

Reimbursement Subcommittee recommendations to the full Commission
(Members: Diane Barnes, Phil Cyr, Rick Erb, Brenda Gallant & John Watson)
October 9, 2014

1. **DHHS convene a technical task force of stakeholders to work on components of rate-setting.** The Task Force must examine the following components and develop a logical proposal:
 - The wage index for direct care;
 - Developing a wage index for routine care;
 - The suitability of the current four labor regions;
 - Extraordinary circumstances (for example, accounting for wage creep if Portland increased the minimum wage); and
 - Acuity.Task Force must retain the values surrounding access, adequate reimbursement for direct care and quality. The Department shall invite members of the Commission to Continue the Study of Long-term Care Facilities to participate. (N.B. Legislators would trigger a fiscal note.)

2. **DHHS convene a task force of stakeholders to develop appropriate pay for performance models to be applied to the industry with new money.** Stakeholders must include DHHS, nursing facilities, the Ombudsman program and organizations devoted to quality such as the Culture Change Coalition, Health Centric Advisors, and Local Areas Networks of Excellence. The Department shall invite members of the Commission to Continue the Study of Long-term Care Facilities to participate. (N.B. Legislators would trigger a fiscal note.)

3. **DHHS set up a formal procedure for rate setting around higher needs patients/residents** (Lisa Harvey-McPherson's letter). If DHHS is already working on this, the subcommittee supports the continuation and completion of that work. A formal process may make nursing facilities more aware and think about taking some of those residents who are currently out of state or in hospitals.

4. **The State take over Cost of Care collection.** Subcommittee believes it would improve cash flow by requiring less money spent by DHHS on collections agencies chase providers; eliminates the provider as the collection agent; saves the provider bad debt expense; keeps the resident or responsible party in front of DHHS rather than the facility; and the state has more tools for collection (e.g. garnishing wages).

5. **Bad debt should be considered a reimbursable cost in a similar manner to Medicare but paid at 100% as a fixed cost.** It takes months for DHHS to make a decision on eligibility and the facility is paying for the resident until eligibility is determined (retroactively) and receives nothing if not determined eligible.

6. **DHHS require more financial information from facilities and create an aggregate non-identified financial picture of the industry.** Facilities provide a

balance sheet and income statement (as required by Medicare). “Vital signs” data including measures of financial condition (liquidity, debt, capital structure, including age of facility), provider subsidies and state shortfalls for direct care and routine cost funding, unreturned health care provider tax, charity care, bad debt, investment earnings, donations, and any other federal or state funding. DHHS would aggregate the data (and de-identify) into a publicly accessible financial picture of the industry to assist in public policy decisions for legislators, DHHS and the industry.

7. **Restore crossover payments to NFs for QMBs.** Cuts were made in the 2014-15 biennial budget (PL 2013, c. 368) without knowing the impact on nursing facilities. Co-pay is \$152 per day for day 21-100 of a Medicare Part A stay so Medicare rate is reduced by \$152 per day without MaineCare making the crossover payment. The co-pay can start as early as 7 days for Medicare Part C covered stays and can be 40%. 3-7 days without a co-pay wipes out up to 3 weeks of Medicare margin (attached). During a Part A stay, any co-pay from the resident is billed by Medicare directly to MaineCare as a crossover billing. Prior to 2014, paid routinely but last year, eliminated certain crossover payments for certain income levels of QMBs. Loss on Medicare must be made up by private payers. (Legal opinion was that it was legal as long as Medicaid rate was lower than 80% of allowed Medicare rate for the same service and it is included in the state plan.)
8. **Eliminate the occupancy penalty and allow 10% of a facility’s beds to be banked.** Facilities incur penalties for occupancy rates below 90% or below 85% for 60 beds or less. Fixed costs do not change if a facility is not at 85% or 90% occupancy. Rural facilities may struggle because a particular area is in decline and occupancy penalties add to the struggle. Bed-banking provides flexibility for providers (e.g. to make room for MDS or for neighborhood concepts).
9. **Continuing education of direct care staff be included in direct care costs.** Currently, all continuing education is included under routine costs regardless of whether the employee is included under direct care or routine.
10. **Increase personal needs allowance.** MaineCare-qualified residents keep \$60 a month for personal needs; the \$40 a month amount has not been increased for at least 30 years. Used for cable, telephone, clothing, newspapers, grooming. (Amount of personal needs allowance does not impact the facility.)
11. **Overall state seed including the health care provider tax and General Fund contributions should remain consistent over time.** The health care provider tax should not be used to supplant General Funds. DHHS should provide a history of the combination of health care provider tax collection and general fund contributions.