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NURSING HOME STAFFING REQUIREMENTS

House Bill 4362 (Substitute H-1)
Sponsor: Rep. Hubert Price Jr.

House Bill 5827 (Substitute H-1)
Sponsor: Rep. Janet Kukuk

Committee: Senior Health, Security and Retirement
First Analysis (5-30-00)

THE APPARENT PROBLEM:

Minimum staffing ratios for nursing homes have remained unchanged for decades, resulting in staffing shortages in many homes. Staff shortages translate into a poorer quality of care for nursing home residents. The result often is that residents may go unfed, teeth may not be brushed, soiled clothing and bedding may go unchanged, and patients may be left in one position so long that life-threatening bed sores develop. Reportedly, horrendous living conditions can be found in about 10 to 15 percent of the state's approximately 430 nursing homes. Apparently, complaints against nursing homes have been increasing over the last few years. The majority of complaints by patients, their families, and nursing home staff have identified short staffing as contributing to the poor delivery of care, with the primary complaints centering around inadequate pressure sore treatment and inadequate food preparation and distribution.

Such problems are usually attributable in part to under staffing; continually working in conditions with inadequate staffing puts a tremendous burden on even the most caring of nursing home workers. In addition, many homes have changed from the traditional care provided by nursing homes to providing more short-term care with a focus on rehabilitation, and so current laws are a poor fit. In response to pressure by advocacy groups and industry members, legislation has been introduced to modify and increase the minimum staffing level for nursing homes.

THE CONTENT OF THE BILLS:

House Bill 4362 and House Bill 5827 would amend the Public Health Code (MCL 333.21720a and 333.21720c, respectively) to increase the required patient to nursing care personnel ratio for nursing homes, and to allow the use of unlicensed nursing personnel to meet those ratios. Further, the bill would specify that money received by the state as a result of lawsuits brought by several states against the tobacco industry (*Kelley ex rel. Michigan* v *Philip Morris Incorporated, et al.*, Docket no. 96-84281CZ) would be used to pay the costs of increased Medicaid reimbursements to nursing homes whose costs increased due to the bill's increased staffing requirements. House Bill 4362 and House Bill 5827 are tie-barred to each other. Together, the bills would do the following:

Currently, a licensed nursing home must have at least one licensed nurse on duty at all times and must employ additional registered nurses and licensed practical nurses to maintain a patient to nursing care personnel ratio of not more than eight to one for morning shifts, not more than twelve to one for afternoon shifts, and not more than fifteen to one for nighttime shifts. In addition, a nursing home must maintain a nursing home staff sufficient to provide not less than 2.25 hours of nursing care by employed nursing care personnel per patient per day.

The bill, by comparison, would establish a staff-to-patient ratio that would require at least 3.0 hours of direct patient care by a direct patient care provider. The ratio would be computed on a 24-hour basis so that at no time could the ratio fall below one direct patient care provider to 15 nursing home residents. A "direct patient care provider" would be a registered professional nurse (RN) or a licensed practical nurse (LPN) whose primary function was as a nurse, or a competency-evaluated nurse assistant (CENA). The term would exclude the director of nursing, a quality assurance nurse, the staff development nurse, a

physical therapist, a certified speech and language therapist, an occupational therapist, an activities director or activities staff, and an individual employed by a resident or his or her family to provide care only for that resident.

Direct Patient Care. The bill would specify that direct patient care would mean one or more of the following activities or services provided by a direct patient care provider:

*Personal care, such as bathing, skin care, routine mouth care, hair and nail care, shaving, dressing, and other matters of personal hygiene.

*Nutrition, including measuring and recording a patient's food intake, and assisting a patient in fluid intake and eating.

*Elimination, including preventing incontinence, catheter care, measuring and recording bladder output, and so on.

*Restoration and rehabilitation, including turning a patient; range of motion exercises; assistance and encouragement with ambulation, walking, and transferring from location to location or position to position; and the use of wheelchairs, walkers, canes, and crutches; and so on.

*Feeding and clothing patients and making and changing beds.

*Administration of medications and treatments.

*Other activities or services performed with or for the care provider's assigned patient to enhance that patient's quality of life.

Staff-to-patient ratios. Between October 1, 2000 and April 1, 2001, the required per-patient-per-day ratio of direct patient care would be 2.75 hours, increased from the current 2.25 hours. The required ratio would increase again to 2.85 hours between April 2, 2001 and October 1, 2001, and then increase again to 3.0 hours after October 1, 2001. Duties other than direct patient care performed by a direct patient care provider could not be counted for the ratio, but time spent in documenting a provider's care for a patient could be used in the computation. A direct patient care provider could not perform duties such as food preparation, housekeeping, laundry, or maintenance (except in an emergency, at which time the hours spent in these activities could be used to compute the ratio). Also in the case of an emergency, a non-patient care employee could provide patient care, as could RNs and LPNs who primarily perform administrative duties. A nursing home could not use a non-direct patient care provider in computing the ratio, but could use such a person to provide some types of patient care services in the home as long as he or she had received proper training in that service. An aide who had completed the necessary training to become a CENA, but had not yet taken the test, could be used to satisfy the staff-to-patient ratio and the hours-per-patient-per-day ratio, but not for longer than 120 days.

Funding. If the nursing home's costs of operation were increased in order to comply with the new staffing ratios, the home could advise the Department of Consumer and Industry Services in writing of the increased costs and request a reimbursement. The department would have to immediately adjust the home's Medicaid reimbursement sufficient to cover the increased costs, using tobacco settlement revenue, regardless of previously applied cost limits. (Note: House Bill 5827 contains references to Title XVIII of the federal Social Security Act; apparently the reference should be to Title XIX. Title XVIII governs the Medicare program, while Title XIX governs Medicaid.) If the department did not adjust the Medicaid reimbursement rates, all of the following would occur:

*The home would be exempt from the new staffing ratios until the reimbursement rate was adjusted.

*The home would staff according to the staffing requirements in place before the bill's effective date.

*The home would have to return to the bill's staffing ratios within 30 days of being notified that the reimbursement rate would be adjusted.

If the department failed to increase the reimbursement within the 30-day time period, the department would have to file a written report with the House and Senate Appropriations Committees and appropriate subcommittees that included its reasons for not adjusting the home's reimbursement rate. The department would also have to determine if the home's operating costs were actually increased or not during its audit of the home's annual cost report. If the department determined that the home's costs were not increased, the department could retroactively disallow the increased costs claimed by the home. Such a retroactive disallowance would be considered an

"adverse action" as defined under administrative rules (R 400.3401), and would be subject to appeal.

A nursing home could also file a petition for temporary, emergency rate relief from either the new 15 to 1 staffing ratio, or the new 3.0 hours of direct patient care ratio, or both. The department could grant the home's petition if the home demonstrated that the new ratios had a substantial effect on the nursing home's operating costs. A decision on the petition would have to be issued within 90 days. If the petition were denied, the department would have to notify the home in writing of the reasons. A failure to rule on the petition within 90 days would constitute a granting of the petition.

A nursing home could appeal a denial for temporary, emergency relief. The department would also have to hold an informal hearing on the appeal. The department would have to issue a written decision of the appeal within 30 days of the hearing. A denial of an appeal would have the effect of creating an emergency under provisions in the federal Social Security Act.

A nursing home could appeal an adverse decision in response to an appeal to the circuit court for the county in which the home was located, or the circuit court for Ingham County. If the nursing home prevailed in court, the court could award the home compensatory damages for the cost of providing care to its residents during the petition and appeal process, and could also award court costs.

Legislative intent. The bill would state that the exemption was not intended to allow the department to reimburse a home at a rate lower than what was needed to maintain the new 3.0 hours of direct care per patient per day. Further, the bill would state that the intent was for the department to sufficiently increase the Medicaid reimbursement rate so that homes could meet the new staffing requirement.

Patient/family notification. A nursing home would have to post the name of the direct patient care provider assigned to a particular patient either in a conspicuous place near the nurse's station or outside the patient's door near the patient's name.

The bills would take effect July 1, 2000.

BACKGROUND INFORMATION:

House Bill 4362 and House Bill 5827 as a package are nearly identical to House Bill 4176, which was passed by the House in the 1997-1998 legislative session.

FISCAL IMPLICATIONS:

Fiscal information is not available.

ARGUMENTS:

For:

Nursing home staffing ratios have not kept up with the times. Ratios that worked for nursing homes forty years ago no longer fit today's nursing home population. Residents today are typically older and more infirm. Many residents are HIV positive, or have serious injuries that have left them mentally incapacitated. Basically, today's residents require a higher acuity of care and more direct care per patient than in the past. In addition, some nursing homes are beginning to specialize in providing skilled nursing to people recuperating from serious illness or injury. This population typically only needs nursing home care for six weeks or more, but the level of care is more intensive, with an emphasis on rehabilitative services.

Though many nursing homes currently staff above the minimum required by the Public Health Code, not all have kept up. The bills would not only raise the minimum direct care-per-patient-per-day ratio, but would also restructure the staff-to-patient ratio. Rather than the current requirement of having a minimum number of staff to patients for morning, afternoon, and night shifts, the bill instead would establish a 24-hour basis where at least one direct care provider would be available for every 15 patients. Members of the nursing home industry have praised this provision as providing more flexibility so that homes can ensure that sufficient staff is on duty to meet the needs of the residents. For example, more people may need to be scheduled for meal times, bath times, or times of the day when residents need to be transported to other departments for medical or rehabilitative services. During quiet times, such as at night, homes would still have to have at least one direct care provider per 15 patients as is currently required for night shifts. Yet, for some homes, the new requirements will result in the addition of new staff. To meet current requirements of

2.25 hours of direct care per patient, a home must have 28 workers for each 100 beds. To maintain the new 3.0 hours of direct care, a 100-bed home would need 37.5 workers. As direct care increases, so should the quality of care.

Response:

The bills allow nursing homes to remain at the current staffing ratios if the Department of Community Health does not increase Medicaid reimbursement for homes experiencing increased costs in response to meeting the new 3.0 hours of direct patient care per patient. Though the bill specifies that revenue from the tobacco settlement be used to fund the increased reimbursement levels, this does not represent a renewable revenue stream. The tobacco settlement money is finite, and much has already been designated to fund other programs. Unless a more permanent funding source can be identified or created, the provisions allowing homes to remain at current levels unless the department increases reimbursement rates should be removed. After all, the current average staffing level is 3.1 hours, with over 60 percent of homes maintaining 3.0 hours of direct patient care at the current Medicaid reimbursement rates. Furthermore, during committee testimony on House Bill 4176 during the 1997-1998 legislative session, the Department of Community Health reported that the nursing home industry had posted a profit margin of approximately $65 million for 1997. Around the same time, industry magazines had reported stories of increasing nursing home profits. It is time for the industry to reinvest its profits in wages for more employees, especially since some of that money comes from taxpayer funded Medicaid and Medicare programs.

Rebuttal:

Industry members disagreed with the $65 million profit figure, and pointed to the fact that the current administration ended the wage pass through reimbursement, where homes received 50 cents on the dollar for employee wages and benefits. This represented a loss of funding to the industry of about $60 million. In addition, Medicare changed to a new payment system for skilled nursing facilities on July 1, 1998, where payment for skilled care is now made according to the needs of the Medicare beneficiary. The impact that this new reimbursement scheme has had on nursing homes is unclear at this time. However, since it has been estimated by the industry that the bill's requirements will result in an increased cost of $25 million to implement, and since all but about a dozen of the state's 300-plus homes are not-for-profit, nursing homes need to know that increased funding will there for those homes unable to handle the cost of meeting the new requirements.

For:

The bills will allow documentation of care given by direct care workers to be counted in the 3.0 hours of direct care. This will encourage workers to take the time to record such things as the fluid intake of a patient, which can then be checked against the fluids voided by the same patient, or how much food a patient ate at dinner, which provides necessary information in monitoring the medical condition of a patient.

Response:

This type of quick documentation definitely can provide information necessary for the charge nurse to monitor and direct a patient's care, but some are interpreting this provision, and one that provides for other activities or services to also be counted in the computation of the 3.0 hours (as long as the service enhances the patient's quality of life), as including the time that the RN or LPN spends in doing patient charts. If this charting time is allowed to be used in the computation, any gains by increasing the hours to 3.0 could be lost or greatly reduced, as charting can represent a significant portion of the nurse's shift and is spent off the floor.

Rebuttal:

If anything, not enough time for charting is provided for nurses. Yet, detailed records of the care provided and information about the patient are instrumental for the nurse to be able to properly direct the care for a patient by the CENAs and other staff. The quality and accuracy of the charts and nursing plan have a direct bearing on the quality of care provided, and anything that would encourage more detailed records of a patient's care and condition should be encouraged.

Against:

Increases in staffing will not necessarily cure the problems of abuse and neglect of patients in some nursing homes that have been widely reported in news accounts. Besides, the majority of homes already exceed the 3.0 hours of direct patient care, and so would be unaffected by the bills. It is important to note that the 3.0 hour level is a minimum, and depending upon the particular needs of a nursing home's residents, 3.0 hours of direct care per person may not be enough to provide adequate care to a population needing a higher acuity of care. In fact, of the fifteen nursing homes considered to be the worst in the state in 1998, eight staffed above the 3.0 level. Increased staff does not necessarily equal increased quality of care. With a turnover rate of 65 percent (100 percent turnover

within a two-year period), the problem lies more with the inability of homes to retain trained staff. The wages for CENAs, who provide most of the unskilled labor, is typically not much higher than minimum wage. The work is too demanding for low wages and poor benefits. Nursing homes need to reinvest more of their profit margins in wages for employees.

Further, cases of abuse and neglect can often be attributed to poor administration by the nursing personnel in charge. The nurse in charge needs to be aware of whether her or his staff is out on the floor taking care of patients, or retreating to the break room. Even if all necessary functions are fulfilled such as bathing, feeding, and so on, many patients, especially those with no family members, would love to have someone to talk to. The quality of care in many homes could be improved with better administrative oversight.

Response:
The legislation is not seen as a cure-all, but is an important first step in addressing the problem of under staffing in nursing homes. Nursing home residents deserve the improvements these bills would supply.

Against:
The bills raise a number of questions. For example, the emergency rate relief section of House Bill 5827 creates an unknown liability for the department. A court could award compensatory damages and court costs to a nursing home regardless of whether it participates in the Medicaid program. Further, a home could appeal a denial of a petition for temporary, emergency rate relief, but if the department denies the petition for an appeal, the denial would automatically create an emergency under federal Social Security Laws, and the home could bring a suit in circuit court against the department. In effect, the department could be forced to reimburse a home at a higher rate regardless of whether there is merit in the petition.

Response:
The nursing homes must have some legal recourse to ensure adequate funding to meet the new staffing requirements; otherwise, they will continue to be hostage to the department withholding increased funding.

Against:
Several provisions of the bills remain problematic and inconsistent. For example, some feel that the listing of specific tasks in defining direct patient care may become outdated quickly and borders on micro management. Some feel that the bills need to be clearer in stating that nursing care provided by the CENAs is to be under the direction and supervision of the professional nurse. Posting the name of a patient's care giver outside the patient's door continues to promote an institutional "feel". The goal of improving patient and family communication with caregivers could be easily met by having the staff wear name badges and requiring the charge nurse to be available to identify care givers to those asking to speak to a patient's care giver. Though there have been repeated and longstanding attempts to amend this section of nursing home law, and though reform should not be delayed, there is a need to clear up inconsistent language and problematic provisions in this bill. The state's nursing home residents deserve no less.

POSITIONS:

The Michigan Association of Homes and Services for the Aging (MAHSA) indicated support for the bills. (5-25-00)

The Health Care Association of Michigan (HCAM) indicated support for the bills. (5-25-00)

Citizens for Better Care does not have a formal position on the bills. (5-26-00)

The Department of Community Health indicated opposition to the bills. (5-25-00)

Analyst: S. Stutzky

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.