	-	(2,095,000)	11,034,484	13,129,484	(2,095,000)
55	Borderview Holdings Corp.	Aroostook	Van Buren	01/01/11	12/31/11	14,464	18,978	84.72	2,019,460	106.41	1,225,390	1,539,114	(313,724)	79.62%	53.44	971,024	51.17	772,956	740,123	32,833	104.44%	18,978	22.59	428,777	22.59	326,742	326,742	-	(280,891)	2,325,088	2,605,979	(280,891)
78	Brentwood Manor	Cumberland	Yarmouth	01/01/11	12/31/11	18,003	23,929	96.14	2,357,249	98.51	1,730,808	1,773,476	(42,668)	97.59%	55.86	1,520,122	63.53	1,005,648	1,143,731	(138,083)	87.93%	23,576	33.09	811,710	34.43	595,719	619,843	(24,124)	(204,875)	3,332,175	3,537,050	(204,875)
99	Brewer Rehab & Living Center	Penobscot	Brewer	01/01/11	12/31/11	19,676	35,099	84.64	2,970,882	84.64	1,665,377	1,665,377	0	100.00%	48.25	1,693,396	48.25	949,367	949,367	0	100.00%	35,083	34.33	1,204,426	34.33	675,477	675,477	-	0	3,290,221	3,290,221	0
43	Bridgton Hlth. Care Center	Cumberland	Bridgton	01/01/11	12/31/11	10,098	13,871	69.72	1,403,819	101.21	905,993	1,022,019	(116,026)	88.65%	58.21	947,710	68.32	587,805	689,895	(102,090)	85.20%	13,871	39.56	548,727	39.56	399,477	399,477	-	(218,116)	1,893,275	2,111,391	(218,116)
61	Caribou Nursing Home	Aroostook	Caribou	10/01/10	09/30/11	17,659	21,041	99.73	2,183,630	103.78	1,761,132	1,832,651	(71,519)	96.10%	55.86	1,316,489	62.57	986,432	1,104,924	(118,492)	89.28%	21,041	37.19	782,499	37.19	656,738	656,738	-	(190,011)	3,404,302	3,594,313	(190,011)
75	Cedar Ridge Nursing Care Center	Somerset	Skowhegan	01/01/11	12/31/11	17,210	25,920	90.50	2,557,720	98.68	1,557,505	1,698,283	(140,778)	91.71%	53.14	1,861,095	71.8	914,539	1,235,678	(321,139)	74.01%	25,833	36.45	941,516	36.45	627,305	627,305	-	(461,917)	3,099,349	3,561,266	(461,917)
102	Cedars Nursing Care Center	Cumberland	Portland	05/01/10	04/30/11	14,755	33,955	104.19	4,240,115	124.87	1,537,323	1,842,457	(305,134)	83.44%	54.39	2,818,515	83.01	802,524	1,224,813	(422,289)	65.52%	33,955	46.08	1,564,541	46.08	679,910	679,910	-	(727,423)	3,019,757	3,747,180	(727,423)
109	Clover Manor, Inc.	Androscoggin	Auburn	01/01/11	12/31/11	25,951	37,919	91.44	3,570,907	94.17	2,372,959	2,443,806	(70,847)	97.10%	54.68	1,969,983	51.95	1,419,001	1,348,154	70,847	105.26%	37,908	25.06	950,764	25.08	650,851	650,851	-	0	4,442,811	4,442,811	0
39	Coastal Manor	Cumberland	Yarmouth	01/01/11	12/31/11	9,207	13,983	89.44	1,267,572	90.65	823,474	834,615	(11,141)	98.67%	58.21	846,579	60.54	535,939	557,392	(21,453)	96.15%	13,983	25.32	354,017	25.32	233,121	233,121	-	(32,594)	1,592,534	1,625,128	(32,594)
40	Collier's Health Care Center	Hancock	Ellsworth	01/01/11	12/31/11	7,600	11,448	79.30	1,072,210	93.66	618,540	730,548	(112,008)	84.67%	58.21	818,735	71.52	454,038	557,856	(103,818)	81.39%	11,320	28.17	333,779	29.49	219,726	230,022	(10,296)	(226,122)	1,292,304	1,518,426	(226,122)
60	Colonial Health Care	Penobscot	Lincoln	01/01/11	12/31/11	14,724	18,577	78.09	1,590,103	85.60	1,149,797	1,260,374	(110,577)	91.23%	57.43	960,633	51.71	845,599	761,378	84,221	111.06%	18,550	23.96	444,950	23.99	352,787	353,229	(442)	(26,798)	2,348,183	2,374,981	(26,798)
30	Country Manor Nursing Home	Waldo	Coopers Mills	01/01/11	12/31/11	8,385	9,910	73.86	796,109	80.33	619,316	673,567	(54,251)	91.95%	55.73	559,047	56.41	467,296	472,998	(5,702)	98.79%	9,910	18.27	181,099	18.27	153,194	153,194	-	(59,953)	1,239,806	1,299,759	(59,953)
54	Courtland Living Center	Hancock	Ellsworth	01/01/11	12/31/11	10,604	18,177	92.52	1,977,817	108.81	981,082	1,153,821	(172,739)	85.03%	56.94	930,324	51.18	603,792	542,713	61,079	111.25%	18,176	27.68	503,041	27.68	293,519	293,519	-	(111,660)	1,878,393	1,990,053	(111,660)
76	Cove's Edge	Lincoln	Damariscotta	10/01/10	09/30/11	15,622	26,707	109.78	3,577,825	133.97	1,714,983	2,092,879	(377,896)	81.94%	55.86	2,248,589	84.19	872,645	1,315,216	(442,571)	66.35%	26,707	31.60	844,034	31.6	493,655	493,655	-	(820,467)	3,081,283	3,901,750	(820,467)
34	Cummings Health Care Facility	Penobscot	Howland	01/01/11	12/31/11	9,644	11,440	81.59	986,440	86.23	786,854	831,602	(44,748)	94.62%	58.21	676,650	59.15	561,377	570,443	(9,066)	98.41%	11,440	22.50	257,382	22.5	216,990	216,990	-	(53,814)	1,565,221	1,619,035	(53,814)
53	Dexter Nursing Home	Penobscot	Dexter	01/01/11	12/31/11	12,698	16,092	81.63	1,367,249	84.96	1,036,538	1,078,822	(42,284)	96.08%	58.21	1,082,109	67.25	739,151	853,941	(114,790)	86.56%	16,092	25.29	411,534	25.57	321,132	324,688	(3,556)	(160,630)	2,096,821	2,257,451	(160,630)
81	Durgin Pines was Harbor Home	York	York	01/01/11	12/31/11	16,353	27,346	96.51	2,910,316	106.43	1,578,228	1,740,450	(162,222)	90.68%	52.66	1,931,996	70.65	861,149	1,155,339	(294,190)	74.54%	27,335	54.42	1,487,550	54.42	889,930	889,930	-	(456,412)	3,329,307	3,785,719	(456,412)
69	Eastside Rehab & LC (Bangor CC)	Penobscot	Bangor	01/01/11	12/31/11	15,869	22,122	79.86	1,756,680	79.86	1,267,298	1,267,298	0	100.00%	55.22	1,221,616	55.22	876,286	876,286	0	100.00%	21,534	22.60	492,882	22.89	358,639	363,241	(4,602)	(4,602)	2,502,223	2,506,825	(4,602)
33	Edgewood Manor	Franklin	Farmington	01/01/11	12/31/11	7,865	11,088	89.39	1,083,742	97.74	695,187	768,725	(73,538)	90.43%	58.50	580,473	52.35	460,103	411,733	48,370	111.75%	11,082	25.59	283,640	25.59	201,265	201,265	-	(25,168)	1,356,555	1,381,723	(25,168)
42	Evergreen Manor	York	Saco	01/01/01	12/31/11	9,408	13,669	95.07	1,388,553	101.58	894,419	955,665	(61,246)	93.59%	58.21	967,433	70.78	547,640	665,898	(118,258)	82.24%	13,637	28.04	382,351	28.04	263,800	263,800	-	(179,504)	1,705,859	1,885,363	(179,504)
65	Falmouth By The Sea	Cumberland	Falmouth	01/01/11	12/31/11	11,091	22,912	96.42	2,628,449	114.72	1,069,394	1,272,360	(202,966)	84.05%	55.86	1,422,567	62.09	619,543	688,640	(69,097)	89.97%	22,912	35.52	813,735	35.52	393,952	393,952	-	(272,063)	2,082,889	2,354,952	(272,063)
45	Forest Hill Manor	Aroostook	Fort Kent	10/01/10	09/30/11	12,626	16,040	98.77	1,756,335	109.62	1,247,070	1,384,062	(136,992)	90.10%	82.16	1,143,864	71.31	1,037,352	900,360	136,992	115.22%	15,597	29.84	465,388	29.84	376,760	376,760	-	0	2,661,182	2,661,182	0
61	Freeport Nursing Home	Cumberland	Freeport	01/01/11	12/31/11	16,251	18,937	99.30	1,880,362	99.30	1,613,724	1,613,724	0	100.00%	55.86	1,206,952	63.74	907,781	1,035,839	(128,058)	87.64%	18,937	24.31	471,981	24.92	395,062	404,975	(9,913)	(137,971)	2,916,567	3,054,538	(137,971)
30	Fryeburg Health Care Center	Oxford	Fryeburg	01/01/11	12/31/11	8,684	10,227	86.46	961,719	94.04	750,992	816,643	(65,651)	91.96%	58.21	638,800	62.46	505,496	542,403	(36,907)	93.20%	10,227	20.90	213,744	20.9	181,496	181,496	-	(102,558)	1,437,984	1,540,542	(102,558)
45	Gardiner Health Care Facility	Aroostook	Houlton	01/01/11	12/31/11	11,009	14,820	71.87	1,065,046	71.87	791,217	791,217	0	100.00%	48.87	783,138	52.84	538,010	581,716	(43,706)	92.49%	14,820	22.35	331,202	22.35	246,051	246,051	-	(43,706)	1,575,278	1,618,984	(43,706)
52	Gorham House	Cumberland	Gorham	01/01/11	12/31/11	8,409	17,640	94.99	2,069,377	117.31	798,771	986,460	(187,689)	80.97%	58.51	1,066,780	60.48	492,011	508,576	(16,565)	96.74%	17,640	36.78	648,860	36.78	309,283	309,283	-	(204,254)	1,600,065	1,804,319	(204,254)
86	Greenwood Center	York	Sanford	07/01/10	06/30/11	24,028	29,600	92.60	2,882,577	97.38	2,224,993	2,339,847	(114,854)	95.09%	55.86	1,593,508	53.83	1,342,204	1,293,427	48,777	103.77%	29,600	35.36	1,046,801	35.36	849,630	849,630	-	(66,077)	4,416,827	4,482,904	(66,077)
40	Harbor Hill	Waldo	Belfast	01/01/11	12/31/11	5,745	13,840	91.06	1,884,189	136.14	523,140	782,124	(258,984)	66.89%	58.50	1,123,944	81.21	336,083	466,551	(130,468)	72.04%	13,826	45.78	632,985	45.78	263,006	263,006	-	(389,452)	1,122,229	1,511,681	(389,452)
63	Hawthorne House	Cumberland	Freeport	01/01/11	12/31/11	14,583	20,961	101.74	2,387,221	113.89	1,463,674	1,660,858	(177,184)	89.33%	53.44	1,033,306	49.3	779,316	718,942	60,374	108.40%	20,961	28.69	601,297	28.69	418,386	418,386	-	(116,810)	2,681,376	2,798,186	(116,810)
28	Heritage Manor	Kennebec	Winthrop	01/01/11	12/31/11	5,724	9,432	89.41	997,152	105.72	511,783	605,141	(93,358)	84.57%	58.50	561,456	59.53	334,854	340,750	(5,896)	98.27%	9,432	26.15	246,674	26.15	149,683	149,683	-	(99,254)	996,320	1,095,574	(99,254)
97	Hibbard Nursing Home	Piscataquis	Dover-Foxcrof	10/01/10	09/30/11	20,212	30,754	88.03	3,251,202	105.72	1,779,262	2,136,813	(357,551)	83.27%	55.86	1,929,072	62.73	1,129,042	1,267,899	(138,857)	89.05%	30,754	22.65	707,599	23.01	457,802	465,078	(7,276)	(503,684)	3,366,106	3,869,790	(503,684)
51	High View Manor	Aroostook	Madawaska	01/01/11	12/31/11	13,395	16,989	81.02	1,695,133	99.78	1,085,263	1,336,553	(251,290)	81.20%	58.21	923,211	54.34	779,723	727,884	51,839	107.12%	16,769	28.21	473,106	28.21	377,873	377,873	-	(199,451)	2,242,859	2,442,310	(199,451)
65	Horizons Living & Rehab Ctr (See Amenity)	Cumberland	Brunswick	06/15/11	12/31/11	8,829	12,624	86.64	1,154,367	92.23	764,945	814,299	(49,354)	93.94%	50.86	717,651	56.85	449,043	501,929	(52,886)	89.46%	12,624	52.35	660,813	52.35	462,198	462,198	-	(102,240)	1,676,186	1,778,426	(102,240)
28	Houlton Regional Hospital	Aroostook	Houlton	10/01/10	09/30/11	309	7,774	112.44	1,808,748	232.67	34,744	71,895	(37,151)	48.33%	103.34	1,077,496	138.6	31,932	42,827	(10,895)	74.56%	7,774	35.71	286,511	36.86	11,034	11,390	(356)	(48,402)	77,710	126,112	(48,402)
38	Island Nursing Home	Hancock	Deer Isle	07/01/10	06/30/11	9,954	13,675	84.35	1,324,350	96.84	839,620	963,945	(124,325)	87.10%	58.21	845,316	61.81	579,422	615,257	(35,835)	94.18%	13,675	24.21	331,099	24.21	240,986	240,986	-	(160,160)	1,660,026	1,820,186	(160,160)
18	Jackman Region Health Center	Somerset	Jackman	07/01/10	06/30/11	3,591	4,832	139.58	895,385	185.30	501,232	665,412	(164,180)	75.33%	103.34	456,198	94.41	371,094	339,026	32,068	109.46%	4,375	26.92	128,633	29.4	96,670	105,575	(8,905)	(141,017)	968,996	1,110,013	(141,017)
36	Katahdin Nursing Home	Penobscot	Millinocket	01/01/11	12/31/11	11,149	12,968	79.46	1,030,482	79.46	885,900	885,900	0	100.00%	58.21	852,847	65.77	648,983	733,270	(84,287)	88.51%	12,968	24.83	321,931	24.83	276,830	276,830	-	(84,287)	1,811,713	1,896,000	(84,287)
78	Kennebunk Nursing Home	Oxford	Kennebunk	01/01/11	12/31/11	12,833	24,311	87.58	2,427,355	99.85	1,123,914	1,281,375	(157,461)	87.71%	55.86	1,732,784	71.28	716,851	914,736	(197,885)	78.37%	23,670	27.13	658,371	27.81	348,159	356,886	(8,727)	(364,073)	2,188,924	2,552,997	(364,073)
64	Knox Center for Long Term Care	Knox	Rockland	04/01/10	03/31/11	18,470	29,066	98.79	3,474,552	119.54	1,824,651	2,207,904	(383,253)	82.64%	54.41	2,127,207	73.19	1,004,953	1,351,819	(346,866)	74.34%	29,054	31.95	928,136	31.95	590,117	590,117	-	(730,119)	3,419,721	4,149,840	(730,119)
105	Lakewood Manor Nursing Home	Kennebec	Waterville	09/26/10	09/24/11	23,306	36,551	98.43	4,217,604	115.39	2,294,010	2,689,279	(395,269)	85.30%	55.86	2,554,980	69.9	1,301,873	1,629,089	(327,216)	79.91%	36,535	42.44	1,550,619	42.44	989,107	989,107	-	(722,485)	4,584,990	5,307,475	(722,485)
81	Ledgeview Living Center	Oxford	West Paris	07/01/10	06/30/11	19,901	25,277	88.30	2,231,995	88.30	1,757,258	1,757,258	0	100.00%	52.06	1,315,923	52.06	1,036,046	1,036,046	0	100.00%	25,212	10.43	273,738	10.86	207,567	216,125	(8,558)	(8,558)	3,000,871	3,009,429	(8,558)
60	Ledgewood Manor	Cumberland	North Windha	01/01/11	12/31/11	16,931	21,110	83.69	1,867,014	88.44	1,416,955	1,497,378	(80,423)	94.63%	53.20	1,022,705	48.45	900,729	820,307	80,422	109.80%	21,110	15.12	319,177	15.12	255,997	255,997	-	(1)	2,573,681	2,573,682	(1)
86	Madigan Estates	Aroostook	Houlton	01/01/11	12/31/11	18,794	29,409	72.93	2,469,190	83.96	1,370,646	1,577,944	(207,298)	86.86%	55.56	1,640,538	55.78	1,044,195	1,048,329	(4,134)	99.61%	29,409	17.71	520,749	17.71	332,842	332,842	-	(211,432)	2,747,683	2,959,115	(211,432)
125	Maine General - Glenridge	Kennebec	Augusta	07/01/10	06/30/11	34,989	43,732	92.14	4,260,684	97.43	3,223,886	3,408,978	(185,092)	94.57%	50.20	2,256,172	51.59	1,756,448	1,805,083	(48,635)	97.31%	43,666	20.12	878,571	20.12	703,979	703,979	-	(233,727)	5,684,313	5,918,040	(233,727)
77	Maine General - Graybirch	Kennebec	Augusta	07/01/10	06/30/11	16,442	25,736	108.67	3,058,991	118.86	1,786,752	1,954,296	(167,544)	91.43%	55.86	1,568,090	60.93	918,450	1,001,811	(83,361)	91.68%	25,678	23.41	601,106	23.41	384,907	384,907	-	(250,905)	3,090,109	3,341,014	(250,905)
120	Maine Veterans Home - Augusta	Kennebec	Augusta	07/01/10	06/30/11	24,601	41,363	102.52	4,731,144	114.38	2,522,095	2,813,862	(291,767)	89.63%	55.86	2,666,055	64.46	1,374,212	1,585,780	(211,568)	86.66%	41,350	26.94	1,114,121	26.94	662,751	662,751	-	(503,335)	4,559,058	5,062,393	(503,335)
120	Maine Vet. Home - Bangor	Penobscot	Bangor	07/01/10	06/30/11	24,692	42,253	106.65	5,134,072	121.51	2,633,402	3,000,325	(366,923)	87.77%	55.86	2,976,865	70.45	1,379,295	1,739,551	(360,256)	79.29%	42,219	35.72	1,508,245	35.72	881,998	881,998	-	(727,179)	4,894,695	5,621,874	(727,179)
40	Maine Veterans Home-Caribou	Aroostook	Caribou	07/01/10	06/30/11	9,735	12,405	86.03	1,395,398	112.49	837,502	1,095,090	(257,588)	76.48%	58.21	992,194	79.98	566,674	778,605	(211,931)	72.78%	12,405	30.47	378,139	30.48	296,625	296,723	(98)	(469,617)	1,700,801	2,170,418	(469,617)
120	Maine Veterans Home-Scar.	Cumberland	Scarborough	07/01/10	06/30/11	25,850	42,330	109.06	5,981,080	141.30	2,819,201	3,652,605	(833,404)	77.18%	55.86	2,923,947	69.08	1,443,981	1,785,718	(341,737)	80.86%	42,326	33.34	1,411,321	33.34	861,839	861,839	-	(1,175,141)	5,125,021	6,300,162	(1,175,141)
62	Maine Vet. Home - So. Paris	Oxford	So. Paris	07/01/10	06/30/11	13,919	21,777	105.61	2,910,237	133.64	1,469,986	1,860,135	(390,149)	79.03%	55.86	1,814,160	83.31	777,515	1,159,592	(382,077)	67.05%	21,777	38.73	843,348	38.73	539,083	539,083	-	(772,226)	2,786,584	3,558,810	(772,226)
58	Maplecrest Living Center	Somerset	Madison	01/01/11	12/31/11	14,450	19,418	83.33	1,800,321	92.71	1,204,119	1,339,660	(135,541)	89.88%	57.53	983,304	50.64	831,309	731,748	99,561	113.61%	19,372	24.40	472,659	24.4	352,580	352,580	-	(35,980)	2,388,006	2,423,986	(35,980)
76	Market Square Health Center	Oxford	South Paris	10/01/10	09/30/11	13,798	22,987	103.83	3,229,183	140.48	1,432,646	1,938,343	(505,697)	73.91%	55.86	1,632,952	71.04	770,756	980,210	(209,454)	78.63%	22,987	26.06	623,593	27.13	359,576	374,340	(14,764)	(729,915)	2,562,978	3,292,893	(729,915)
50	Marshall's Health Care Facility	Washington	Machias	04/01/11	12/31/11	10,866	12,566	82.71	1,051,307	83.65	898,727	908,941	(10,214)	98.88%	52.76	651,237	51.82	573,290	563,076	10,214	101.81%	12,563	24.49	307,713	24.49	266,108	266,108	-	0	1,738,125	1,738,125	0
108	Marshwood Nursing Care Center	Androscoggin	Lewiston	01/01/11	12/31/11	19,770	35,290	104.45	3,686,071	104.45	2,064,977	2,064,977	0	100.00%	56.14	2,382,575	67.51	1,109,888	1,334,673	(224,785)	83.16%	35,259	43.18	1,531,994	43.44	853,669	858,809	(5,140)	(229,925)	4,028,534	4,258,459	(229,925)
40	Mercy Home	Aroostook	Eagle Lake	07/01/10	06/30/11	10,745	12,590	81.45	1,111,516	88.29	875,180	948,676	(73,496)	92.25%	58.21	919,422	73.03	625,466	784,707	(159,241)	79.71%	12,590	23.99	302,070	23.99	257,773	257,773	-	(232,737)	1,758,419	1,991,156	(232,737)
42	Mid Coast Geriatric Services - was Bodwell	Cumberland	Brunswick	10/01/10	09/30/11	2,858	13,128	90.76	2,107,883	160.56	259,392	458,880	(199,488)	56.53%	58.21	1,009,127	76.87	166,364	219,694	(53,330)	75.73%	13,128	42.73	560,998	42.73	122,122	122,122	-	(252,818)	547,878	800,696	(252,818)
57	Montello Manor	Androscoggin	Lewiston	01/01/11	12/31/11	10,934	14,990	87.26	1,507,030	100.54	954,101	1,099,304	(145,203)	86.79%	58.21	921,685	61.49	636,468	672,332	(35,864)	94.67%	14,990	28.66	429,580	28.66	313,368	313,368	-	(181,067)	1,903,937	2,085,004	(181,067)
25	Mountain Heights Health Care Facility	Penobscot	Patten	01/01/11	12/31/11	6,690	8,742	70.31	629,283	71.98	470,374	481,546	(11,172)	97.68%	58.21	564,746	64.6	389,425	432,174	(42,749)	90.11%	8,742	24.37	213,024	24.37	163,035	163,035	-	(53,921)	1,022,834	1,076,755	(53,921)
83	Mt. St. Joseph Nursing Home	Kennebec	Waterville	01/01/11	12/31/11	25,200	32,711	91.22	3,546,739	108.43	2,298,744	2,732,436	(433,692)	84.13%	55.86	1,863,399	56.97	1,407,672	1,435,644	(27,972)	98.05%	32,481	34.93	1,134,583	34.93	880,236	880,236	-	(461,664)	4,586,652	5,048,316	(461,664)
35	Narraguagus Bay Health Care Facility	Washington	Milbridge	01/01/11	12/31/11	8,515	11,655	81.80	1,122,076	96.27	696,527	819,739	(123,212)	84.97%	58.21	657,159	56.38	495,658	480,076	15,582	103.25%	11,655	31.99	372,829	31.99	272,395	272,395	-	(107,630)	1,464,580	1,572,210	(107,630)
74	Newton Center - Hillcrest Manor	York	Sanford	06/01/10	05/31/11	17,010	24,822	93.75	2,837,941	114.33	1,594,688	1,944,753	(350,065)	82.00%	55.33	1,083,313	43.64	941,163	742,316	198,847	126.79%	24,784	21.87	541,937	21.87	372,009	372,009	-	(151,218)	2,907,860	3,059,078	(151,218)
42	Norway Convalescent Center	Knox	Norway	01/01/11	12/31/11	8,075	13,830	83.50	1,390,635	100.55	674,263	811,941	(137,678)	83.04%	58.21	923,059	66.74	470,046	538,926	(68,880)	87.22%	13,830	25.69	355,225	25.69	207,447	207,447	-	(206,558)	1,351,756	1,558,314	(206,558)
90	Oak Grove Nursing Care Ctr.	Kennebec	Waterville	01/01/11	12/31/11	17,524	31,886	90.63	3,023,081	94.81	1,588,200	1,661,450	(73,250)	95.59%	56.16	2,151,037	67.46	984,148	1,182,169	(198,021)	83.25%	31,870	41.73	1,329,903	41.73	731,277	731,277	-	(271,271)	3,303,625	3,574,896	(271,271)
31	Oceanview Nursing Home	Washington	Lubec	01/01/11	12/31/11	8,092	9,561	89.74	868,536	90.84	726,176	735,077	(8,901)	98.79%	57.93	543,343	56.83	468,770	459,868	8,902	101.94%	9,561	19.90	190,825	19.96	161,031	161,516	(485)	(484)	1,355,977	1,356,461	(484)
26	Odd Fellow's Home of Maine	Androscoggin	Auburn	07/01/10	06/30/11	8,257	9,284	78.68	789,594	85.05	649,661	702,258	(52,597)	92.51%	57.36	532,891	68.17	473,622	562,880	(89,258)	84.14%	9,265	24.22	224,369	24.22	199,985	199,985	-	(141,855)	1,323,268	1,465,123	(141,855)
38	Orchard Park Living Center	Franklin	Farmington	01/01/11	12/31/11	7,974	12,232	80.82	1,099,237	89.87	644,459	716,623	(72,164)	89.93%	58.50	789,002	64.5	466,479	514,323	(47,844)	90.70%	12,213	31.12	380,030	31.12	248,151	248,151	-	(120,008)	1,359,089	1,479,097	(120,008)
80	Orono Commons	Penobscot	Orono	01/01/11	12/31/11	20,196	27,143	91.81	2,811,683	103.59	1,854,195	2,092,104	(237,909)	88.63%	56.14	1,848,107	68.09	1,133,803	1,375,146	(241,343)	82.45%	27,117	25.06	679,504	25.06	506,112	506,112	-	(479,252)	3,494,110	3,973,362	(479,252)

Nursing Facilities
Comparison of MaineCare Funding & Costs
Based on Provider's 2011 "As Filed" Cost Reports
for the Fiscal Years Ending in 2011

(1)	(2)				(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)			
# of Beds	Facility	County	Town	Fiscal Year Begin	Fiscal Year Ending In 2011	State Days	Total Resident Days	Sch A Direct Care Rate	Sch G Direct Care Costs	Sch G Direct Care Cost per Day (col 7 / col 5)	Direct Care MaineCare Funding (col 4 x col 6)	Pre-Cap Allowable Direct Care Cost (col 4 x col 8)	Variance between DC Funding & Pre-Cap Cost (col 9 - col 10)	a) % of Pre-Cap Direct Care Costs Funded (col 9 / col 10)	Sch A Routine Rate	Sch G Routine Costs	Sch G Routine Cost per Day (col 14 / col 5)	Routine MaineCare Funding (col 4 x col 13)	Pre-Cap Allowable Routine Cost (col 4 x col 15)	Variance between Routine Funding & Pre-Cap Cost (col 16 - col 17)	b) % of Pre-Cap Routine Costs Funded (col 16 / col 17)	Total days net of DWP	Sch A Fixed costs rate	Schedule G Fixed Costs	Schedule G Fixed costs per day	Fixed Costs MaineCare Reimbursement	Per-Cap Fixed Allowable Fixed costs	Variance between FC funding & Pre-Cap costs	Total Net Variance DC & Routine (col 11 + col 18)	Total MaineCare Reimbursement	Total Pre-Cap Allowable Costs	Variance between total funding & total Pre-Cap costs
54	Penobscot Nursing Home	Hancock	Penobscot	01/01/11	12/31/11	9,395	13,200	87.73	1,411,143	106.80	824,223	1,004,326	(180,103)	82.07%	46.43	750,051	56.82	436,210	533,824	(97,614)	81.71%	13,200	10.82	176,441	13.37	101,654	125,811	(23,957)	(301,674)	1,362,087	1,663,761	(301,674)
55	Pine Point Nursing Care Center	Cumberland	Scarborough	01/01/11	12/31/11	13,374	20,207	104.99	2,388,095	117.09	1,404,136	1,565,962	(161,826)	89.67%	58.50	1,557,399	77.07	782,379	1,030,734	(248,355)	75.91%	20,200	41.04	829,109	41.05	548,669	548,003	(134)	(410,315)	2,735,384	3,145,699	(410,315)
67	Presque Isle Nursing Home	Aroostook	Presque Isle	10/01/10	09/30/11	17,015	23,368	97.75	2,285,109	97.79	1,663,218	1,663,867	(681)	99.96%	56.86	1,457,456	62.37	950,458	1,061,226	(110,768)	89.56%	23,368	31.74	741,730	31.74	540,056	540,056	-	(111,449)	3,153,730	3,265,179	(111,449)
39	Quarry Hill (Camden H.C.C.) - The Gardens	Knox	Camden	04/01/10	03/31/11	4,681	12,914	94.11	1,858,189	143.89	440,529	673,549	(233,020)	65.40%	57.15	784,615	60.76	267,519	284,415	(16,899)	94.06%	12,897	43.52	561,293	43.52	203,717	203,717	-	(249,919)	811,765	1,161,684	(249,919)
32	Riveridge	York	Kennebunk	01/01/11	12/31/11	8,060	11,700	128.01	1,909,547	163.21	1,039,821	1,315,473	(275,652)	79.05%	58.50	1,233,370	105.42	471,510	649,685	(178,175)	55.49%	11,538	61.37	714,172	61.37	494,642	494,642	-	(653,827)	2,005,973	2,659,800	(653,827)
83	Rose Manor	Penobscot	Bangor	01/01/11	12/31/11	16,493	28,375	98.87	3,476,073	122.56	1,630,663	2,021,712	(391,049)	80.65%	56.86	1,601,742	63.5	921,299	1,047,306	(129,007)	87.97%	28,201	46.62	1,314,774	46.62	768,904	768,904	-	(517,056)	3,300,886	3,837,922	(517,056)
32	Rumford Community Home	Oxford	Rumford	07/01/10	06/30/11	9,170	10,742	82.96	1,129,546	105.15	760,743	964,226	(203,483)	78.90%	58.21	634,083	59.03	533,786	541,305	(7,519)	98.61%	10,722	23.24	249,181	23.24	213,111	213,111	-	(211,002)	1,507,640	1,718,642	(211,002)
50	Russell Park Manor	Androscoggin	Lewiston	01/01/11	12/31/11	12,792	17,244	87.75	1,608,282	93.32	1,122,498	1,193,749	(71,251)	94.03%	49.67	884,547	51.3	635,379	655,230	(20,851)	96.82%	17,241	25.26	435,485	25.26	323,126	323,126	-	(92,102)	2,061,003	2,173,105	(92,102)
62	Sandy River Nursing Care Ctr.	Franklin	Farmington	01/01/11	12/31/11	13,805	21,555	94.32	2,137,767	99.18	1,302,088	1,369,180	(67,092)	95.10%	56.14	1,418,516	65.81	775,013	908,507	(133,494)	85.31%	21,551	28.00	603,441	28	386,540	386,540	-	(200,586)	2,463,641	2,664,227	(200,586)
23	Sanfield Living Center	Somerset	Hartland	01/01/11	12/31/11	6,713	8,209	87.75	720,317	87.75	589,066	589,066	0	100.00%	58.51	481,713	59.9	382,778	402,109	(9,331)	97.68%	8,209	23.60	193,712	23.6	158,427	158,427	-	(9,331)	1,140,271	1,149,602	(9,331)
105	Seal Rock	York	Saco	01/01/11	12/31/11	18,051	36,872	98.56	4,212,990	114.26	1,779,107	2,062,507	(283,400)	86.26%	55.86	2,158,490	58.54	1,008,329	1,056,706	(48,377)	95.42%	36,845	54.69	2,015,214	54.69	987,209	987,209	-	(331,777)	3,774,645	4,106,422	(331,777)
124	Seaside Nursing and Ret. Home	Cumberland	Portland	01/01/11	12/31/11	24,604	40,757	108.17	4,793,520	117.61	2,661,415	2,893,675	(232,261)	91.97%	55.42	2,270,690	55.71	1,363,554	1,370,689	(7,135)	99.48%	40,686	34.11	1,387,603	34.11	839,242	839,242	-	(239,396)	4,884,211	5,103,607	(239,396)
57	Sebastlcook Valley Health Care facility	Somerset	Pittsfield	01/01/11	12/31/11	15,302	18,990	85.70	1,686,217	88.79	1,311,381	1,358,665	(47,284)	96.52%	58.21	1,146,979	60.4	890,729	924,241	(33,512)	96.37%	18,990	24.56	466,380	24.56	375,817	375,817	-	(80,796)	2,577,927	2,658,723	(80,796)
65	Sedgewood Commons	Cumberland	Falmouth	01/01/11	12/31/11	11,039	23,272	102.19	2,510,793	107.89	1,128,075	1,190,998	(62,923)	94.72%	56.14	1,594,484	68.52	619,729	756,392	(136,663)	81.93%	23,272	51.33	1,194,660	51.33	566,632	566,632	-	(199,586)	2,314,436	2,514,022	(199,586)
73	So. Portland Nursing Home	Cumberland	South Portland	01/01/11	12/31/11	18,201	25,748	95.18	2,566,119	99.27	1,827,551	1,906,083	(78,532)	95.88%	55.86	1,782,758	69.24	1,072,568	1,329,477	(256,909)	80.68%	25,748	19.78	509,362	19.78	379,796	379,796	-	(335,441)	3,279,915	3,615,356	(335,441)
21	Somerset Manor	Somerset	Bingham	01/01/11	12/31/11	5,886	7,090	88.74	696,127	98.18	522,501	578,084	(55,583)	90.38%	58.48	475,295	67.04	344,330	394,732	(50,402)	87.23%	7,090	27.20	192,816	27.2	160,154	160,154	-	(105,985)	1,026,985	1,132,970	(105,985)
35	Sonogee Estates	Hancock	Bar Harbor	01/01/11	12/31/11	6,145	11,047	83.55	1,160,629	105.06	513,661	645,594	(131,933)	79.56%	58.50	654,019	59.2	359,483	363,784	(4,301)	98.82%	11,047	27.78	306,932	27.78	170,708	170,708	-	(136,234)	1,043,852	1,180,086	(136,234)
65	Southridge Living Center	York	Biddeford	01/01/11	12/31/11	15,159	20,672	104.93	2,470,752	119.52	1,593,782	1,815,389	(221,607)	87.79%	56.14	1,068,761	51.75	852,710	785,031	66,679	108.48%	20,844	26.17	547,721	26.53	397,495	402,964	(5,469)	(160,396)	2,843,988	3,004,384	(160,396)
100	Springbrook Nursing Care Center	Cumberland	Westbrook	01/01/11	12/31/11	18,977	34,688	108.71	4,094,745	118.05	2,062,990	2,240,235	(177,245)	92.09%	56.13	2,345,268	67.61	1,065,179	1,283,035	(217,856)	83.02%	34,637	38.45	1,331,660	38.45	729,666	729,666	-	(395,101)	3,857,835	4,252,936	(395,101)
96	St. Andre Health Care Facility	York	Biddeford	01/01/11	12/31/11	22,289	31,129	98.32	3,071,504	98.67	2,191,454	2,199,256	(7,802)	99.65%	56.14	2,197,872	70.61	1,251,304	1,573,826	(322,522)	79.51%	31,129	28.69	899,021	28.88	639,471	643,706	(4,235)	(334,559)	4,082,229	4,416,788	(334,559)
30	St. Andrews Village	Lincoln	Boothbay Harb	10/01/10	09/30/11	6,357	10,721	105.92	1,201,705	112.09	673,333	712,556	(39,223)	94.50%	79.04	977,425	91.17	502,457	579,568	(77,111)	86.70%	10,721	32.28	346,066	32.28	205,204	205,204	-	(116,334)	1,380,994	1,497,328	(116,334)
43	St. Joseph Operating Co - St. Joseph N.H.	Aroostook	Upper Frenchv	01/01/11	12/31/11	14,205	15,560	85.25	1,363,375	87.62	1,210,976	1,244,642	(33,666)	97.30%	58.21	934,170	60.04	826,873	852,868	(25,995)	96.95%	15,560	42.99	668,865	42.99	610,673	610,673	-	(59,661)	2,648,522	2,708,183	(59,661)
121	St. Joseph's Rehabilitation and Residence	Cumberland	Portland	07/01/10	06/30/11	2,463	41,547	99.85	4,801,380	115.57	245,931	284,649	(38,718)	86.40%	55.86	2,537,382	61.07	137,583	150,415	(12,832)	91.47%	41,547	25.97	1,078,926	25.97	63,964	63,964	-	(51,550)	447,478	499,028	(51,550)
210	St. Marguerite D'Youville Pav.	Androscoggin	Lewiston	01/01/11	12/31/11	53,476	73,573	104.70	9,607,135	130.58	5,598,937	6,982,896	(1,383,959)	80.18%	55.86	5,616,597	76.34	2,987,169	4,082,358	(1,095,189)	73.17%	73,362	34.69	2,544,603	34.69	1,855,062	1,855,062	-	(2,479,148)	10,441,188	12,920,336	(2,479,148)
63	Stillwater Health Care	Penobscot	Bangor	01/01/11	12/31/11	11,131	21,011	89.62	1,883,064	89.62	997,580	997,580	0	100.00%	55.86	1,232,697	58.67	621,778	653,059	(31,276)	95.21%	20,988	35.35	741,949	35.35	393,481	393,481	-	(31,278)	2,012,819	2,044,097	(31,278)
28	Sunrise Residential Care Facility	Washington	Jonesport	01/01/11	12/31/11	5,577	8,970	73.72	897,892	100.10	411,136	558,258	(147,122)	73.65%	58.50	668,397	74.51	326,255	415,542	(89,287)	78.51%	8,970	25.78	231,239	25.78	143,775	143,775	-	(236,409)	881,166	1,117,575	(236,409)
53	Tallpines Health Care Facility	Waldo	Belfast	01/01/11	12/31/11	11,293	17,580	90.05	1,583,098	90.05	1,016,935	1,016,935	0	100.00%	57.98	1,019,241	57.98	654,768	654,768	0	100.00%	17,571	26.07	458,082	26.07	294,409	294,409	-	0	1,966,112	1,966,112	0
64	Varney Crossing Nursing Care Center	York	North Berwick	07/01/10	06/30/11	16,098	23,027	88.97	2,173,270	94.38	1,432,239	1,519,329	(87,090)	94.27%	55.86	1,460,283	63.42	898,234	1,020,935	(121,701)	88.08%	23,027	21.13	486,567	21.13	340,151	340,151	-	(208,791)	2,571,624	2,880,415	(208,791)
47	Victorian Villa Nursing Home	Oxford	Canton	01/01/11	12/31/11	13,550	16,647	80.48	1,341,643	80.59	1,090,604	1,091,995	(1,491)	99.86%	56.03	984,397	59.13	745,657	801,212	(55,555)	93.07%	16,604	23.63	392,354	23.63	320,187	320,187	-	(57,046)	2,156,348	2,213,394	(57,046)
65	Westgate Manor	Penobscot	Bangor	01/01/11	12/31/11	13,499	23,245	90.39	2,105,953	90.64	1,220,175	1,223,549	(3,374)	99.72%	58.28	1,162,861	50.03	678,730	675,355	3,375	100.50%	23,243	27.05	628,619	27.05	365,148	365,148	-	1	2,264,053	2,264,052	1
38	Windward Gardens	Knox	Camden	01/01/11	12/31/11	6,331	12,905	97.16	1,756,139	136.08	615,120	861,522	(246,402)	71.40%	58.50	991,076	76.8	370,364	486,221	(115,857)	76.17%	12,890	45.03	580,445	45.03	285,085	285,085	-	(362,259)	1,270,569	1,632,828	(362,259)
72	Winship Green Nursing Center	Cumberland	Bath	01/01/11	12/31/11	14,280	23,521	89.62	2,194,865	93.31	1,279,774	1,332,467	(52,693)	96.05%	55.86	1,353,177	57.53	797,581	821,528	(23,947)	97.10%	23,399	26.67	625,746	26.74	380,848	381,847	(999)	(77,639)	2,458,303	2,535,942	(77,639)
46	Winthrop Manor - was Nicholsons	Kennebec	Winthrop	01/01/11	12/31/11	13,221	14,856	84.57	959,209	64.57	853,680	853,680	0	100.00%	54.29	806,598	54.29	717,788	717,788	0	100.00%	14,856	14.52	215,764	14.52	191,969	191,969	-	0	1,763,417	1,763,417	0
46	Woodlawn Nursing Home	Somerset	Skowhegan	01/01/11	12/31/11	10,884	15,343	76.03	1,167,276	76.03	857,862	857,862	0	100.00%	58.21	971,936	63.35	639,961	695,470	(55,509)	91.89%	14,736	31.17	459,312	31.17	342,883	342,883	-	(58,509)	1,840,505	1,897,015	(58,509)
	Totals										140,651,914	#########	(18,061,008)	88.62%				85,032,258	95,833,095	(10,800,839)	88.64%					=5,773,268	45,925,775	(152,507)	(29,114,354)	271,457,438	300,571,792	(29,114,354)
																									=5,773,268	45,925,775					

Notes:
a) Direct care funding at 100% indicates that the allowable direct care costs are at or below the direct care rate.
b) Routine funding exceeds 100% when there is a direct care disallowance equal to or greater than the routine savings per Principle 80.5.7.
c) the routine rate for Forest Hills has been adjusted to correct a calculation error on schedule B of the cost report.

APPENDIX H

Public Law 1999, Chapter 731, Part BBBB

PART BBBB

Sec. BBBB-1. Rule amendment regarding Medicaid long-term care policy and the home care program. The Department of Human Services shall review and amend its rules regarding Medicaid long-term care policy in order to enhance the flexibility of Medicaid benefits to the extent possible under federal law. The department shall consider the report of the Joint Advisory Committee on Select Services for Older Persons dated January 2000. The review must include but is not limited to the feasibility of amending Medicaid rules to ensure that consumers do not lose critical benefits when they make a transition from the state-funded home care program to the Medicaid program. Rules adopted pursuant to this section take effect January 1, 2001. Rules adopted pursuant to this section are routine technical rules as defined in the Maine Revised Statutes, Title 5, chapter 375, subchapter II-A.

Sec. BBBB-2. Rule amendment regarding consumers of long-term care services who have chronic conditions that change. The Department of Human Services shall amend its rules regarding eligibility for nursing facility services to allow for increased eligibility for consumers of long-term care services who have chronic conditions that change enough to qualify and disqualify them for services on a cyclical basis. Rules adopted pursuant to this section take effect October 1, 2000. Rules adopted pursuant to this section are routine technical rules as defined in the Maine Revised Statutes, Title 5, chapter 375, subchapter II-A.

Sec. BBBB-3. Labor force initiatives. The Department of Human Services and the State Board of Nursing, in consultation with consumers, providers and other interested parties, shall adopt or amend rules and propose such legislation to the Legislature as may be required to create career ladders and address labor shortage issues. By August 1, 2000, the Department of Human Services shall amend its rules to provide for continuing certification on the Maine Registry of Certified Nursing Assistants of a certified nursing assistant who, over a 24-month period, performs for 8 hours nursing or nursing-related services that are supervised by a registered nurse. The rules may not require that nursing or nursing-related services be performed in a nursing facility or hospital. The rules must be retroactive for 2 years. Rules adopted pursuant to this provision are routine technical rules as defined in the Maine Revised Statutes, Title 5, chapter 375, subchapter II-A.

Sec. BBBB-4. Provision of best practices forums. The Department of Human Services shall participate in a series of best practices forums to provide educational workshops and opportunities to providers of long-term care services. Workshops and forums may be cosponsored by entities other than the department.

Sec. BBBB-5. Development of standardized contracts and rule adoption. The Department of Human Services shall develop and adopt rules to require the use of standardized contracts to be used for long-term care services between the service provider and the consumer when appropriate to the service and setting. Rules adopted pursuant to this section take effect January 1, 2001. Rules adopted or amended pursuant to this section are routine technical rules as defined in the Maine Revised Statutes, Title 5, chapter 375, subchapter II-A.

Sec. BBBB-6. Rule amendment regarding default licensing. The Department of Human Services and the Department of Public Safety shall amend their rules regarding licensing for long-term care facilities and services to provide for default licensing for new applicants. The rules must provide that default licensing takes effect when a new applicant has filed a completed application, has not been provided the necessary notifications, inspections or services from state agencies and a period of more than 90 days has elapsed since notification that the application is complete. The Department of Human Services and the Department of Public Safety and persons

or entities performing functions for those departments shall notify a new applicant within 2 weeks of filing by the applicant on whether the application is complete. The Department of Human Services and the Department of Public Safety shall provide necessary services and inspections within 90 days of the filing of the completed application. Rules adopted pursuant to this section take effect January 1, 2001. Rules adopted pursuant to this section are routine technical rules as defined in the Maine Revised Statutes, Title 5, chapter 375, subchapter II-A.

Sec. BBBB-7. Expansion of the National Fire Protection Association Life Safety Code inspection capacity. The Department of Human Services, the Department of Public Safety and municipal fire officials shall work together to devise ways to expand the delegation of the National Fire Protection Association Life Safety Code inspections. The Department of Human Services and the Department of Public Safety shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 1, 2001 on their progress under this section. The joint standing committee of the Legislature having jurisdiction over health and human services matters has authority to report out legislation on life safety code inspections.

Sec. BBBB-8. Rule amendment regarding the principles of reimbursement for nursing facilities. The Department of Human Services shall amend the principles of reimbursement for nursing facilities to ensure that reimbursement reflects the current cost of providing services in an efficient manner. The department shall reconsider the provision that allows retention of 25% of cost savings in the direct cost component. The revised principles of reimbursement must merge routine and indirect cost components into a single routine cost component category; must include medical supplies as a direct cost component; must incorporate the most recent time-study information; must rebase to the most recent audited year; must contain an annual inflation adjustment appropriate to the industry; must include performance standards, measurable outcomes and satisfaction surveys of consumers and family members; must utilize cost caps, including, but not limited to, cost caps for facilities based on size; and must recognize regional variations in labor costs. Rules amended pursuant to this section take effect September 1, 2000. Rules amended pursuant to this section are routine technical rules as defined in the Maine Revised Statutes, Title 5, chapter 375, subchapter II-A.

Sec. BBBB-9. Report on long-term care insurance. The Department of Human Services, the Maine State Retirement System and the State Employee Health Insurance Program shall work together to study the provision of group long-term care insurance to employees of the State and other public sector employees and retirees and to their family members and to the citizens of the State. The study must consider the CalPERS system operating in California, other models used in other states and the feasibility of regional cooperation among states. The State Employee Health Insurance Program is the lead agency in the study and shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters by April 1, 2001 regarding the study and any recommendations.

Sec. BBBB-10. Development of a public awareness campaign. The Department of Human Services, Bureau of Elder and Adult Services shall coordinate with the Bureau of Health a public awareness campaign that focuses on the benefits of a healthy lifestyle and the need to plan for long-term care. The department shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 1, 2001 on its progress on the campaign.

Sec. BBBB-11. Staffing ratios. By October 1, 2000, the Department of Human Services shall amend the rules on minimum staffing ratios in long-term care facilities to provide for ratios in accordance with this provision.

1. The minimum staffing ratios may not be less than the following:

A. On the day shift, one direct-care provider for every 5 residents;

B. On the evening shift, one direct-care provider for every 10 residents; and

C. On the night shift, one direct-care provider for every 18 residents.

2. The minimum staffing ratio rule must provide definitions for "direct-care providers" and "direct care" as follows:

A. "Direct-care providers" means registered nurses, licensed practical nurses and certified nursing assistants who provide direct care to nursing facility residents; and

B. "Direct care" means hands-on care provided to residents, including, but not limited to, feeding, bathing, toileting, dressing, lifting and moving residents. "Direct care" does not include food preparation, housekeeping or laundry services except in circumstances when such services are required to meet the needs of an individual resident on a given occasion.

The Department of Human Services shall undertake pilot projects to determine appropriate staffing ratios for mealtimes and shall report on progress on the pilot projects to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 1, 2001.

The Department of Human Services shall begin work to develop staffing ratios based on resident acuity level. In developing the new staffing ratios, the department shall contract with one or more experts in nurse staffing research and long-term care who shall recommend a methodology for determining appropriate ratios. By May 1, 2001, the Commissioner of Human Services shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding the progress of the department in developing acuity-based staffing ratios, a proposal for adopting acuity-based staffing ratios and any required legislation.

Sec. BBBB-12. Rule amendment regarding licensing and surveys of providers of long-term care services. Consistent with the requirements of the federal Medicaid and Medicare programs, the Department of Human Services shall amend its rules regarding the duration of licenses for providers of long-term care services and the surveys required of those providers. In preparing the amendments, the department shall consider performance standards, recognized standards of best practice, desired and measurable outcomes and satisfaction surveys of consumers and their families. To the extent not in conflict with the requirements of applicable federal programs, the rules must provide for the reasonable lengthening of license periods and some relaxation of survey requirements for providers of services with a documented track record of consistently high-quality service delivery as measured by performance standards and other appropriate criteria. Rules adopted pursuant to this section take effect July 1, 2001. Rules adopted or amended pursuant to this section are major substantive rules as defined in the Maine Revised Statutes, Title 5, chapter 375, subchapter II-A.

Sec. BBBB-13. Rule amendment regarding assessment for eligibility for reimbursement under the Medicaid program for long-term care services. The Department of Human Services shall review its rules for determining eligibility for reimbursement under the Medicaid program for long-term care. The review process must include consumers, providers and other interested persons. It must identify ways to make the process of assessment of medical condition and cognitive function more flexible without undermining its objectivity. The review must include, but is not limited to, providing the nurse assessor authority to utilize professional skills and to consider input from the consumer's family and physician. The review should include the establishment of guidelines to provide to the nurse assessor standards with regard to consumer need and care plan development. The rules must eliminate the requirement of automatic annual assessments of the medical condition of consumers whose medical conditions are unlikely to improve sufficiently to cause a change in their eligibility for services. The review process must also include verification of financial information in the process of determining financial

eligibility and cost-sharing for state-funded services. By January 15, 2001, the department shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters its recommendation and any necessary legislation on assessment for eligibility.

Sec. BBBB-14. Review of reimbursement under the Medicaid program. The Department of Human Services shall review its rules on reimbursement for assisted living and home care services and shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 1, 2001 its recommendations for including in the reimbursement formulas for those services, factors for acuity of consumer condition, level of need for services, performance standards and consumer satisfaction surveys.

Sec. BBBB-15. Establishment of the Long-term Care Implementation Committee. There is established the Long-term Care Implementation Committee, referred to in this section as the "committee," to monitor the progress of state departments and offices in implementing the provisions of this Part. The committee shall review the adoption and amendment of rules performed in response to this Part and may make recommendations to the Department of Human Services and to the joint standing committee of the Legislature having jurisdiction over health and human services matters for amendments to those rules. The committee shall review the quality of care in the long-term care system.

1. Membership. The committee consists of 13 members. The President of the Senate shall appoint 5 members as follows: one member representing providers; one member representing the Long-term Care Steering Committee; one member representing consumers of long-term care services; and 2 Legislators, one representing the joint standing committee of the Legislature having jurisdiction over health and human services matters and one representing the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs. One Legislator must represent the majority party and one Legislator must represent the minority party. The Speaker of the House of Representatives shall appoint 5 members follows: one person representing providers; one member representing the long-term care ombudsman program; one member representing consumers of long-term care services; and 2 Legislators, one representing the joint standing committee of the Legislature having jurisdiction over health and human services matters and one representing the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs. One Legislator must represent the majority party and one Legislator must represent the minority party. The Commissioner of Human Services or the commissioner's designee and 2 other persons representing the Department of Human Services, appointed by the commissioner, are ex officio members of the committee. All appointments must be complete by January 1, 2001.

2. Meetings. The committee may meet up to 9 times per year. The committee members shall select 2 persons from among the members to serve as cochairs. Persons serving as cochairs may serve in that capacity for a maximum of 12 months. The Department of Human Services shall provide staff and support services. Committee members not otherwise reimbursed for expenses of attending meetings are entitled to reimbursement.

3. Duties. The committee shall report by February 1, 2001; February 1, 2002; and December 31, 2002 to the joint standing committee of the Legislature having jurisdiction over health and human services matters. The report must include activities of the committee in the prior year, the opinion of the committee on the progress being made to implement this Part and any recommendations for action, including recommending necessary legislation to the Legislature. This section is repealed January 1, 2003.

Sec. BBBB-16. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

HUMAN SERVICES, DEPARTMENT OF

Medical Care - Payments to Providers

All Other $273,000

Provides for the appropriation of funds to increase wages for home-care workers.

Nursing Facilities

All Other 300,000

Provides for the appropriation of funds to provide increased eligibility for consumers of long-term care services who have chronic conditions that change.

Nursing Facilities

All Other 1,600,000

Provides for the appropriation of funds to ensure that the principles of reimbursement for nursing facilities reflect the current cost of providing services in an efficient manner.

Nursing Facilities

All Other 1,336,000

Provides for the appropriation of funds to increase the minimum staffing ratios in long-term care facilities.

Long-term Care - Human Services

All Other 1,074,000

Provides for the appropriation of funds to provide services to persons on waiting lists for home-based care.

Long-term Care - Human Services

All Other 327,000

Provides for the appropriation of funds to increase wages for home-care workers.

Long-term Care - Human Services

All Other 90,000

Provides for the appropriation of funds for increased costs of home-care programs due to changes in the cost-sharing formula.

DEPARTMENT OF HUMAN SERVICES

TOTAL $5,000,000

Sec. BBBB-17. Allocation. The following funds are allocated from the Federal Expenditures Fund to carry out the purposes of this Part.

2000-01

HUMAN SERVICES, DEPARTMENT OF

Medical Care - Payments to Providers

All Other $533,380

Provides for the allocation of funds for the federal match to increase wages for home-care workers.

Nursing Facilities

All Other 586,132

Provides for the allocation of funds for the federal match to provide continuing eligibility for consumers of long-term care services who have chronic conditions that change.

Nursing Facilities

All Other 3,126,038

Provides for the allocation of funds for the federal match to ensure that the principles of reimbursement for nursing facilities reflect the current cost of providing services in an efficient manner.

Nursing Facilities

All Other 2,610,241

Provides for the allocation of funds for the federal match to increase the minimum staffing ratios at long-term care facilities.

DEPARTMENT OF HUMAN SERVICES
TOTAL $6,855,791

APPENDIX I

Department of Health and Human Services Rules, Chapter 110, Licensing and Functions of Skilled Nursing Facilities and Nursing Facilities, Chapter 9, Resident Care Staffing

CHAPTER 9

RESIDENT CARE STAFFING

9.A. Minimum Nursing Staff Requirements

The following minimum nursing staff requirements shall be met:

9.A.1. Director of Nursing

a. In each licensed nursing facility there shall be a Registered Professional Nurse employed full-time who shall be responsible for the direction of all nursing services delivered in the facility.

b. The Director of Nursing must be qualified by education, training and experience in both Gerontology and nursing administration.

c. If the Director of Nursing is functioning as a Temporary Administrator, a nurse shall be appointed to act as the Director of Nursing during that period of time.

d. Lines of responsibility shall be clearly established in writing and shall be made known to all nursing staff and other appropriate personnel.

9.A.2. Director of Nursing - Responsibilities

The Director of Nursing shall be responsible and accountable to the Administrator for:

a. Assuring the delivery of all required services to residents;

b. Developing and maintaining nursing service objectives, current standards of nursing practice, nursing policy and procedure and manuals, and written job descriptions for each level of personnel;

c. Coordination of nursing services with other resident services;

d. Establishment of the means of assessing the needs of residents and staffing to meet those needs on all shifts;

e. Assuring the delivery of orientation programs and staff development;

f. Participating in the selection of prospective residents in terms of nursing service they need and nursing competencies available;

g. Assuring that a comprehensive assessment and plan of care is established for each resident, and that his/her plan is reviewed and modified and implemented as is necessary;

h. Assuring the evaluation of the performance for all nursing personnel at regular intervals and making recommendations to the administrator;

i. Recommending action when needed to control noise, maintain, repair or replace equipment; ensuring cleanliness and safety measures; providing proper allocation and utilization of space and equipment;

j. Recommending to the administrator the number and levels of nursing personnel, supplies and equipment for safe resident care;

k. Establishing priorities for budget items that are necessary to provide services;

l. Participating in the Quality Assurance Committee and other committees as necessary.

9.A.3. **Licensed Staff Coverage**

a. There shall be a Registered Professional Nurse on duty for at least eight (8) consecutive hours each day of the week.

b. Licensed nurse coverage shall be provided according to the needs of the residents as determined by their levels of care. The following minimum coverage shall be met:

1. Day Shift

a. In each facility there shall be a licensed nurse on duty seven (7) days a week.

b. Each facility must designate a Registered Professional Nurse or a Licensed Practical Nurse as the charge nurse. In facilities with twenty (20) beds or less, the Director of Nursing may also be the charge nurse.

c. In facilities larger than twenty (20) beds, in addition to the Director of Nursing, there shall also be another licensed nurse on duty.

d. An additional licensed nurse shall be added for each fifty (50) beds above fifty (50).

e. In facilities of one hundred (100) beds and over, the additional licensed nurse shall be a Registered Professional Nurse for each multiple of one hundred (100) beds.

2. Evening Shift

a. There shall be a licensed nurse on duty eight (8) hours each evening.

b. An additional licensed nurse shall be added for each seventy (70) beds.

c. In facilities of one hundred (100) beds and over, one of the additional licensed nurses shall be a Registered Professional Nurse.

3. Night Shift

a. There shall be a licensed nurse on duty eight (8) hours each night.

b. An additional licensed nurse shall be added for each one hundred (100) beds.

c. In facilities of one hundred (100) beds and over there shall be a Registered Professional Nurse on duty.

d. Registered Professional Nurse on Call

All licensed nursing facilities, regardless of size, shall have a Registered Professional Nurse on duty or on call at all times.

e. Private Duty Nurses

The presence of private duty nurses shall have no effect on the nursing staff requirements.

9.A.4. **Minimum Staffing Ratios**

A. The nursing staff-to-resident ratio is the number of nursing staff to the number of occupied beds. Nursing assistants in training shall not be counted in the ratios.

The minimum nursing staff-to-resident ratio shall not be less than the following:

1. On the day shift, one direct-care provider for every 5 residents;
2. On the evening shift, one direct-care provider for every 10 residents; and
3. On the night shift, one direct-care provider for every 15 residents

The definition of direct care providers and direct care is found in Chapter 1 of these Regulations. (see Page 2)

9.A.5. **Multi-Storied Facilities**

There shall be staff assigned to each resident floor at all times when residents are present.

9.B. **Assignment of Tasks**

9.B.1. **Licensed Practical Nurse**

Only nursing tasks for which that nurse has been trained and which are within the LPN scope of practice, as defined by the Maine State Board of Nursing, shall be assigned to the LPN.

9.B.2. **Certified Nursing Assistants**

The nursing tasks assigned to a CNA shall only be those for which the CNA has been trained and which are within the scope of the duties, as defined by the Maine State Board of Nursing rules and regulations.

9.B.3. **Nursing Assistant**

a. Prior to the initial assignment of a nursing task to a nursing assistant, the Registered Professional Nurse shall determine if the individual is enrolled in a course preparing nursing assistants. The Registered Professional Nurse may assign to that individual only those tasks for which the individual has been satisfactorily prepared as documented by the instructional staff. Such

training program or course must be satisfactorily completed within four (4) months from the date of employment.

b. When a nursing assistant is waiting for a training program to start, he/she may participate in non-direct care activities, such as making unoccupied beds and passing trays, and water and linens.

9.B.4. **Administration of Medication by a Certified Nursing Assistant/Medications**

A certified nursing assistant/medications may administer medications only when this function is assigned by a registered professional nurse and there is a licensed nurse on duty.

Eff. 10/15/04 9.B.5. **Feeding Assistants**

All trained feeding assistants shall work under the supervision of a registered or licensed practical nurse. The decision to allow a feeding assistant to feed a resident is based on the charge nurse's assessment and the resident's latest assessment and plan of care. Facilities are responsible for any adverse actions resulting from the use of feeding assistants.

9.C. **Sharing of Staff**

Sharing of nursing staff is permitted between the nursing facility and other levels of assisted living on the same premises as long as there is a clear documented audit trail and the staffing in the nursing facility remains adequate to meet the needs of residents. All sharing of nursing staff must be approved in writing by the Department. There may not be sharing of nursing staff between the nursing facility and another non-nursing facility, whether it is physically attached or in proximity to the nursing facility without written approval by the Department. The non-nursing facility must provide its own separate activities, but may share housekeeping, laundry, dietary and maintenance staff, and account for these hours.

9.D. **Staffing Patterns**

The facility is responsible for establishing its own staffing pattern according to the needs of the residents and in accordance with the provisions of these regulations.

APPENDIX J

42 Code of Federal Regulations section 483.30

§ 483.30 Nursing services.

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

(a) *Sufficient staff.* (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (c) of this section, licensed nurses; and

(ii) Other nursing personnel.

(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(b) *Registered nurse.* (1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

(2) Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

(c) *Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis.* To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if—

(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;

(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;

(4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review;

(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;

(6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

(d) *SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.* (1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—

(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;

(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and

(iii) The facility either—

(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period, or

(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;

(iv) The Secretary provides notice of the waiver to the State long term care

ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

(2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.

(e) *Nurse staffing information*—(1) *Data requirements.* The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).

(C) Certified nurse aides.

(iv) Resident census.

(2) *Posting requirements.* (i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

(3) *Public access to posted nurse staffing data.* The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

(4) *Facility data retention requirements.* The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

[56 FR 48873, Sept. 26, 1991, as amended at 57 FR 43925, Sept. 23, 1992; 70 FR 62073, Oct. 28, 2005]

§483.35 Dietary services.

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

(a) *Staffing.* The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.

(b) *Sufficient staff.* The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.

(c) *Menus and nutritional adequacy.* Menus must—

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;

(2) Be prepared in advance; and

(3) Be followed.

(d) *Food.* Each resident receives and the facility provides—

(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

(2) Food that is palatable, attractive, and at the proper temperature;

(3) Food prepared in a form designed to meet individual needs; and

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

(e) *Therapeutic diets.* Therapeutic diets must be prescribed by the attending physician.

(f) *Frequency of meals.* (1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.

(3) The facility must offer snacks at bedtime daily.

VerDate Mar<15>2010 14:23 Jan 03, 2012 Jkt 223185 PO 00000 Frm 00071 Fmt 8010 Sfmt 8010 Q:\42\X42\COPY223185.XXX ofr150 PsN: PC150

APPENDIX K

Letter from Charlene Harrington

UCSF
University of California
San Francisco

Department of Social and Behavioral Sciences

Laurel Heights Campus
Box 0612

Site Address:
3333 California Street
Suite 455
San Francisco, CA 94118

415.476-3964
415.476-6552(fax)

October 8, 2013

Brenda Gallant R.N.
State Long-Term Care Ombudsman
Executive Director
Maine Long-Term Care Ombudsman Program
61 Winthrop Street
Augusta, Me. 04330

Dear Ms. Gallant

I am writing to express my strong opposition to proposed reductions in Maine's current nurse staffing standards. I understand that proposals have been made to reduce staffing from the current 3.49 hours per resident per day (hprd) to a 3.0 hprd minimum and to eliminate the current ratio requirements of 1:5, 1:10. 1:15.

As you know, low nurse staffing levels are the single most important contributor to poor quality of nursing home care in the US. Over the past 20 years, more than 100 research studies have documented the important relationship between nurse staffing levels, particular RN staffing, and the outcomes of care. The benefits of higher staffing levels, especially RN staffing, can include lower mortality rates; improved physical functioning; less antibiotic use; fewer pressure ulcers, catheterized residents, and urinary tract infections; lower hospitalization rates; and less weight loss and dehydration (Bostick et al., 2006; Castle, 2008; Spilsbury, Hewitt, Stirk, et al., 2011; U.S. CMS, 2001; Schnelle et al., 2004). Moreover, states that have introduced higher minimum staffing standards for nursing homes have been found to have nurse staffing levels and improved quality outcomes (Bowblis 2011; Harrington, Swan and Carrillo, 2007; Mukamel et al. 2012; Park and Stearns 2009). Moreover, Mukamel et al. (2013) found that higher state staffing standards and regulatory enforcement was cost effective.

A study published by the Centers for Medicare and Medicaid Services (CMS) (2001) found that staffing levels for long-stay residents below 4.1 hours per resident day (hprd) resulted in harm or jeopardy for residents (including levels below 0.75 for RNs and 0.55 for LPNs). The study conducted a simulation analysis which showed that nursing assistant (NA) time should range from 2.8 to 3.2 hprd, depending on the care residents need, just to carry out five basic nursing care activities (CMS, 2001). This amounts to 1 NA per seven residents on the day and evening shifts and 1 NA per 12 residents at night. Nursing homes below these levels had poor quality of care that caused harm and jeopardy. An Institute of Medicine (2003) report recommended the staffing levels indentified in CMS 2001 study.

Another study found widespread quality problems in many nursing homes: inadequate assistance with eating; poor verbal interactions; false charting; inadequate toileting assistance; infrequent turning of residents in bed; over half of residents left in bed most of the day; inadequate walking assistance; and widespread untreated pain and untreated depression (Schnelle et al., 2004). The authors concluded that staffing levels were a better predictor of high-quality care processes than quality measures and nursing homes with nurse staffing levels of 4.1 hprd or higher performed significantly better on 13 of 16 care processes compared with homes with lower staffing.

In another paper, experts recommended that minimum nurse staffing levels should be at least 4.5 hprd (Harrington, Kovner, Mezey, Kayser-Jones, et al., Zimmerman, 2000). Of course, nurse staffing levels need to be increased beyond the minimum levels in nursing homes that have high resident acuity (case mix) to assure that the needs of individual residents are met.

In 2013, the average U.S. nursing home provided a total of 4.1 hours per resident day (hprd) of total nursing care, provided by the Director of Nursing, registered nurses (RNs), licensed vocational or practical nurses (LVN/LPN), and nursing assistants (NAs) (CMS Medicare nursing home compare website). In the U.S., on average, only non-profit and government nursing homes nursing homes meet the CMS recommended staffing standards because for-profit nursing homes cut staffing to save money (Harrington, Olney, Carrillo, and Kang, 2012). Low nursing home staffing expenditures were directly associated with high nursing home profits (Harrington, Ross, Mukamel, and Rosenau, 2013).

Maine has higher staffing requirements than many other states and its staffing requirements of 3.46 hprd are closer to the 4.1 hprd level recommended by the study for CMS in 2001 and the experts' opinion that the staffing standards should be 4.55 hprd at a minimum. Maine's staffing standards are still below the average 4.1 hprd of actual nursing provided in the US. Because of it's staffing requirements, Maine has had higher quality nursing homes than many other states reported on Medicare Nursing Home Compare.

Maine and many other states have established ratios for its staffing standards (Harrington, 2010). Ratios are important because they are easier to understand and measure than when standards are set in hours per resident day. The ratios allow nursing home providers and consumers to quickly count how many residents each staff member is caring for on each shift. This is important provision that promotes transparency in public reporting as well as staffing accountability.

If Maine were to reduce it's staffing standards and eliminate it's ratio requirements, the quality of care in Maine's nursing homes could dramatically decline in many homes that would take advantage of reduced requirements. Any reduction in Maine's staffing requirements would be a serious step backward.

Sincerely,

Charlene Harrington

Charlene Harrington, Ph.D.
Professor of Sociology

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NURSING HOME STAFFING STANDARDS IN STATE STATUTES AND REGULATIONS

State	MINIMUM STAFFING STANDARD FOR SKILLED NURSING OR NURSING FACILITIES	STATE STANDARD: Estimated variance from federal standard for facility with 100 beds	STATE STANDARD: Staffing Standard Citation and URL	Comments
ME	**SUFFICIENT STAFF:** to meet the needs of residents as determined by their levels of care.. **LICENSED STAFF** (RN, LPN/LVN) 1 DON RN full-time included in 1 RN 8 consecutive hrs, 7 d/wk on Days 1 RN/LPN Charge Nurse 7 d/wk on Days For 20+ beds: DON may not be Charge Nurse For 100, 150, 200 etc. beds: add 1 LN for each increment of 50 For 100+: for each multiple of 100, the additional LN shall be an RN and 1 RN/LPN Eve, on duty 8 hrs every eve. and 1 RN/LPN for multiples of 70 beds For 100+: one of additional LNs shall be an RN and 1 RN/LPN Night & 1 RN/LPN for multiples of 100 For 100+: an RN shall be on duty at night **DIRECT CARE STAFF** 1:5 ratio Days 1:10 ratio Evenings 1:15 ratio Nights Include RNs, LPNs, CNAs who provide direct care.	(RN .32) LN .56 DC 2.93 Total 3.49	**SAL:** ***Code of ME Rules*** 10-144 *CMR* 110 Ch. 9 Sec. 9.A.3 and 9.A.4. ME Sec of State, Rules By Department: Eff. 2/1/01 http://www.maine.gov/sos/cec/rules/10/ch110.htm	***Previous Regulation:*** **SC:** Public Law 1999 Ch. 731 Sec. BBBB -11 Direct care ratios were: Day 1:5 Eve 1:10 and Night 1:18. Passed & Signed 4-25-00. Eff. 10-1-00. http://www.mainelegislature.org/ros/LOM/lom119th/5pub701-750/5Pub701-750-110.htm ***OnLine Updates:*** Dept. of Health & Human Services (DHHS) Homepage: http://www.maine.gov/dhhs/ ***DHHS Rule Updates:*** http://www.maine.gov/dhhs/dlrs/rulemaking/index.shtml ***ME Legislative Updates:*** http://www.mainelegislature.org/legis/bills/
MI	**SUFFICIENT STAFF:** to meet the needs of residents. **LICENSED STAFF** (RN, LPN/LVN) 1 DON RN (with training in gerontology) included in 1 RN/LPN 24 hrs/7d/wk **DIRECT CARE STAFF** 2.25 hprd or ratio of 1:8 ratio Days 1:12 ratio Evenings 1:15 ratio Nights For 30+ beds, exclude time of DON.	(RN .06) LN .24 DC 2.25 Total 2.31	**SC:** ***MI Compiled Laws, Public Health Code*** "Act 368 of 1978" Sec. 333.21720a(2) Eff. 3-30-79. http://www.legislature.mi.gov/(S(r30sqz452jdpbqzpy3yk0x45))/mileg.aspx?page=getObject&objectName=mcl-333-21720a	***OnLine Updates:*** For pending legislation, text and status, see MI Legislature homepage: http://www.legislature.mi.gov/(S(zhnvpk55hzqitk4554icfiaz))/mileg.aspx?page=home

APPENDIX L

Office of the State Auditor, Report on Cost of Care

STATE OF MAINE
OFFICE OF THE STATE AUDITOR

66 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0066

TEL: (207) 624-6250
FAX: (207) 624-6273

POLA A. BUCKLEY, CPA, CISA
STATE AUDITOR

MARY GINGROW-SHAW, CPA
DEPUTY STATE AUDITOR
MICHAEL J. POULIN, CIA
DIRECTOR OF AUDIT and ADMINISTRATION

October 29, 2013

Mary Mayhew, Commissioner
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Commissioner Mayhew,

The Office of the State Auditor conducted a limited procedures engagement of the Department of Health and Human Services' computation and application of Cost of Care amounts to provider payments for the nine month period July 1, 2012 to March 31, 2013.

We have completed our report and DHHS has responded to our concerns in writing. These responses have been incorporated into our report and the report is attached to this letter.

Our report will be available on the Office of the State Auditor website at http://www.maine.gov/audit/reports.htm, in the section for Other Reports.

We thank Deputy Director Michael Frey, Director Bethany Hamm, Acting Director of Policy Beth Ketch, Director Stefanie Nadeau, and their staff; as well as the Department of Administrative and Financial Services (DAFS), Office of Information Technology and Department of Health and Human Services Service Center personnel for their assistance during this engagement.

Sincerely,

Pola A. Buckley, CPA, CISA
State Auditor

cc: Honorable Dawn Hill, Chairperson, Appropriations and Financial Affairs
Honorable Margaret Rotundo, Chairperson, Appropriations and Financial Affairs
Honorable Margaret Craven, Chairperson, Health and Human Services
Honorable Richard Farnsworth, Chairperson, Health and Human Services
Honorable H. Sawin Millett, Commissioner, Department of Administrative and Financial Services
Jim Smith, Commissioner, Office of Information Technology
Michael Frey, Deputy Director, DHHS
Herb Downs, Director, DHHS, Division of Audit
Ray Girouard, Director, Department of Administrative and Financial Services, DHHS Service Center
Bethany Hamm, DHHS, Director, Policy and Programs
Beth Ketch, DHHS, Acting Director of Policy
Stefanie Nadeau, Director, DHHS, Office of MaineCare Services

Office of the State Auditor
Report on Limited Procedures Engagement – Cost of Care
Report Issued On October 29, 2013

Summary

The Office of the State Auditor reviewed internal controls over the calculation, application and review of Cost of Care amounts assessed to long term care (LTC) facility residents for the first nine months of fiscal year[1] 2013. The term "Cost of Care" refers to a MaineCare member's personal monthly required contribution towards his or her nursing home (NH) or private non-medical institution (PNMI) facility care. This amount is separately calculated for each resident based on their financial situation. In effect, Cost of Care is a "deductible" that an individual must pay to live in a Long Term Care (LTC) facility. LTC facilities collect this amount directly from residents eligible for the State LTC program, bill MaineCare for the usual and customary charges; and then, the claims processing system, the Maine Integrated Health Management Solution (MIHMS) is supposed to deduct the Cost of Care. LTC providers are required to return overpayments when MIHMS does not make this deduction.

The Office of Family Independence (OFI) coordinates eligibility for the various LTC Assistance Group programs that provide MaineCare benefits for certain Medicaid or state funded coverable group residents; and the Office of MaineCare Services (OMS) is responsible for payments to the NH and PNMI facilities in Maine. The Office of the State Auditor finds that improvements are needed. These needed improvements are identified in this report.

We found that known logical errors in the Automated Client Eligibility System (ACES) frequently cause income and expense information for LTC residents to be incorrect or missing. This results in Cost of Care assessments calculated by ACES to be incorrect. In order to address this, OFI personnel are required to apply "manual workarounds" to correct any errors they find in client case information pertaining to Cost of Care. Test results indicated that OFI staff did not always apply manual fixes correctly; and that other system errors remained undetected by staff altogether.

Furthermore, we found that MIHMS is not appropriately deducting Cost of Care amounts; and system edits were not appropriately set to deny, pend or re-open claims for review in two circumstances. In both circumstances, providers were or would be paid by both the resident and by MIHMS for the same monthly room and board costs. Immediately following is a description of the audit procedures performed, the results of those applied procedures and our conclusions and recommendations.

Range of Estimated Financial Impact

OFI Assessments: Total Cost of Care assessed to potential LTC residents for the first nine months of fiscal year 2013 was $89 million. Audit procedures applied to our sample indicated that nine (or, about 15%) of the sixty Cost of Care assessments tested remained in error despite manual correction by OFI staff in some cases. The dollars associated with the 15% error rate were minor because income and expense errors offset each other.

OMS Payments: Based on eligibility calculations, the theoretical maximum[2] Cost of Care deduction from LTC provider payments for the first nine months of fiscal year 2013 is $89 million. We estimate that the actual Cost of Care deductions that should have been taken for the first nine months of fiscal year 2013 are $76 million (85%[3] of $89 million). We found that in a sample of sixty randomly selected claims and interim rates set by the Department, providers were overpaid by $16,924 (or about 29%) of the total $57,713 Cost of Care amounts. Twenty-nine percent of $76 million is $22 million, *annualized* this amounts to $29 million. We know that DHHS has some procedures in place to recover these funds since the MIHMS implementation in 2010. However, we believe these procedures are far from adequate and do not address the root causes on a timely basis.

Included in the $16,924 overpayment amount are $6,324 of MIHMS payment processing errors identified in more detail below, for five NH payments and two PNMI facility payments.

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[1] All references to a fiscal year are for the State fiscal year ending June 30.

[2] Not all individuals assessed a Cost of Care amount by OFI reside in a NH or PNMI. Some choose to stay at home, or remain in a hospital or other LTC facility type.

[3] Nine of our original 60 item sample used to test OFI Assessments had to be replaced because they were not yet residing in an NH or PNMI. Therefore, our testing indicates that approximately 15% of individuals for whom a potential Cost of Care was calculated, were not yet residing in a NH or PNMI.

The remaining $10,600 was because Cost of Care was not fully deducted from twenty-two other PNMI claims, or over 75% of the 30 PNMI claims sampled prior to payment. One issue is that although these PNMI payments were for residents eligible for Medicaid, Cost of Care deductions were not applied to all their monthly federal and State charges because such deductions are not allowed by this federal program for residents of PNMI facilities. The other issue is that these PNMI overpayments were primarily due to a nominal amount of $1 per day being paid for room and board on an interim basis until costs are settled annually. Obviously, PNMI providers cannot function on a periodic payment of one dollar per day per resident. Except for the one dollar per day, DHHS classifies the payment as All Inclusive Comprehensive and Other Therapeutic Services, which we find to be misleading, at the least. DHHS has a manual partially effective procedure in place to recover overpayments from these providers. However, MIHMS continues to overpay; OMS continues to seek recoupment from providers; OMS provides some receivable amounts to HHSSC[4] as a limited number of PNMI providers send in payments; OMS continues to track remaining balances and offset amounts; and applicable credits should be applied by HHSSC to the quarterly federal financial report. Some providers are cooperating, and some are not. This "overpay and recover" procedure cannot mitigate the fact that at any given time about $27 million or more of State and federal money is not available for government use. It remains unclear why OMS has assumed sole financial responsibility for these overpayments, rather than with the HHSSC. The Service Center is ultimately responsible for crediting the federal share of these overpayments on the federal CMS-64 reports. This is a serious matter that deserves priority attention by the State.

Background

We originally discovered issues with Cost of Care while auditing Medicaid for fiscal year 2006. These issues might have existed prior to this date. Cost of Care amounts had not been deducted from NH or PNMI facility payments correctly; and the result is that providers were being paid both by the MaineCare member and by MaineCare.

Problems persist in the current MIHMS system.

Procedures

We performed the following procedures[5] for the nine month period ending 3/31/2013:

- reviewed State law pertaining to Cost of Care,
- reviewed relevant sections of the State Medicaid Manual promulgated by the federal government, the MaineCare Eligibility Manual and the MaineCare Benefits Manual,
- evaluated OIT technical design documents that depict how ACES assesses Cost of Care for individuals and related mechanical and human controls,
- evaluated OMS and fiscal agent technical design documents that depict how MIHMS adjudicates Cost of Care for individuals and the related mechanical and human controls,
- determined whether the MIHMS system logic is correct,
- tested the accuracy of a sample of sixty Cost of Care assessments[6] made by ACES for clients that are classified as members of certain DHHS program coverage groups residing in NH and PNMI facilities,
- tested the accuracy and success rate of manual compensating controls[7] over the same sixty Cost of Care assessments,
- tested sixty claim payments to LTC providers to determine whether payments made to providers for monthly resident charges were reduced by Cost of Care amounts[8],
- tested existing compensating controls, such as "pend or deny" edits in MIHMS, that would force resolution of payment errors related to Cost of Care for a sample of sixty NH and PNMI provider payments,
- tested the consistency of eligibility and Cost of Care information from system-to-system (ACES[9] to MIHMS) through the DataHub[10] for a sample of sixty claims,
- reviewed the adequacy of the DHHS process used by a contractor to measure and track the amounts due back from NH facilities that received overpayments because the correct Cost of Care amount was not deducted from payments for monthly resident costs,

[4] HHSSC - Health and Human Services Service Center

[5] not in order of importance

[6] certain types of client income, expenses and allowances are used in this calculation

[7] Part of the typical case management process is for OFI eligibility personnel to determine whether cost of care was computed correctly by ACES for each client, correcting errors as they are encountered and at times in a more directed manner.

[8] Cost of care amounts that should be collected by LTC providers from the clients housed in their facility.

[9] The ACES system electronically transfers cost of care amounts and other eligibility information for each client to the DataHub in an ongoing basis.

[10] The DataHub is Maine's intermediary Health Care Information database system between ACES and MIHMS.

- reviewed the adequacy of the OMS controls in place to measure and track the amounts due back from PNMI facilities that received overpayments because the appropriate Cost of Care amount was not deducted from payments for monthly resident costs, and
- identified other issues that were detected during the audit that pertained to compliance with State law.

Results

Our testing of a sample of 60 randomly selected cases from all clients in a NH or PNMI residence assessed a Cost of Care for the period indicated that ACES incorrectly computed Cost of Care because known system errors caused income or expense information to be incorrect or missing for 13 of the 60 random Cost of Care assessments, as follows:

Instances	ACES Error Observed
10	ACES did not include all or part of State Supplement payments[11] as income for SSI clients.
2	ACES miscalculated the spousal income allocation.
1	ACES failed to update annual SSI[12] income from SVES[13] since 2009; and to list case on the SVES discrepancy report.
13	Total

In response, OFI has established manual workarounds or "fixes" as compensating controls to address such known ACES system design problems in automatically assessing Cost of Care to client cases. Test results indicated; however, that OFI staff did not correctly apply manual fixes or detect system errors for 9 of the 13 system errors, as follows:

Instances	Errors Observed
3	ACES did not include all or part of State Supplement payment as income for SSI clients.
6	OFI personnel did not detect system errors and apply manual fixes to client records.
9	Total

Continued on next page...

[11] A standard applies that is established by the State for the total SSI payment. The federal SSI payment and any countable income are deducted from the State standard. The remainder is the State Supplementation. This is typically an additional $10 or $15 per month, but can be as high as $234 in some client cases.

[12] Supplemental Security Income (SSI) guarantees a minimum monthly income to people who are at least 65 years old, or blind, or disabled with limited income and resources.

[13] State Verification and Exchange System

Our testing of a sample of 60 claim payments for the same clients and period tested above, indicated that Cost of Care for 8 (5 NH and 3 PNMI) claims were not correctly deducted from provider payments, because:

Instances	Errors Observed
4	Situation No. 1: Claims were found submitted for payment in a manner which could potentially be used to force a payment to be improperly paid from both MaineCare and from the client. We are not disclosing specific details of the issue in this report to avoid the possibility of compromising Department data and resources. However, we have notified appropriate Department management of the specific issues.
4	Situation No. 2: Retroactive Eligibility Payment Errors - MIHMS system edits were not actively set to reopen four tested claims when retroactive DataHub information was received by MIHMS and caused client Cost of Care and eligibility information to change only after NH or PNMI providers were paid for monthly resident costs. The end result is that the provider is or ultimately will be erroneously paid by both the client and by the State, so the State needs to recover the excess payment from the provider in some manner. A solution[14] to this retroactive Cost of Care and Eligibility assessment dilemma is being developed.
8	Total

The results of other tests we performed were not found to be problematic; or will be tested further during our testing of the federal Medicaid program.

Conclusions

We found important opportunities for needed improvement. These opportunities relate to key controls over system functionality and compensating controls that are in place to correct for known system deficiencies.

(1) Known system errors, which occur consistently as ACES computes Cost of Care amounts, must be addressed by the Department. Allowing such errors to continue is inefficient and wasteful of financial and human resources. It creates too many opportunities for human error and testing indicates there is no guarantee that system errors will be detected through manual processes.
(2) Systemic errors (caused by MIHMS and ACES system flaws) are predictable and typically can be resolved once identified. The root causes for MIHMS payment errors we detected were systemic and not isolated in nature, indicating these internal control weaknesses should be addressed by the Department. If not, payment errors and an opportunity for improper activity will continue.
(3) Consistent and meaningful exception review on an ongoing basis would allow for timely detection and tracking of payment errors; and the efficient recovery of overpayments.

Root Causes

Systemic ACES and OFI deficiencies include:

- Known ACES system errors which occur consistently for Cost of Care calculations include:

  (1) SSI recipients: not counting State Supplement payments between $10 and $234 per month as income
  (2) NH residents: miscalculation of the monthly spousal income allocation[15] and daily medical rates
  (3) SSI recipients: not consistently updating all SSI income amounts from SVES
  (4) SSI recipients: not reporting all instances of SVES failure on the SVES discrepancy report
  (5) NH residents: computed spousal income allowance is off by about $33 to $37 per month

- Inefficient compensating controls because OFI personnel need additional training

  Manual recalculations of Cost of Care amounts included arithmetic errors and misunderstandings regarding what client information should be considered when performing these computations. Also, correct procedures were not always followed by OFI staff as they applied manual fixes to ACES records.

[14] TR#5620 - A trouble report (TR) is a system defect that the system contractor must fix for free, without additional negotiated funding.
[15] This known system issue is referred to by OFI as, ACES task #13658.

Systemic MIHMS claim processing errors detected:

- No MIHMS system edit is set to pend or deny claims when they are submitted by a NH or PNMI facility provider in a certain way that we are intentionally not disclosing to protect Department resources

  System edits that could resolve this matter were set to ignore during our testing. In all 4 instances detected within our sample, no Cost of Care amount was deducted from room and board costs prior to payment. The result is that the provider erroneously got paid by both the client and by the State.

- Compensating controls to detect and reopen claims for retroactive Cost of Care or other eligibility changes are insufficient

  Electronic methods to detect instances when DataHub client eligibility and Cost of Care information is received by MIHMS exist only after payments are made are not set to reopen such claims for review by OMS to force resolution. Another 4 of the 60 claims we tested were such instances. It was also discovered that no State personnel were instructed to regularly generate and review exception reports or use other tools that can detect such retroactive eligibility or Cost of Care assessments to force resolution of claims previously paid in error.

- Fractured Communication

  Improvement of cross system communication and review processes should continue to expand the pockets of understanding to a less selective group of personnel within the Department and in certain DAFS[16] entities. The path from eligibility determination to MaineCare provider payments and ultimately to proper financial reporting is complicated involving multiple systems and complex business rules, which requires a large and diverse team of management, program, policy, financial and Information Technology (IT) experts, internal and external to the Department. The decision to outsource payment processing to a fiscal agent and the limitations of State agency resources adds additional complexity to this communications process. While the State and its contractors have developed communication channels, defining all user roles and responsibilities will need to continue in an ongoing basis, unless a more centralized approach to operations is put into place.

Recommendations

We recommend that OFI continue to improve internal controls to ensure that Cost of Care amounts are computed correctly for clients residing in LTC facilities, such as:

- coordinating the remediation of ACES system problems with DAFS - OIT[17],
- continuing their efforts to review and correct client records related to income, expenses, personal needs allowances, and daily medical rates to compensate for ACES deficiencies in computing Cost of Care amounts, and
- providing additional training to staff who must make manual corrections to Cost of Care information in ACES.

We recommend that OMS continue to implement additional controls and system corrections that would allow Cost of Care amounts to be properly deducted from monthly NH and PNMI facility payments. These include:

- directing Molina to activate certain system edits that will cause LTC claims to pend, deny or reopen for manual review prior to paying providers (this will allow for more offsets against future claims),
- assigning more personnel to review exception reports or use other tools to detect and track errors for adjustment against future claims,
- ensuring that an adequate number of staff is assigned to track and manage the significant balances due back to the State from overpaid PNMI facilities, that staff is adequately educated, qualified, and employed on a permanent basis, and

[16] DAFS (Department of Administration and Finances) - HHSSC (Health and Human Services Service Center) and OIT (Office of Information Technology).
[17] Office of Information Technology

- providing comprehensive receivable, payment and offset information to the HHSSC; and consider transferring responsibility for overpayment accounting and collections activities to the HHSSC, subject to internal audit oversight.

Agency Responses

Agency contact, Acting Director of Health Care Management and Policy, OMS.

- The State's Change Management staff is researching a variety of solutions (to the undisclosed situation). No estimated date can be provided for a decision or implementation of a system change. In the interim, we will implement a manual review by State Quality Assurance staff to research and identify claims that meet the (undisclosed) criteria for adjustment. Also, the State is actively involved in a redesign of the reimbursement methodology for Private Non-Medical Institutions.

- Retroactive Cost of Care determinations obviously create collection problems. As was discussed in our 5/29/13 meeting with Molina and State staff, most claims in this situation have finalized before the COC information is received. The State has a dedicated resource who works on COC issues. She does not use the certain report that Molina referred to in our meeting, as we believe other tools are more useful; (but she does use) a different Molina-generated report and coordinates her findings with the State adjustment supervisor. Because your audit did show that our current efforts are incomplete, we will be reconsidering our overall COC review to see where it can be strengthened.

- The Cost of Care process has been corrected for members with Cost Reimbursement Boarding Home (Rate Code 53) coverage.

APPENDIX M

Pay for Performance Models, Maine Health Care Association

Pay for Performance – Considerations for Maine

Potential Measures

Staffing

1.Direct Care Staff Turnover

- All nursing staff
  - RN
  - LPN
  - CNA

Criteria:

Achievement – Less than ____% (state or national average)

OR

Improvement – ___% reduction in ____ (timeframe)

Tracking/Reporting Tool: Advancing Excellence staff turnover tracking tool reported via AE website (define frequency)

Other state comparisons:

Colorado – Staff retention rate (excluding NHA and DON) at or above 60% (3 points of 100) & Staff retention improvement (3 points of 100) - A 5% improvement on the staff retention rate per year for facilities with less than a 55% retention rate. Facilities with 60% retention rate or greater must remain consistent from year to year.

Georgia – quarterly average RN/LPN (1 point of 3 required), CNA (1 point of 3 required).

Kansas – staff turnover rate less than/equal to 75th percentile (41%) = $2.50 per diem add-on. Or greater than 75th percentile but reduced more than or equal to 10% = $0.25 per diem add-on.

Indiana – ratio from Medicaid cost reports annually – RN/LPN (3 points of 100) & CNA (3 points of 100).

Oklahoma – retention, % CNA & nurses with 12 mos or more tenure. Minimum 50% CNA's with 12 months or more tenure. Minimum 60% nurses with 12 mos or more tenure.

2.Staffing Levels (case mix adjusted)

- RN
- LPN
- CNA

Criteria:

Achievement – More than ____ hours per patient day (state or national average)

OR

Improvement – ___% increase in ____ timeframe

Tracking/Reporting Tool: OSCAR data submitted by facility during annual licensing survey (adjust for case mix)

Other state comparisons:

Kansas – CMI adjusted staffing ratio greater than or equal to 75th percentile (4.81) = $2.50 per diem add-on. Or less than 75th percentile but improved more than or equal to 10% = $0.25 per diem add-on.

Indiana – nursing hours per resident day weighted by facility specific wage rates by staff type and facility total acuity from Medicaid cost reports (10 points of 100).

Oklahoma – minimum 3.5 hours per patient day required.

Person Centered Care

Consistent Assignment

- CNA

Criteria:

Achievement - No more than 12 caregivers per resident in a month for long stay residents and no more than 12 caregivers per resident in a two week period for short stay residents

OR

Improvement – ___% reduction of number of caregivers in ____ timeframe

Tracking/Reporting Tool: Advancing Excellence consistent assignment tracking tool reported via AE website

Other state comparisons:

Colorado – (6 points of 100) Use AE tool. Measure 4th quarter. Rewarded for 50% or 80% consistent assignments.

Oklahoma –meets AE criteria.

Satisfaction

1.Resident Satisfaction

- Overall recommendation score
- Response rate

Criteria:

Achievement – More than ___% (state or national average)

OR

Improvement – ___% increase in ____ timeframe

Tracking/Reporting Tool: MyInnerView survey

Other state comparisons:

Colorado: (Pre-requisite) Survey must be developed, recognized, and standardized by an entity external to the facility. Must be administered on an annual basis with results tabulated by an agency external to the facility.

Indiana: face to face survey of sample of nursing home residents conducted by independent organization using valid and reliable, publicly available survey instrument (12 points of 100).

Oklahoma – Oklahoma Health Care Authority Focus on Excellence survey, combined score of 72 on 100 point scale.

2.Family Satisfaction

- Overall recommendation score
- Response rate

Criteria:

Achievement – More than ___% (state or national average)

OR

Improvement – ___% increase in ____ timeframe

Tracking/Reporting Tool: MyInnerView survey

Other state comparisons:

Colorado: (Pre-requisite) Survey must be developed, recognized, and standardized by an entity external to the facility. Must be administered on an annual basis with results tabulated by an agency external to the facility.

Georgia – Score for "would you recommend this facility" % excellent and % good to meet or exceed state average of 85% combined (1 point of 3 required). Quarterly review.

Indiana: Mail out or online survey of representative sample of nursing home family members conducted by independent organization using valid and reliable, publicly available survey instrument (9 points of 100).

Oklahoma – Oklahoma Health Care Authority Focus on Excellence survey, combined score of 72 on 100 point scale.

Quality Program Participation

Advancing Excellence (AE) Campaign in America's Nursing Homes

Criteria:

Achievement – Registered, two goals selected & participating by entering data on AE website for two goals monthly for six consecutive months

OR

Improvement – Registered, two goals selected & participating by entering data on AE website for one goal monthly for six consecutive months

Tracking/Reporting Tool: AE website report

Other state comparisons:

Colorado: (1 point) Participation in AE campaign

Quality Measures

1.Pain

- Percent of short stay residents who self-report moderate to severe pain
- Percent of long stay residents who self-report moderate to severe pain

Criteria:

Achievement – Less than ____% (state or national average)

OR

Improvement – ___% reduction in ____ (timeframe)

Tracking/Reporting Tool: Quality Measures report

Other state comparisons:

Colorado – Long stay 6.3 or less (5 points), Greater than 6.3 but less than or equal to 9.9 (3 points)

Georgia – (1 point)

2.Antipsychotic medication

- Percent of short stay residents who newly received an antipsychotic medication
- Percent of long stay residents who received an antipsychotic medication

Criteria:

Achievement – Less than ____% (state or national average)

OR

Improvement – ___% reduction in ____ (timeframe)

Tracking/Reporting Tool: Quality Measures report

Other state comparisons:

Colorado – 8.7 or less (5 points), Greater than 8.7 but less than or equal to 11.3 (3 points)

APPENDIX N

Testimony from Leo J. Delicata, Legal Services for the Elderly

LEGAL SERVICES FOR THE ELDERLY, INC.

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Offices in Augusta, Bangor, Lewiston, Portland, and Presque Isle
•••
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Statement of Leo J. Delicata, Esq, Legal Services for the Elderly to the Commission to Study Long-term Care Facilities on November 15, 2013

Co-chairpersons Senator Craven and Representative Stuckey, and members of the Commission,

On behalf of Legal Services for the Elderly I would like to offer a general comment about your draft recommendations and a specific comment about the staffing issue.

Most of the draft recommendations are premised on a conclusion that MaineCare payments to nursing facilities are inadequate and have been so for many years. We agree with this conclusion.

The facts are simple enough. Tough economic times caused a policy change that significantly reduced the number of nursing facilities. Changes to the MaineCare principles of reimbursement ensured a system of underfunding for the remaining facilities. Ultimately this caused a shift to other payment sources with a resulting reduction of access for MaineCare eligible consumers. Over time, payments from those other sources have been reduced or in some cases virtually eliminated depending on the size and location of the particular facility. Many nursing facilities are now challenged to continue providing quality care. Indeed, some are in danger of ceasing to provide care altogether. We agree that it is time to address this general lack of adequate funding. We support all of the draft recommendations of this Commission in this regard and applaud your effort to begin the process of making the changes necessary to appropriately fund this important level of care.

With respect to the staffing recommendation, we agree with the recommendation not to change the current minimal staffing ratios. At the same time we do not believe that these minimums ensure quality of care or

that they adequately promote quality of life as required by the Nursing Home Reform Act of 1987. They should do both.

We understand that many facilities staff beyond the numbers required by our regulations. Many others are not able to do so because of financial challenges. As was suggested several times by several commissioners it is not the lack of will that is a barrier to better staffing it is truly a matter of money. If the economic issues are successfully addressed as proposed by this Commission, the shared expectation of providers and consumers should be that the current staffing standards will also be significantly improved. The future system of reimbursement must include enough funding to enable all facilities to staff at a level that makes the promise of quality of care and quality of life a reality for all nursing facility residents. Otherwise this level of care will become more unavailable and more problematic for the residents of our State.

We commend the Commission for the number of issues that you discussed throughout the course of your sessions. We also recognize and appreciate the range and depth of your discussion on many of those issues. As someone who represents many older consumers of long-term care services, I personally thank you for the time and effort that you devoted to the work of this Commission. The residents of nursing facilities are among the most physically and mentally challenged in our State and your discussions were ultimately about improving their lives and the lives of those who love them. We hope that your recommendations are accepted and that the funding necessary to make them a reality will be a high priority for all.

Thank you for giving me this opportunity to provide this statement.

Leo J.Delicata, Esq

APPENDIX O

Department of Health and Human Services calculation for increased reimbursement for high Medicaid utilization

Calculation of adding $.20 per day to NF reimbursement for high Mediciaid utilization

The attached work papers ESTIMATES the amount of funds needed to pay ALL NF, RURAL NF and URBAN NF providers an added cost per MaineCare resident day for each percentage point above a certain threshold.

There are 3 TABS: ALL NFs, RURAL ONLY, and URBAN ONLY

The percentage used to compare to the threshold percentages is the ratio of State to Total resident days. (State = MaineCare)

The percentages are 70%, 75%, 80% and 85%.

There are four (4) estimates involved:

1. $0.20 for each percentage point greater than 70%
   (see columns 9 and 10)
2. $0.20 for each percentage point greater than 75%
   (see columns 11 and 12)
3. $0.20 for each percentage point greater than 80%
   (see columns 13 and 14)
4. $0.20 for each percentage point greater than 85%
   (see columns 15 and 16)

Based on this ESTIMATE

The cost (state and federal combined) would be APPROXIMATELY:

	ALL NF's	RURAL	URBAN
Greater than 70% is	$1,452,201	$753,414	$698,787
Greater than 75% is	$734,655	$407,400	$327,255
Greater than 80% is	$254,083	$165,388	$88,695
Greater than 85% is	$101,669	$67,141	$34,528

ESTIMATED DATA **

*** Data Source: As filed cost report data. Some of the data may be derived from cost reports prior to being "accepted". Sometimes data changes through the cost report acceptance process.*

The cost (state funds only) would be APPROXIMATELY:

	ALL NF's	RURAL	URBAN
Greater than 70% is	$390,787	$202,744	$188,044
Greater than 75% is	$197,696	$109,631	$88,064
Greater than 80% is	$68,374	$44,506	$23,868
Greater than 85% is	$27,359	$18,068	$9,291

APPENDIX P

Maine Health Care Association calculations for increased reimbursement models

High MaineCare Facilities Supplement	$	2,881,190	$	2,881,190
Rebasing Routine Component to 110%	$	9,835,382	$	9,835,382
Rebasing Direct Component to 110%	$	15,695,158	$	-
Rebasing Direct Component at actual cost	$	-	$	18,181,159
2% COLA in 2014	$	4,254,079	$	4,254,079
Total	$	32,665,809	$	35,151,810
ACA Complianace as a fixed cost (2015)	?		?	
State Share Only (37%)	$	12,086,349	$	13,006,170

APPENDIX Q

Office of Policy and Legal Analysis, memo pay for performance program, Kristin Brawn

OPLA RESEARCH REQUEST MEMO

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

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Hi Jane,

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

Summaries of Nursing Home Pay for Performance Program Articles

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

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

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

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

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

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

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

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

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

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

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