Reimbursement Subcommittee of
Commission to Continue the Study of Long-term Care Facilities

Non-fiscal note changes to Reimbursement Rules:

A. Financial Data and Cost Reports: How many times did we (first Commission) or legislators ask for information critical to understanding the financial health of our industry and come up short? We need better information than we collect to assess and make recommendations related to funding. Making a case for funding on the basis of how much we think we need fails those of whom we ask and those who think we are overpaid. Making a case for funding based on fundamental measures of financial condition allows us to set funding to reasonable benchmarks that are easier to quantify and defend.

I. **At a Minimum:**
   - Require GAAP balance sheet as required by Medicare
   - Require GAAP income statement as required by Medicare

II. **Require a "Vital Signs" page** on the Cost Report based largely on two new forms above:

"Vital Signs" page would be derived from data supplied exclusively from MaineCare cost report and provide legislators, DHHS and industry with key financial data not currently used in funding decisions:

- Liquidity measures used by lendors/investors:
  - Current Ratio (current assets/current liabilities)
  - Acid test (liquid assets/current liabilities)
  - Days Cash on Hand (ability to cash flow operations)
- Debt measures used by lenders/investors to assess capacity
  - Debt Ratio and Debt to Equity Ratio
  - Debt Service Coverage Ratio (loan covenants require minimum DSCR)
  - Capitalization Ratio (use of leverage/quality of investment)
- Operating measures
  - Net Operating Margin
  - ROI
- Capital Structure
  - Age of Facility (Accum Depr divided by Depr Exp)
  - Capital Capacity (capacity to fund plant improvements, lower age)
- Provider Subsidy
  - State Subsidy by Provider
    - Direct Care funding shortfall
    - Routine Cost funding shortfall
    - HCPT (unreturned)
    - Total provider subsidy of state
  - Other Subsidies
    - Charity Care
    - Bad Debts
    - Investment Earnings
    - Donations/gifts
    - Other state and Federal subsidies/funding
- Add RUG days as in Medicare cost report to capture acuity related to costs

Reimbursement Subcommittee of
Commission to Continue the Study of Long-term Care Facilities

Non-fiscal note changes to Reimbursement Rules:

B. Audits, Cost Settlements, Appeals, Payments: In the first Commission it was discovered that the current reimbursement rules allow the state to let filed cost reports sit unaudited as a means of not paying over $8 million due providers spanning over three years. While some rules exist that require DHHS to act, the rules don't always provide for various situations that commonly come up nor are there consequences for failure of an Agency to act. This can cause a provider to incur significant working capital costs which are not reimbursable as well as significant consulting/legal fees to force the state to comply with the law.

There are also some things we could do to improve the audit process for provider and auditor as well.

- **Allow Cost reports** prepared by independent CPA firm who also provided an audit of the provider's financial statements (as required by bonding authorities, trustee banks, lenders) to submit to a lesser audit standard as much of that work has already been done and doing it again requires more consulting fees which are not reimbursed
    - No need to audit paid bills; payroll records (941 forms); cash reconciliations, ect. if already done

- **Audit Settlement and appeal timeframes**: Require audits to be deemed complete as filed when filed; establish a 90 day audit review from date of filed report (vs 180 days); establish 30 day window for DHHS response to appeals; establish 30 window for payment of all uncontested items; establish settlement be as filed for any agency failure to act.

- **Require DHHS to pay** all consulting, legal fees and market rate interest expense (for extending credit to the state while they fail to do their job) for any legal action brought for failure of an agency to act (not to be added to Routine or Fixed Costs but paid as separate line on settlement)

C. Cost of Care management: MaineCare patient days annually approach 950,000 which translates into about 32,000 months and each month requires processing a cost of care obligation of the resident. The average cost of care could range from $600-$1,200 per month. Providers chase this, chase the state when the obligation is not accurate or changes and state has shown itself to be poor at managing this middleman structure. If the cost of care were just $500 per month, that would be over $16 million. The state leaves millions on the table chasing duplicate payments, pays outside consultants to chase providers and could eliminate that cost by requiring cost of care directly from resident. Would also place fraudulent attempts to avoid cost of care directly in front of the agency which qualifies the resident

How does the current system fail labor?

The greatest two failures of the existing system are:

1. Its failure to relate resident acuity to the labor costs unique to the service delivery model or the community within which that resident is located and
2. Its design is so ambiguous, complicated and unapproachable that it obscures our funding issues from providers, legislators and policy makers, making it impossible to advocate for change.

Inadequate funding of labor forces providers to minimize all staffing (not just Direct Care but also support services staff) and to use capital reimbursement intended for facility investment to support labor costs. Unless we change the system to be responsive to existing labor needs of the industry, we'll be unable to make the case for funding in the future that will be needed as our NF population grows and unable to maintain a labor force required for our resident population.

The existing system requires a high acuity high admissions provider in a high labor market to operate at the cost structure of an entirely different service delivery model with an inherently much lower cost structure. It is designed to leverage the non-MaineCare revenues of a narrow group of providers rather than to capture actual costs of care and relate the actual cost of care to resident need or to even allocate funds according to resident need.

To truly appreciate how poorly designed our existing system is, we could have had $30 million appropriated by LD 1776 and the rate setting process could still not get all those funds to many providers. Try taking the rate setting spreadsheet and fitting $30 million into it using the existing Peer Grouping model – it won't work. If we want that level of funding we have to change the system and it will require legislation to do it.

Changes to make to current system:

- Stop the reliance on Medicare and Private Pay revenues and HCPT to work
- DROP current rate setting system and develop rates for RUG system based on actual allowable costs specific to the provider and cap rates uniformly across all providers to relate cost of labor specific to acuity and labor markets in communities where care was provided
- Design to meet competitive labor market demands
- Design to advance staff education and make attractive to labor market
- Relate system to Medicare quality ranking system and acuity
- Separate out fixed costs to ensure capital cash flow
- Rate structure needs to provide a floor related to financial benchmarks
- Provide investment and quality incentives to reward committed providers