

**COMMISSION TO STUDY DIFFICULT-TO-PLACE PATIENTS**

**MEETING AGENDA**

**Wednesday, December 2, at 10:00 am  
Room 216, Cross State Office Building, Augusta**

- 10:00 a.m. Welcome and introductions
- 10:05 a.m. Staff overview of draft Commission report, including recommendations requiring further review and discussion by Commission members
- 10:45 a.m. Commission discussion of draft report and recommendations
- 12:00 p.m. Break for lunch (1 hour)
- 1:00 p.m. Public comment opportunity
- 1:30 p.m. Continued Commission discussion on draft report and additional voting on Commission recommendations
- 2:25 p.m. Future meeting planning
- 2:30 p.m. Adjourn

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## DRAFT LEGISLATION

### **Resolve, To Establish the Commission To Continue the Study of Difficult-to-place Patients**

**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 Commission To Study Difficult-to-place Patients, established pursuant to Resolve 2015, chapter 44, reviewed and deliberated on numerous issues related to difficult-to-place patients with complex medical conditions and the feasibility of making policy changes to the long-term care system for those patients; and

**Whereas,** this resolve establishes the Commission To Continue the Study of Difficult-to-place Patients to address various complex, important and unresolved issues identified by the Commission to Study Difficult-to-place Patients; and

**Whereas,** immediate enactment of this resolve is necessary to provide the Commission to Continue the Study of Difficult-to-place Patients adequate time to complete 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 established. Resolved:** That, notwithstanding Joint Rule 353, the Commission To Continue the Study of Difficult-to-place Patients, referred to in this resolve as "the commission," is established; and be it further

**Sec. 2. Commission membership. Resolved:** That the commission consists of 13 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;
3. The Commissioner of Health and Human Services or the commissioner's designee;
4. Four members, appointed by the President of the Senate, who possess expertise in the subject matter of the study, as follows:
  - A. The director of the long-term care ombudsman program described under the Maine Revised Statutes, Title 22, section 5106, subsection 11-C;
  - B. An individual representing a statewide association of hospitals;
  - C. An individual representing a statewide organization advocating for people with mental illness; and

D. An individual or a family member of an individual with a complex medical condition; and

5. Three members, appointed by the Speaker of the House of Representatives, who possess expertise in the subject matter of the study, as follows:

A. An individual representing a statewide association of long-term care facilities;

B. An individual representing an organization that represents people with disabilities; and

C. An individual representing an organization promoting independent living for individuals with disabilities; 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. Any subcommittees established by the chairs 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 placing individuals with complex medical conditions in long-term care placements, individuals who provide long-term care to individuals with complex medical conditions, individuals affected by neurodegenerative diseases and individuals affected by mental illness; 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 and after adjournment of the Second Regular Session of the 127th 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; 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 for patients with complex medical conditions:

1. Identification of medical staffing needs in the State and the barriers to and, with input from the Department of Labor, solutions for increasing the availability of trained staff across the spectrum of care, including, with input from the Department of Health and Human Services and the Board of Nursing, an examination of the feasibility of implementing in-house staff certification programs, such as a certified nursing assistant training program, by licensed medical facilities;

2. Determination of existing capacity and demand for additional capacity in appendix C PNMI facilities in the State and options to expand or reconfigure the State's appendix C PNMI system to better meet identified demands;

3. Examination of the feasibility of implementing a presumptive eligibility option whereby a medical facility would be authorized to presume a patient's eligibility for MaineCare and receive

reimbursement for the patient's eligible care costs prior to final approval of eligibility by the Department of Health and Human Services;

4. With input from the Department of Health and Human Services, identification of efficiencies that can be implemented to expedite the MaineCare application process, and consideration of methods of prioritizing MaineCare application processing for hospitalized individuals eligible for discharge, but who are awaiting placement at an appropriate facility with available capacity;

5. Review of options for amending the MaineCare application process to better address financial exploitation of an applicant by a family member or relative of the applicant;

6. Examination of methods of expediting the Department of Health and Human Services' placement process for open geropsychiatric beds, including a review of the application of the Preadmission Screening and Resident Review process within the placement process and the application of the geropsychiatric placement criterion that a patient have a long history of mental illness;

7. Determination of existing need for medical facility "step-down" options for geropsychiatric and other patients who no longer require the level or type of care they are receiving at a specialized facility, as well as addressing issues relating to geropsychiatric patients that develop dementia, expansion of residential care options at facilities that offer geropsychiatric services and a discussion of applicable assessment criteria for admission and discharge at geropsychiatric facilities; and

8. Any other issue identified by the commission; 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 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 15, 2016, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the joint standing committee of the Legislature having jurisdiction over health and human services matters.

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

## SUMMARY

This resolve establishes the Commission to Continue the Study of Difficult-to-place Patients, which is charged with studying the following issues and the feasibility of making policy changes to the long-term care system for patients with complex medical conditions:

1. Identification of medical staffing needs in the State and the barriers to and, with input from the Department of Labor, solutions for increasing the availability of trained staff across the spectrum of care, including, with input from the Department of Health and Human Services and the Board of Nursing, an examination of the feasibility of implementing in-house staff certification programs, such as a certified nursing assistant training program, by licensed medical facilities;

2. Determination of existing capacity and demand for additional capacity in appendix C PNMI facilities in the State and options to expand or reconfigure the State's appendix C PNMI system to better meet identified demands;

3. Examination of the feasibility of implementing a presumptive eligibility option whereby a medical facility would be authorized to presume a patient's eligibility for MaineCare and receive reimbursement for the patient's eligible care costs prior to final approval of eligibility by the Department of Health and Human Services;

4. With input from the Department of Health and Human Services, identification of efficiencies that can be implemented to expedite the MaineCare application process, and consideration of methods of prioritizing MaineCare application processing for hospitalized individuals eligible for discharge, but who are awaiting placement at an appropriate facility with available capacity;

5. Review of options for amending the MaineCare application process to better address financial exploitation of an applicant by a family member or relative of the applicant;

6. Examination of methods of expediting the Department of Health and Human Services' placement process for open geropsychiatric beds, including a review of the application of the Preadmission Screening and Resident Review process within the placement process and the application of the geropsychiatric placement criterion that a patient have a long history of mental illness;

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8. Any other issue identified by the commission.

No later than December 15, 2016, the Commission shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the joint standing committee of the Legislature having jurisdiction over health and human services matters.



**STATE OF MAINE  
127th LEGISLATURE  
FIRST REGULAR SESSION**

**Commission to Study Difficult-to-Place Patients**

**December 2015**

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Brenda C. Gallant  
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## Executive Summary

The Commission to Study Difficult-to-place Patients (hereinafter “the Commission”) was created in 2015 by the 127th Legislature to address the challenge of ensuring the availability of appropriate treatment options in the State for patients with complex medical conditions and the feasibility of making policy changes to the long-term care system for those patients.

The Commission was established by Resolve 2015, chapter 44 (see Appendix A) and was composed of two members of the Senate, three members of the House of Representatives and nine public members.<sup>1</sup> A list of Commission members is included as Appendix B. The Commission’s duties are set forth in the enacting legislation and include the following:

- Identification of categories of patients with complex medical and mental health conditions unable to be discharged from hospitals because no facilities or providers are able to care for them or accept them for care;
- Determination of how these patients are placed currently and identify primary barriers to placement of these patients;
- Review of the facilities in which these patients are currently placed, including the location of these facilities and the facility costs associated with these patients’ care;
- Identification of options for increasing availability of residential and long-term care facilities for specialized populations that are difficult to place for care, such as ventilator-dependent patients, geropsychiatric patients and bariatric patients; and
- Determination of rates of reimbursement necessary to operate facilities to manage patients with complex medical conditions.

The Commission held five public meetings in Augusta on October 26, November 5, November 20, December 2 and December 7. All meetings were open to the public and were broadcast by audio transmission over the Internet. Although this report contains several appendices, additional resources and background materials, including materials submitted by Commission members or presenters, are available at:

<http://legislature.maine.gov/legis/opla/difficulttoplacepatients.htm>.

Due to the broad nature of the Commission’s duties, as set forth in the enacting legislation, the Commission relied upon the guidance and expertise of its members, as well as representatives of executive branch agencies and other individuals and organizations who participated in and provided valuable information and insight at the Commission’s meetings. Section III of this report provides an overview of the Commission process, including a description of the participants in and information provided at each Commission meeting.

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<sup>1</sup> Michael Lemieux was appointed to the Commission by the Governor to represent an individual or a family member of an individual with a complex medical condition, but later resigned his seat on the Commission. No replacement was appointed in his place.

The Commission's final recommendations include proposals for immediate legislative action during the Second Regular Session of the 127th Legislature, as well as proposals to be addressed in the future through the establishment of a Commission to Continue the Study of Difficult-to-place Patients (see Appendix TBD). Specific recommendations, including the votes in favor of each recommendation, are as follows:

**A. Pay hospitals a “days awaiting placement” rate**

Throughout its meetings, the Commission heard testimony on the issue of hospitalized patients who meet all medical criteria for discharge, but remain hospitalized due to the lack of an appropriate or available placement to which the patient can be discharged. Once discharge criteria are met, hospitals are no longer able to receive any reimbursement for medical care provided to the patient despite the patient having to be cared for by the hospital in the manner of a nursing facility (or specialized nursing facility). Under the current MaineCare manual, critical access hospitals are paid a “days awaiting placement” rate under the same circumstances.

The Commission's recommendation on this matter is to implement a “days awaiting placement” reimbursement rate for PPS hospitals for patients awaiting discharge after meeting applicable discharge criteria. The rate would be the same that is currently paid to critical access hospitals under the MaineCare manual, which is the statewide average nursing facility rate (currently just under \$200 per day). For the fiscal year in which this new rate is first implemented, total reimbursements to all eligible hospitals would be capped at \$1,000,000/\$500,000.

See Appendix TBD for legislation.

**B. Expand Long-term Care Ombudsman program**

Testimony received by the Commission indicated that the Long-term Care Ombudsman program provides invaluable assistance to patients, families and providers in facilitating the successful and appropriate placement of patients with complex medical conditions. The Ombudsman expressed an interest in expanding the program's provision of these services, but indicated that additional staff would be necessary to accomplish this.

The Commission's recommendation on this matter is to provide funding adequate to support two additional full-time equivalent (FTE) staff to the Ombudsman program to provide assistance in placement of patients with complex medical conditions, including assistance to facilities post-placement. The program's statutory authority would be expanded to reflect these changes.

See Appendix TBD for legislation.

**C. Expand resources provided by Maine DHHS**

Testimony received by the Commission indicated that the nurse education consultant position at DHHS is an important resource for many facilities in the State. This individual, who is a trained nurse, visits facilities to assess patients and meets with staff to consult on and make recommendations for patient care as well as to assist in medication changes.

The Commission's recommendation on this matter is to provide funding adequate to support one additional FTE nurse education consultant position at DHHS.

Another related proposal concerns the demand for and lack of behavioral health support at long-term care facilities. To address these demands, the Commission recommends that DHHS fund long-term care contracts for behavioral health support at long-term care facilities for care plan consults, treatment and staff education.

See Appendix TBD for legislation.

#### **D. Expand community placement options**

Testimony indicated that a major barrier to community placement of patients with complex (and non-complex) medical conditions is lack of staffing support, both in terms of staff training and staff availability. State reimbursement for home care services is currently a low, flat rate that does not account for the needs of the patient.

The Commission's recommendation on this matter is to implement an enhanced reimbursement rate for home care services that accounts for the needs of the patient.

See Appendix TBD for legislation.

#### **E. Facilitate reporting of data regarding facility refusal of placement**

When a patient with complex medical conditions is refused placement at a facility, that facility's basis for refusing placement is often not communicated to the patient, the patient's provider or the State. The reasons a facility may refuse placement of such a patient may relate to a lack of an available bed, but could also relate to a lack of appropriate staffing, specialized equipment or other resources. An understanding of these reasons for refusal of placement is critical to removing barriers to placement for patients with complex medical conditions.

The Commission's recommendation on this matter is to....

See Appendix TBD for legislation.

#### **F. Increase prosecution of financial exploitation cases**

A MaineCare eligibility determination involves a DHHS review of an applicant's financial assets. In most situations where an applicant's family members or relatives have improperly taken that applicant's assets prior to the filing of the application, the applicant will be denied for failing to meet MaineCare's asset limits. This financial exploitation by family members or relatives can often be prosecuted as elder abuse; however, for a number of reasons, these cases are often not prosecuted.

The Commission's recommendation on this matter is to....

See Appendix TBD for legislation.

### **G. Provide authority for expansion of geropsychiatric facility capacity**

At present, there are only 3 facilities in Maine that specialize in the care of geropsychiatric patients. Hawthorne House in Freeport and Gorham House in Gorham provide geropsych services in a nursing facility setting, while Mount Saint Joseph in Waterville provides those services in a PNMI setting. In total at these 3 facilities, there are between 50 and 55 geropsych beds. Testimony before the Commission indicated that these beds are in high demand and rarely vacant, indicating an immediate need for additional capacity.

Under the existing Certificate of Need (CON) statutory provisions, CON unit approval from DHHS is required for new nursing facility services including expansion of capacity, relocation of beds from one nursing facility to another, replacement nursing facilities, changes in ownership and control of nursing facilities, and building modifications and capital expenditures by nursing facilities. Criteria for the CON application are established in 22 MRSA §335 as well as in the Department's applicable rules. The CON process and criteria focus only on the need in the area where the beds were previously located. In order to increase the overall number of beds, the nursing facility MaineCare funding pool would have to be increased.

As such, the Commission's recommendation on this matter is to exempt from the CON statutory requirements and, where applicable, budget neutrality cap provisions the creation of additional nursing facility or PNMI facility capacity for geropsych patients, with a maximum total capacity increase of 25 beds.

See Appendix TBD for legislation.

### **H. Development of temporary guardianship process**

During its review of the factors contributing to the extended hospitalization of medically complex patients, the Commission recognized that DHHS's APS/public guardianship processes can often result in long delays in the appropriate placement of a hospitalized patient. Lisa Harvey-McPherson (EMHS) suggested that, in addition to reviewing these processes to remove unnecessary aspects that do not add value to the patient and unnecessarily extend the patient's hospitalization, the Commission consider supporting the development of a temporary guardianship status to facilitate hospital discharge while permanent guardianship is completed.

Because a resolution of these questions and proposals require input from both DHHS and the State's judiciary, the Commission's recommendation on this matter is to recommend to DHHS that it engage in discussions with representatives from hospitals and the judiciary to identify options for improving the efficiency of the APS/public guardianship process and to evaluate the feasibility of implementing a temporary guardianship process.

See Appendix TBD for letter to DHHS.

## **I. Establishment of Commission to Continue the Study of Difficult-to-place Patients**

In its work, the Commission identified a number of additional important issues relating to the placement of medically complex patients, but recognized that solutions to these particular problems would require additional study and consideration than the Commission could accomplish during its short existence. To solve these additional complex issues, input from various stakeholder groups will be necessary and the Commission recommends the continuation of its work by recommending the formation of a Commission to Continue the Study of Difficult-to-place Patients.

As set forth in the draft legislation contained in Appendix TBD, the issues and solutions to be considered by this new commission include the following:

- Identification of medical staffing needs in the State and the barriers to and, with input from the Department of Labor, solutions for increasing the availability of trained staff across the spectrum of care, including, with input from the Department of Health and Human Services and the Board of Nursing, an examination of the feasibility of implementing in-house staff certification programs, such as a certified nursing assistant training program, by licensed medical facilities;
- Determination of existing capacity and demand for additional capacity in appendix C PNMI facilities in the State and options to expand or reconfigure the State's appendix C PNMI system to better meet identified demands;
- Examination of the feasibility of implementing a presumptive eligibility option whereby a medical facility would be authorized to presume a patient's eligibility for MaineCare and receive reimbursement for the patient's eligible care costs prior to final approval of eligibility by the Department of Health and Human Services;
- With input from the Department of Health and Human Services, identification of efficiencies that can be implemented to expedite the MaineCare application process, and consideration of methods of prioritizing MaineCare application processing for hospitalized individuals eligible for discharge, but who are awaiting placement at an appropriate facility with available capacity;
- Review of options for amending the MaineCare application process to better address financial exploitation of an applicant by a family member or relative of the applicant;
- Examination of methods of expediting the Department of Health and Human Services' placement process for open geropsychiatric beds, including a review of the application of the Preadmission Screening and Resident Review process within the placement process and the application of the geropsychiatric placement criterion that a patient have a long history of mental illness; and
- Determination of existing need for medical facility "step-down" options for geropsychiatric and other patients who no longer require the level or type of care they are

receiving at a specialized facility, as well as addressing issues relating to geropsychiatric patients that develop dementia, expansion of residential care options at facilities that offer geropsychiatric services and a discussion of applicable assessment criteria for admission and discharge at geropsychiatric facilities.

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## **I. INTRODUCTION**

The Commission to Study Difficult-to-place Patients was created in 2015 by the 127th Legislature to address the challenge of ensuring the availability of appropriate treatment options in the State for patients with complex medical conditions and the feasibility of making policy changes to the long-term care system for those patients.

The Commission was established by Resolve 2015, chapter 44 (see Appendix A) and was composed of two members of the Senate, three members of the House of Representatives and nine public members. A list of the Commission members is included as Appendix B. The Commission held five public meetings in Augusta on October 26, November 5, November 20, December 2 and December 7. All meetings were open to the public and were broadcast by audio transmission over the Internet. Although this report contains several appendices, additional resources and background materials, including materials submitted by Commission members or presenters, are available at: <http://legislature.maine.gov/legis/opla/difficulttoplacepatients.htm>.

## **II. RESOLVE 2015, CHAPTER 44**

Resolve 2015, Chapter 44, titled Resolve, To Establish the Commission To Study Difficult-to-place Patients, was created as an amendment to LD 155, a concept draft bill introduced during the First Regular Session of the 127th Legislature by Representative Richard Malaby, with the original title, An Act To Expand Housing Opportunities for Patients with Complex Medical Conditions. In creating Resolve 2015, Chapter 44, the Joint Standing Committee on Health and Human Services (HHS Committee) combined the issues raised by LD 155 with those raised by LD 75 (Resolve, To Strengthen Health Care Services for Maine Residents Affected by Neurodegenerative Diseases) and LD 966 (An Act To Assist Patients in Need of Psychiatric Services). The HHS Committee voted “ought not to pass” on LD 75 and carried over LD 966 to the Second Regular Session of the 127th Legislature.

During the Second Regular Session, the HHS Committee may choose to amend LD 966 to include any proposed legislation relating to the Commission’s findings or recommendations. Alternatively, under Joint Rule 353(8), after receiving the Commission’s report, the HHS Committee may introduce a new bill to implement recommendations relating to the study.

The Commission’s duties, set forth in Resolve 2015, Chapter 44, include the following:

- Identification of categories of patients with complex medical and mental health conditions unable to be discharged from hospitals because no facilities or providers are able to care for them or accept them for care;
- Determination of how these patients are placed currently and identify primary barriers to placement of these patients;
- Review of the facilities in which these patients are currently placed, including the location of these facilities and the facility costs associated with these patients’ care;

- Identification of options for increasing availability of residential and long-term care facilities for specialized populations that are difficult to place for care, such as ventilator-dependent patients, geropsychiatric patients and bariatric patients; and
- Determination of rates of reimbursement necessary to operate facilities to manage patients with complex medical conditions.

### III. COMMISSION PROCESS

#### A. First meeting – October 26, 2015

The first meeting of the Commission was held on October 26. After calling the meeting to order and introducing the members, Chair Gattine provided some background on the legislative history of LD 155 and its background in the HHS Committee during the previous session. Commission staff provided a brief overview of Resolve 2015, chapter 44 – Resolve, To Establish the Commission To Study Difficult-to-place Patients. This resolve was created out of LD 155, a concept draft bill introduced by Representative Malaby, with the original title, An Act To Expand Housing Opportunities for Patients with Complex Medical Conditions. The HHS Committee combined the issues raised by LD 155 with those raised by LD 75 (Resolve, To Strengthen Health Care Services for Maine Residents Affected by Neurodegenerative Diseases) and LD 966 (An Act To Assist Patients in Need of Psychiatric Services). The HHS Committee voted “ought not to pass” on LD 75 and carried over LD 966 to the Second Regular Session of the 127th Legislature. Upon receiving the Commission’s recommendations, the HHS Committee may use LD 966 as a vehicle for adoption of any related proposed legislation or, under Joint Rule 353(8), may report out a new bill relating to the study recommendations.

Jeff Austin provided the Commission with a briefing on behalf of the Maine Hospital Association (MHA). Mr. Austin acknowledged the problems the Commission faces are complex and varied and may require a number of different solutions to fully address. Addressing the most pressing issue from the perspective of the state’s hospitals, he provided some recent statistics regarding patients eligible for discharge from hospitals who remain in the hospital primarily due to the lack of a facility to discharge that patient to with the care resources they require (lack of resources, lack of skilled staff, no existing facility in Maine, etc.) or the lack of availability at a facility that would otherwise meet the patient’s needs. Mr. Austin described a 2014 study conducted by MHA, which found that roughly 120 hospital patients were in this situation, with nearly 40 of them having waited more than 40 days for a discharge. He also recognized that once a hospital patient meets criteria for discharge, the hospital is no longer authorized to seek reimbursement for that patient’s care costs, but must absorb those costs while it seeks an appropriate or available discharge facility. Finally, Mr. Austin asked the Commission, in the interest of time, to focus on solutions to these issues, rather than documenting these problems.

Richard Erb provided the Commission with a briefing on behalf of the Maine Health Care Association. Addressing the three complex patient populations specified in the enabling legislation, Mr. Erb first discussed the issues relating to ventilator-dependent patients. He

acknowledged that the financial viability of treating these patients has been the primary issue in the past, as such patients require specialized, skilled staff, often 24 hours per day, as well as expensive, specialized equipment and private rooms. He estimated that only 2-3 ventilator-dependent patients are currently being treated in Maine nursing facilities, but believed that these services could be provided to more patients if the reimbursement rate for these patients was reasonable to meet treatment costs.

Turning to bariatric patients, Mr. Erb estimated that 5-10 bariatric patients are currently being treated in Maine nursing facilities. For the purposes of this population, he defined a bariatric patient as a patient weighing 350 lbs. or greater (or of a certain BMI) with an inability to ambulate. The primary impediment to treating this population is similar to that of the ventilator-dependent patients in that they require additional staff training or skilled staff, specialized equipment and even facility renovations (e.g., wider doorways, etc.), and private rooms. Mr. Erb also stated a concern over potential patients' rights violations related to facilities that encourage or assist bariatric patients in losing weight.

Finally addressing patients with complex behavioral issues (especially geropsychiatric patients), Mr. Erb stipulated that nursing facilities are not an ideal setting for treating these patients, as such facilities are open concept, house relatively frail patients, have no full time security, are not designed in a manner to confine patients and have a limited ability to prescribe sedation medications. Geropsychiatric patients typically require 1:1 staffing and can become physically violent, which is challenging to address in the nursing facility context. Other barriers noted by Mr. Erb include the issue that nursing facilities are prohibited from accepting residents they do not believe they can adequately care for, and that most nursing facilities in Maine are small and cannot deal with geropsychiatric patients as well as a larger facility might be able to. He noted three existing geropsychiatric nursing facilities in Maine (Gorham, Freeport, Waterville) and acknowledged that reimbursement rates for these patients continues to be an issue.

Brenda Gallant provided the Commission with a briefing in her capacity as the State Long-Term Care Ombudsman. She noted that in the last 6 months, her office has fielded 26 referrals relating to the placement of complex patients in long-term care facilities. She described a common problem she encountered of Maine patients being sent out-of-state for care and the strain this can put on families and relatives (financially, etc.). Addressing the new reimbursement rate process for ventilator care services, as previously described by Mr. Erb, Ms. Gallant suggested that these changes should allow for the development of new facilities or additional availability at existing facilities for ventilator-dependent patients. She acknowledged, however, that additional discussion of and work on reimbursement rates for these specialized populations will be necessary. Ms. Gallant also recommended the Commission look into expanding the role of and funding for certain assistive resources offered by DHHS, such as its nurse education consultant.

Peter Rice, appearing on behalf of Kim Moody and Disability Rights Maine, and Simonne Maline, representing Consumer Council System of Maine, gave a joint briefing to the Commission regarding patient rights and complex behavioral health patients. Mr. Rice provided the Commission with a copy of a Maine Human Rights Commission decision finding that a facility had improperly discharged a patient and refused to reaccept that patient in violation of state law (Maine Human Rights Act, etc.). Despite the favorable decision, Mr. Rice noted the

difficulties in resolving the situation and recommended the Commission look further into the ability of DHHS to enforce its regulatory standards against facilities that are found in violation of applicable laws or regulations as well as issues regarding contract compliance. Ms. Maline next provided the Commission with an overview of her background and experiences and the issues and barriers faced by patients with complex behavioral health conditions. She also reminded the Commission to endeavor to treat the patients they are discussing as unique individuals rather than broadly-described patient groups.

The Commission next opened up the floor for discussion amongst its members. Members first discussed expenses to hospitals for caring with patients eligible for discharge but for whom there was no facility to discharge to. Mr. Austin acknowledged this may be a significant cost, but since it is not reimbursed, it's not really tracked. He noted that it often includes a higher range of costs because of these patients' complex conditions and also because the hospital setting can only inefficiently, from a cost-perspective, provide the specialized treatment these patients need.

Discussion next turned to Medicaid eligibility for these groups of patients and how that contributes to the problems faced by hospitals or care facilities. Mr. Hamilton described the guardianship process, both from a public and private perspective, and noted the time and effort involved for the State in establishing public guardianship. He noted that even where family members of a patient have improperly taken that patient's assets, and the patient would otherwise be Medicaid ineligible, if the State completes the guardianship process, then a favorable Medicaid determination is possible. Mr. Hamilton also noted that Mainecare eligibility determinations in situations involving fraudulent taking of a patient's assets by family members is in large part directed by federal Medicaid regulations. He suggested that part of the problem is that these elder abuse and theft cases are not being adequately prosecuted by the State. Mr. Erb noted that while nursing facilities will regularly accept patients with Mainecare applications pending, no facility will accept a Mainecare ineligible patient without another payment source.

Negotiated reimbursement rates were discussed next. Mr. Erb described this process, which involves services that are not covered under the normal rate, with the negotiated rate based largely on the Resource Utilization Group or RUG score and the special equipment and staff needed to care for the patient. Mr. Austin noted the issue is often in a provider's lack of information regarding the negotiated rate DHHS might provide. He suggested certainty over reimbursement rates would help encourage more providers to make available services these complex patient populations require, and questioned whether the reimbursement rate process for ventilator services could be replicated for other populations, such as geropsychiatric patients.

Representative Malaby next described a RFI (Request for Information) currently under development by DHHS, which might be of interest to the Commission. According to Representative Malaby, this RFI would address reimbursement rates for geropsychiatric populations, medically-rare diseases and other populations of complex patients. The RFI is anticipated to be completed in November and put out shortly thereafter. The Commission asked Mr. Hamilton to provide whatever information on this RFI that he can share at the next meeting.

Additional requests for information were made of Mr. Hamilton at this time, including: more generalized information on negotiated rates; specific information on the reimbursement rate for

geropsychiatric patients, including the eligibility criteria and service level/scope of service expectations for the rate; the population size served by the rate, the geographic distribution of that population; and the “turnover rate” for patients at geropsychiatric facilities (i.e., on average, for how long do patients typically continue to receive specialized care at these facilities).

Senator Katz asked members whether these complex patient populations would be adequately served if an appropriate reimbursement rate was in place. Both Ms. Gallant, Mr. Erb and Ms. Maline answered affirmatively, generally noting that if the facilities can anticipate the rate, they can figure out staffing needs and other cost considerations. Mr. Erb noted, however, that the geropsychiatric population problem also involves having an appropriate treatment setting as the traditional nursing facility setting typically is not appropriate for treatment of these patients.

Representative Gattine reminded the Commission to consider options for assisting these patients in remaining in the community. Ms. Gallant noted that home care staffing is a major problem and, although the new rates are helping, reimbursement of associated costs, low salaries for workers and other barriers make home care challenging for these complex patients. Mr. Clarrage also recognized that accessibility is a problem too, whether that involves outfitting an existing residence for accessibility or construction of accessible housing. Mr. Rice reminded the Commission that another consideration is a patient’s ability to assert and enforce their rights.

Senator Katz posited that there will be small group of behavioral patients that will be very difficult to place regardless of the reimbursement rate. Ms. Gallant agreed, noting the only way to adequately address this population is by expanding the number of facilities, or existing facilities, that can adequately care for these patients. Mr. Erb recommended the Commission first determine exactly how many patients fall into this group, what the State’s current capacity is for caring for these patients, so that it can be determined how much additional capacity is needed. Senator Katz also raised the issue of inpatients at the State-run mental health hospitals who meet discharge criteria but cannot be discharged due to the lack of an appropriate facility or community placement. Mr. Hamilton agreed to provide some information on this question and Mr. Austin offered to provide similar information from privately-run mental health hospitals.

The Commission next opened up the floor for public comment. Jill Lufkin Robinson testified first on behalf of Home, Hope and Healing, a homecare company that specializes in the treatment of medically complex patients throughout Maine. She briefly noted the regulatory issues they had encountered in trying to develop cost-effective housing options to treat ventilator-dependent patients (“vent houses”). She also discussed the cost implications for the State in sending patients out-of-state for treatment. Commission members were intrigued by Ms. Robinson’s comments regarding the State’s payment of costs for treatment out-of-state of Maine residents and requested additional information on the matter.

John Gregoire testified on behalf of the Hope-JG Foundation, which has been working towards building a world class ALS/MS residence in Maine. Mr. Gregoire described the mission of his foundation and its plans for the future. He asked the Commission to ensure that Commission continues to consider the needs of patients with neurodegenerative diseases in its deliberations.

As a result of its discussions at the first meeting, the Commission requested the following information from the following entities:

- DHHS – information on negotiated rates; geropsychiatric rates, eligibility criteria and population served; reimbursements for out-of-state care of Maine residents; patients housed at State-run mental health hospitals; DHHS actions and authority in response to facility violations of patient rights; and RFI under development relating to geropsychiatric and other rates.
- Jeff Austin – information on patients housed at privately-run mental health hospitals.
- Richard Erb – information on provider wait lists for patients in need of these specialized care services.
- Brenda Gallant – information regarding the possible expansion of the services provided by the long-term care ombudsman.
- Commission staff – research if NCSL/other states have provided responses to similar issues; provide a link to the recent related study completed by New Hampshire.

The Commission determined that its second meeting would be held on Thursday, November 5, 2015 and adjourned for the day.

#### **B. Second meeting – November 5, 2015**

The second meeting of the Commission was held on November 5. After calling the meeting to order and introducing the members, the Commission received a panel presentation on the approval process for admission to the 3 geropsychiatric facilities in Maine, an explanation of the rate structure for these geropsychiatric units and a discussion of their operational capacity and turnover rates. The presenters on this panel were Richard Erb (Maine Health Care Association), Michelle Bellhumeur (Gorham House, Gorham) and Larry Davis (Hawthorne House, Freeport).

To open up the panel, Mr. Erb provided a brief overview of the State's 3 geropsychiatric facility units. He noted that these facilities are not always operating at full capacity, although he also recognized that there is a demand for more geropsych beds statewide. Mr. Erb explained that there is a set fee for geropsychiatric units that typically includes a private room differential (most nursing rooms are semi-private) and that these units usually receive reimbursement for their actual costs for services, provided they are determined to be reasonable. Mr. Erb, however, was not aware of any complaints from these facilities regarding the issue of payment for services.

Michelle Bellhumeur stated that Gorham House has 17 geropsych nursing facility beds. Patients at Gorham House are heavily monitored and generally treated successfully at the facility. This sometimes means that because a patient is doing so well, a GOOLD assessment may indicate they are ready to transfer to a traditional nursing home setting, which often does not work well because of the lack of support in those facilities for patients with mental illness. Ms. Bellhumeur noted that in order for a patient to receive placement at a geropsych facility, their psychiatric

diagnosis must be the primary diagnosis. If a reassessment is done and it demonstrates that a different diagnosis, such as dementia, has become the primary diagnosis, that patient typically must be transferred to a traditional nursing facility.

In follow-up by Commission members, the issue of the limited number of dementia beds in the State was discussed, and panelists agreed that the current number of dementia beds does not match the level of need from the increasing population of dementia patients in Maine. Panelists also raised their concerns that nurses and not licensed mental health clinicians (APRNs, PMH-NPs, etc.) are conducting these GOOLD assessments, and that their more limited knowledge of mental health issues and disorders affects the assessment, often to the detriment of geropsychiatric patients. Additionally, panelists questioned whether PNMI level 4 facilities need to be considered for providing geropsych services and whether the Preadmission Screening and Resident Review (PASRR) process can be amended to better focus on psychiatric behavior.

Larry Davis stated that Hawthorne House has 18 geropsychiatric beds and that the average length of stay at his facility is 4.25 years. He noted, however, that his facility has 3 residents who have been there more than 10 years, 4 residents that have been there between 5 and 10 years and 11 residents that have been there for less than 5 years. Mr. Davis also stated that Hawthorne House has discharged over 30 patients since 2008.

Ms. Bellhumeur noted that Gorham House has 2 empty beds at present and that they can go 6 months at times without filling an empty bed. Much of this delay, according to the panelists, is due to the complex nature of the placement/referral process conducted by DHHS. Because of the unique behavioral and other related issues that are present in mental health units like geropsych units, there is not as much of a cycle of movement in such units as there is in the traditional nursing facility context. Additionally, because of these patient concerns, PNMI and traditional nursing facilities are nervous to take residents from a geropsychiatric facility.

Panelists recognized that ensuring regular provision of behavioral health services can be challenging for geropsych facilities. Ms. Bellhumeur noted that Gorham House is fortunate to finally have a PA and psychiatrist to manage residents at their facility and that because of this, they no longer need to call the police as frequently to assist with physically violent patients. However, as a result, DHHS' utilization review (UR) nurse wants to discharge some residents because they are doing so well, which the facility believes is a result of how well their needs are managed, and not a result of any substantive change in the underlying diagnoses or patient needs. The panelists also explained that there is pressure on the UR nurse to discharge people from geropsychiatric facilities to free up beds for patients stuck in community hospitals.

Representative Stuckey stated that perhaps there is a need for a new facility or process that focuses more on mental health and dementia to find the safest residence for people. Brenda Gallant stated there are 16 residential care geropsych units at Mount Saint Joseph in Waterville and that it would be helpful to have more of these types of beds. Ms. Gallant asked panelists how long it takes to place a patient in a geropsych bed once a referral has been made to the UR nurse, to which they responded that it is a very different process than for referring to a traditional nursing facility bed. For placement in a geropsych bed, a LCSW performs an assessment, which requires documentation of long-term treatment for mental illness and behavioral problems, and a

GOOLD nursing level of assessment and then a referral is made to the facility for a referral review. The geropsych facility then meets the patient to assess their needs, determine if they will be a good fit for the facility and review Medicare or MaineCare eligibility. Once all this is completed – a process that can take a number of weeks or more – the patient can be placed.

Jeff Austin next raised the question as to how the State is able to determine the cost of adding new additional private, for-profit geropsych facilities, to which the panelists responded that this information is in the cost reports and would involve looking at the room differential (private rooms) and the reimbursement for actual costs. Kim Moody stated that the State has relied upon the 3 existing geropsych facilities to fill the need for decades and have not looked at enhancing specialized services for these patients in regular nursing facilities. In fact, it was noted that the number of geropsych beds in the State has remained unchanged over the last 20 years. Ms. Moody also recognized that even if the State opens up more geropsych beds, they still will find it challenging to secure the psychiatric services necessary to manage those populations.

Panelists next raised the issue that there is a population of nursing facility patients that might be better served in a geropsych unit, but who lack required documentation of a long history of mental illness, often because they never received any treatment despite the need. Representative Gattine suggested that because geropsych beds are a scarce resource in Maine, determining priority for placement into an open bed is the primary contributor to the lengthy referral process. Ms. Gallant recommended the Commission look into improving the referral process, starting with a review at DHHS from the top down. Ms. Moody believed the group should also consider improving specialized services for these patients in traditional nursing facilities.

Panelists also suggested the Commission address the need for mature, trained staff in geropsych facilities. Ms. Moody noted that staffing deficiencies are a problem across the board and recommended the Commission focus efforts with the Department of Labor to train people for community support jobs, which pay a good wage, and increase efforts for public/private partnerships in this area.

Mr. Erb next addressed PNMI capacity issues, noting that appendix C PNMI are generally fully occupied (90-95%), while MaineCare beds in such facilities are closer to 100% occupied and private pay rooms are almost never vacant. The reimbursement rate for these PNMI is nearly half of the nursing facility rate and their staff generally have less than a third of the training as those in geropsych facilities. As such, patients may not be best served by expansion of geropsych services in the appendix C PNMI context. Mr. Erb noted, however, that he was surprised to hear that Mount Saint Josephs has a successful geropsych PNMI unit and recommended further exploration of this option. The Commission requested that Mr. Erb determine the actual rate paid by the State to the 3 geropsych facilities to hold open a bed for a patient requiring hospitalization and for how long they are eligible to receive this rate.

Representative Gattine stated that perhaps some of these issues could be better addressed if the State provides increased support services, including psychiatric support, to better assist facilities with managing the challenges that arise with specific patient populations. Ms. Moody added that more work needs to be done to get the PNMI system to work better for Maine.

The Commission also received brief presentations from Jeff Austin and Brenda Gallant. Mr. Austin summarized a list of proposed recommendations and proposals for discussion that he had provided for the meeting. Ms. Gallant provided the Commission with a summary of the role of the Office of the Long-term Care Ombudsman. She described their outreach efforts with hospitals across the State and their efforts with the federal Homeward Bound program. Representative Gattine suggested that perhaps federal grant funds could be expanded under the Homeward Bound program to serve more people and requested that DHHS provide information on whether the State can request additional federal grant funds to support the program.

The Commission next opened up the floor to discussion. First, Mr. Austin provided additional information on his list of draft proposals. His first proposal addressed the need for hospitals to receive payment for days that a patient is awaiting placement to a long-term care facility. Hospitals care for these patients in a manner that is similar to a nursing facility and, per Mr. Austin's recommendation, should be paid a daily rate similar to that currently received by critical access hospitals. This rate will not cover a hospital's costs of care (e.g., staff salaries, use of bed/services, cost of services, etc.). MaineCare approval and geropsych placement processes are complex and lengthy and if these delays cannot be remedied, then hospitals should be provided with some form of reimbursement for these costs, as they are currently operating at a loss with these patients. Senator Haskell requested that Mr. Austin identify, if possible, what is being done in other states in regards to hospital reimbursement for these types of patients, while Representative Gattine asked for more specific information on this proposal (e.g., what specific rate would be paid, when would the rate kick in, would there be a cap, etc.).

Ms. Moody expressed concern that paying a daily rate to hospitals for these patients would reduce incentives for the hospitals or the State to get these patients placed in a proper facility. Mr. Austin responded that hospitals are paying on average a significant amount per day for patients awaiting placement and they are only proposing to receive \$100-200/day, so they would still be operating at a loss. As such the incentive would still be there for the hospitals. In terms of the State's incentive, he hoped that the existence of a new fiscal cost (i.e., the days awaiting placement reimbursement) would spur action by the State to address barriers to placement.

There was additional Commission discussion regarding the costs and benefits associated with the nurse education consultant position at DHHS and their role in performing patient assessment at hospitals and informing placement facilities of that individual's needs. A number of Commission members agreed this position helps facilitate the referral process to a proper facility.

Another proposal discussed by the Commission concerned the addition of staff to the Long-term Care Ombudsman's office. Commission members generally agreed that the Ombudsman's Office has done great work helping to place individual patients, which is time-intensive, and the Office could use more staff to expand assistance provided to patients in hospitals. Per Ms. Gallant's recommendation, changes to the statutory provisions governing the authority of the Ombudsman may be necessary. Commission members agreed to develop this proposal further.

The Commission next turned to capacity issues relating to geropsych facilities, noting that the number of these beds has not grown with demand and that there is a specific lack of these services in Northern Maine. Members agreed to further discuss the proposal to direct DHHS to issue a Request for Proposals (RFP) for the establishment of a geropsych unit in Northern Maine.

The fourth proposal addressed concerns raised by Disability Rights Maine (DRM) regarding contract compliance and enforcement issues. Commission members were interested in reviewing specific proposals and Ms. Moody, on behalf of DRM, stated that she would provide specific recommendations for the next meeting.

The fifth proposal addressed concerns raised with placements other complex patient populations, including ventilator-dependent and bariatric patients, and the lack of facilities that provide services necessary for these patients. The vent rate rules that allow for negotiated rates for facilities that serve these patients may be sufficient to address the need, but the question was raised as to cost neutrality for special populations and the need for additional geropsych beds to be MaineCare neutral.

The final proposals discussed by the Commission was whether hospitals should be able to waive the 60 mile rule (i.e., patient can refuse placement at facility greater than 60 miles from their residence) in the event that an appropriate facility greater than 60 miles away is available to take the patient, and whether facilities should be allowed to presumptively determine MaineCare eligibility for patients. Both proposals were flagged for future discussion.

The Commission next opened up the floor for public comment. Sheila Pechinski testified first regarding her own experiences caring for family members with Huntington's Disease (HD). She noted that there is a pilot program in New York for HD patients and that there are at least 150 HD patients in Maine who would be interested in similar care as there is at present no specific facility in Maine to treat these patients. Ms. Pechinski noted that the primary barrier to treating HD patients is staffing costs (need specialized skilled staff often around the clock).

Lisa Harvey-McPherson testified next on behalf of EMHS. She noted that retirement facilities in Maine are increasing their staffing and other services for specific patient populations, which is affecting nursing facility enrollment in Maine. Ms. Harvey-McPherson stated there is a need for increased home care services and increased skilled staff working in the field for specialty populations. She recognized that Northern Maine does not have sufficient facilities to meet the demand of specialized patient populations. Geropsych patients in particular need secure units and there are some that cannot be commingled in a long-term care setting. Ms. Harvey-McPherson noted the problems caused by delays in MaineCare application processing that must be addressed; on average, it currently takes DHHS 45 days to process a MaineCare application. She also stated that there needs to be a streamlined process to help people transition back into the community and there need to be more beds to incentivize this transition. To assist in addressing these many issues, she believes that we need more data to identify areas where the capacity for special patient populations is lacking. A State reporting requirement for nursing and long-term care facilities refusing placement of a patient would, in Ms. Harvey-McPherson's opinion, provide us with critical data on these issues. The Commission requested that she draft up her suggestions and proposals in a written document for consideration at the next meeting.

Lastly, the Commission heard testimony from Eric Pooler, who manages Southridge Rehabilitation in Biddeford. He noted that some of the biggest issues he faces are staff burn-out and the lack of mental health providers. In Mr. Pooler's opinion, he can presently work with the State in terms of reimbursement and costs. For example, he described caring for a bariatric patient recently, where he worked with DHHS to secure an adequate reimbursement rate and to provide the resources necessary to outfit the facility with appropriate equipment to address the patient's needs. Mr. Pooler also suggested the Commission look at the possibility of allowing a medical facility, under certain conditions, to offer medical certifications, such as for a certified nursing assistant (CNA), in-house to address staffing deficiencies and barriers to education.

As a result of its discussions at the second meeting, the Commission requested that Commission staff develop a spreadsheet with the proposed recommendations identified to date for consideration at the next meeting. In addition, a number of information requests were made of different parties, as described below.

Maine Health Care Association was asked to provide the following information:

- Can MHCA provide any information on the rates (i.e., what are the actual rates) that the 3 geropsych facilities are receiving from the State through SAMHS for holding open beds for geropsych patients beyond the 7 day federal limit when they decompensate and have to be hospitalized?
- What suggestions does MHCA have for expanding or improving/reconfiguring Appendix C PNMI facilities to better serve these patient populations (i.e., expanding capacity, staff training/availability/skill levels, etc.)?
- What is MHCA's position on the feasibility of implementing a presumptive eligibility standard/option, as described by Jeff Austin/MHA at the meeting (i.e., provider would have ability to presume Medicaid eligibility for a patient with later DHHS follow-up)? Is this a good idea; is it something that could work in Maine?
- What is MHCA's position on the proposal to implement a basic reporting requirement for facilities refusing patient placement (i.e., facility refusing placement of patient would be required to fill out and submit to DHHS a short form outlining reasons for refusal, such as lack of available bed, appropriate staff, necessary resources/equipment, etc.)?

Maine Hospital Association was asked to provide the following information:

- What additional specifics can you provide on the proposed "days awaiting placement" rate for hospital patients awaiting placement, including, what rate would the MHA consider appropriate for reimbursement (dollar figure?), when would the rate kick in; would there be a cap on the rate (# days, total reimbursement cap per patient) etc.?
- What approaches have other states taken in terms of reimbursement for this patient population (i.e., do other states reimburse hospitals in a similar fashion)?

DHHS was asked to provide the following information:

- At the second meeting, Commission members discussed the Department's process for referral of a patient to a geropsych facility. It is our understanding that a team of individuals at DHHS make decisions regarding whether a patient meets the criteria for placement and which patient meeting the criteria will ultimately be placed in an available bed (i.e., a discussion of "placement priority"). It was suggested that this process, from the time a bed at a geropsych facility becomes available, to the time a patient is placed, can often take a number of weeks, despite the fact there may be a number of patients who meet the criteria and would benefit from immediate placement. Could you outline for the Commission how this process is conducted at DHHS and what improvements, if any, could be made to facilitate quicker placement of patients?
- At the first meeting, it was suggested during public comment that when the State places a Mainecare patient for treatment out-of-state, the State is only obligated to reimburse that patient's care for the first two years of placement out-of-state and then no longer has a financial obligation. As you may recall, this assertion surprised most Commission members, and given that we have received no clarification from the individual who made the comment, can DHHS comment on whether or not this is an accurate description of the State's financial obligation to patients placed for care out-of-state?
- At the second meeting, members discussed the Homeward Bound program, specifically the federal grant monies made available to support the program in Maine. It was suggested that one possible recommendation the Commission might make would be to support the expansion of this program, perhaps with the assistance of the Long-term Care Ombudsman, to place more than the current program goal of 26 placements per year. Can the Department comment on the feasibility of expanding the Homeward Bound program in Maine, specifically addressing the possibility of securing additional federal grant monies to support this expansion?
- At the second meeting, there was additional discussion about negotiated rates. Members have asked us to get the Department's perspective on the negotiated rate process and whether it believes that this process is working to adequately and effectively serve these populations of patients with complex medical conditions, including whether expansion of the negotiated rate process for these populations is feasible or would prove effective?

Disability Rights Maine was asked to provide the following information:

- What specific proposals does Disability Rights Maine suggest to address contract compliance and enforcement issues, including any statutory or regulatory changes that would assist DHHS in ensuring facility contract compliance as well as in enforcement when there are violations?

The Commission determined that its third meeting would be held on November 20 and adjourned for the day.

### C. Third meeting – November 20, 2015

The third meeting of the Commission was held on November 20. After calling the meeting to order and introducing the members, the Commission reviewed responses to a number of information requests made at the previous meeting.

The Commission first heard from Mr. Erb on behalf of the Maine Health Care Association (MHCA) regarding requests for information made at the last meeting. The first question asked was for information on the rates that the 3 geropsychiatric facilities are receiving from the State. Mr. Erb stated that the relevant rates were \$328 to \$344 per day (a figure which includes the cost for a private room), except for the Mount Saint Joseph's facility in Waterville, which has 16 PNMI geropsych beds and comes in at \$227 per day. He noted that these rates are respectively higher than the average nursing facility rate (around \$200 per day) and the average PNMI rate (around \$100 per day). Senator Katz questioned whether, given that there appears to be a demand for these types of beds and the rate appears to be adequate, there have been any efforts made to add more beds. Mr. Erb responded in the negative, noting that perhaps because these facilities would be subject to the Certificate of Need (CON) statutory requirements and budget neutrality caps, no initiative to add more geropsych beds has been put forward in recent years.

The second question asked of MHCA was what suggestions they had for expanding or improving/reconfiguring Appendix C PNMI facilities to better serve these complex patient populations. Mr. Erb noted that the geropsych PNMI concept employed by Mount Saint Joseph appears to be serving those patients' needs well, and that perhaps this concept could be expanded to include additional beds in the State. He also stated that MHCA supports expansion of geropsych beds in the nursing facility setting. He did caution, however, that the CON statutory requirements and budget neutrality caps must be addressed to expand capacity in these areas.

The third question asked of MHCA regarded their position on the feasibility of implementing a presumptive eligibility standard/option, where a provider would have the ability to presume Medicaid eligibility for a patient with later final DHHS determination. Although MHCA would certainly support the implementation of such a concept, Mr. Erb expressed concern over the feasibility of implementing this process, especially in terms of the potential issues created for a provider who presumes eligibility and accepts a patient who is later denied. Mr. Austin noted that hospitals are currently able to presume eligibility in some cases and start receiving payments. He suggested that this proposal has merit and should be discussed further. Mr. Hamilton noted that often a MaineCare denial involves financial exploitation of the applicant by family members, and that DHHS is taking steps to address these issues, including the creation of a two-person financial abuse specialist team. One proposal DHHS is looking into is requiring a contractual agreement between DHHS and the applicant's family to create a legally binding obligation on the part of the family to pay for care if denied. Representative Gattine asked Mr. Hamilton to provide some statistics to the Commission regarding how many of these types of financial exploitation cases the Department typically deals with.

The final question for MHCA concerned the proposal to implement a basic reporting requirement for facilities refusing patient placement. Although MHCA recognized the information collected through such a process may be useful, it remains opposed to a formalized

reporting requirement, even if just a simple, one-page form. One of the reasons for this opposition is that many of these cases are too complex to address in a simple form and as such, the requirement could easily turn into a debate over the denial of placement. Ms. Moody stated that collecting this information would be critical to fully understanding the issues involved with a denial of placement. Ms. Gallant agreed, suggesting perhaps just requiring reporting on a refusal to re-admit would lessen the burden on facilities and still provide useful data. Mr. Erb responded that readmission refusals are rare and already require additional reporting to DHHS.

The Commission next heard from Mr. Austin on behalf of the Maine Hospital Association (MHA). The first question for MHA requested specific information on the proposed “days awaiting placement” rate for hospital patients. Mr. Austin responded that this rate should essentially mirror the existing days awaiting placement rate paid to critical access hospitals under the MaineCare manual. This rate is the statewide average nursing facility rate, which is just under \$200 per day. He suggested that this proposal be implemented for the first year on a sort of pilot program basis, and that instead of including a per patient cap, the reimbursement be funded with an appropriation of \$500,000 or \$1 million and that, once that amount is exhausted, no more reimbursement will be paid to any facility for the rest of the fiscal year.

The second question for MHA concerned whether other states have taken a similar approach with respect to this issue. Mr. Austin responded that he canvassed the other New England states and determined that no other state has a similar days awaiting placement rate for hospitals under these same circumstances. He cautioned, however, that it is difficult to compare medical payment systems in different states and noted that each state has developed a unique and complex model that doesn't necessary lend itself to simple comparison.

The Commission next heard from Mr. Hamilton on behalf of DHHS, which had provided a written handout addressing the questions asked of it. The first question concerned the eligibility and placement process for geropsych patients in the case of an open bed. Mr. Hamilton acknowledged the process can unfortunately take some time, but described the many steps and the complexities involved in the process that contribute to this delay. He noted, however, that DHHS is reviewing the process to identify streamlining opportunities to speed up placements.

The second question for DHHS concerned the suggestion made during a prior public comment that the State is only financially responsible for Maine residents receiving treatment out-of-state for the first two years of treatment out-of-state. Mr. Hamilton responded that, for MaineCare patients, if an individual is temporarily or involuntarily absent from the State, but intends to return in the future, then MaineCare eligibility with continue indefinitely.

The third question for DHHS concerned the possibility of expanding the Homeward Bound program and securing additional grants. Mr. Hamilton outlined the federal grant process for this program, noting that at this time, federal grant monies have been requested for calendar year 2016 through September 30, 2020 and that no additional funds can be requested. He noted, however, that the number of individuals available to transition appears to be decreasing, with 13 transitions to date and up to 7 more projected by the end of the year – a number lower than the current goal of 26 placements per year. In discussions surrounding this question, Ms. Gallant noted that a significant barrier to community placement concerns staffing, which is likely

hampered by the flat, low reimbursement rate paid for home care services. She suggested that consideration of an enhanced rate for home care services based on the needs of the individual would go a long way towards improving community placement rates.

The final question for DHHS concerned the potential expansion of the negotiated rate process for complex patient populations. Mr. Hamilton expressed the Department's position that the standardized rate process is preferred in most cases, but that for patients that have complex needs, DHHS may negotiate rates with providers, such as in the case of geropsych rates.

The Commission lastly heard from Ms. Moody on behalf of Disability Rights Maine (DRM), regarding proposals to address compliance and enforcement issues, on which she provided a handout with attachments. Ms. Moody described a number of specific proposals to address DRM's concerns, including amending 22 MRSA §7948 regarding unlawful discharges and clarifying DHHS' licensing's ability to enforce law/rules regarding unlawful patient discharges.

The Commission next opened the floor up for public comment. John Gregoire testified on behalf of the Hope-JG Foundation, which has been working towards building a world class ALS/MS residence in Maine. Mr. Gregoire described the mission of his foundation and its plans for the future. He reiterated that the construction of the facility would be privately funded, but asked the Commission to ensure that the appropriate regulatory system is in place to allow such a facility to be constructed and operated. After describing the green house facility concept, Commission members requested from Mr. Gregoire a list of other states that have addressed green house facilities in their statutes and regulations.

The Commission next began its discussion on the various identified issues and proposals for recommendations to be included in the final report. At Mr. Austin's suggestion, the Commission agreed to attempt to divide proposals into three categories – those requiring immediate and specific action this upcoming session, those requiring further study by stakeholders in the future, those more appropriately addressed by DHHS and other relevant parties and those lacking merit and should not be included in the report. For the purposes of determining which proposals to include in the draft report, members agreed to take non-binding straw votes on the proposals.

During these discussions, Mr. Austin had to leave and, with the Chair's permission, gave his seat and voting authority to Lisa Harvey-McPherson of Eastern Maine Healthcare Systems. Ms. Moody was also absent for the first portion of the discussions and voting but re-joined the Commission for later deliberations and voting. It was also determined during these discussions that the Commission would request both an extension of the December 2 reporting deadline (to December 15) and an additional meeting so that the recommendations could be further discussed and finally voted on at the fourth meeting on December 2 and then the final report could be reviewed at a fifth meeting (see also future meetings planning below).

The Commission discussed, deliberated and conducted non-binding straw votes as follows:

Problem/issue	Identified/proposed solution	Voting information
<p>Patients awaiting discharge remain hospitalized due to lack of appropriate/available placement.</p>	<p>Pay PPS hospitals a daily “days awaiting placement” for MaineCare eligible patients only. Rate will be identical to that paid to critical access hospitals under MaineCare manual. Implement total cap amount for reimbursement for fiscal year (\$1M/\$500K TBD).</p> <p>DHHS to address guardianship and APS processes contributing to unnecessary extended hospital stays. Develop “temporary guardianship process.”</p>	<p>10-1 in favor of implementing immediate legislative solution.</p> <p>11-0 in favor of DHHS addressing with relevant parties, including hospitals and the judiciary.</p>
<p>Insufficient trained staff to serve complex patients (as well as general staffing problems for all patient populations).</p>	<p>Address costs of education and barriers to entry into field (work with DOL). Further examine possibility of certain facilities implementing in-house staff certification programs, such as CNA certification (work with DOE).</p>	<p>10-1 in favor of further study of proposal in a stakeholder group format.</p>
<p>Insufficient resources to assist in placement of patients with complex medical conditions.</p>	<p>Add 2 FTE staff to Long-term Care Ombudsman program to assist in placement. Some statutory changes necessary to expand Ombudsman program authority.</p> <p>Add 1 FTE nurse education consultant to DHHS.</p>	<p>11-0 in favor of immediate legislative solution.</p> <p>7-3 in favor of immediate legislative solution.</p>

	DHHS to fund long-term care contracts for behavioral health support at facilities for care plan consults, treatment, staff education (specifics TBD).	11-0 in favor of immediate legislative solution.
Insufficient capacity across facility spectrum (NFs, SNFs, PNMI, etc.) to meet in-State demand.	Expand/reconfigure appendix C PNMI facilities.  Expand or improve community placement options. Members will bring back specific recommendations. One proposal might include implementing an enhanced reimbursement rate for home care services.	12-0 in favor of further study of proposal in a stakeholder group format.  10-2 in favor of immediate legislative solution.
Insufficient contract compliance and enforcement by DHHS against facilities violating patient rights.	Change to 22 MRSA §7948 regarding unlawful discharges. Additional statutory or regulatory changes to clarify DHHS licensing authority with respect to unlawful discharges.	12-0 in favor of further study of proposal in a stakeholder group format.
60 mile rule, which allows patient to refuse placement at facility greater than 60 miles from residence, may prevent appropriate placement of complex patients.	Exception to 60 mile rule for patients who have been waiting more than 30 days for placement.	10-3 against changing the 60 mile rule (i.e., do not include as recommendation).
MaineCare application approval process takes too long (45 days average processing time).	Implement presumptive eligibility option for facilities to presume patient's MaineCare eligibility.	10-1 in favor of further study of proposal in a stakeholder group format.

	<p>Work with DHHS to specifically expedite application process for hospitalized patients awaiting placement.</p> <p>Amend MaineCare application process to better account for financial exploitation situations.</p>	<p>10-1 in favor of further study of proposal in a stakeholder group format.</p> <p>12-0 in favor of further study of proposal in a stakeholder group format.</p>
<p>Insufficient data is collected regarding basis for facility refusal of placement.</p>	<p>Establish method for data collection to increase understanding of these problems, such as requiring facilities to file simple report with DHHS identifying barriers to admission when refusing to admit patient (specifics TBD).</p>	<p>10-2 in favor of immediate legislative solution.</p>
<p>Theft of patient assets by family member or other persons complicates patient's MaineCare eligibility and delays provision of services.</p>	<p>Increase efforts for prosecution of these types of cases (specifics TBD; DHHS will provide suggestions).</p>	<p>12-0 in favor of immediate legislative solution.</p>
<p>Currently insufficient geropsych capacity in Maine (usually most beds full).</p>	<p>Provide statutory authority to waive CON to facilitate the expansion of geropsych beds in State (NF and/or PNMI expansion) and implement all other necessary statutory or regulatory changes to accomplish this.</p>	<p>11-1 in favor of immediate legislative solution.</p> <p>Note DHHS testimony that RFI will go out in December 2015 to solicit responses for medical and psychiatric needs patients, special medical needs patients and neurobehavioral needs patients.</p>
<p>Despite immediate needs, geropsych placement process for open bed takes too long (often 6 weeks).</p>	<p>Implement options for improving/speeding up placement process, including addressing</p>	<p>11-0 in favor of further study of proposal in a stakeholder group format.</p>

	application of criterion that patient has “long history of mental illness” and challenges in applying PASRR process to geropsych patients.	
Insufficient capacity/ placement options (“step-down”) for geropsych patients who no longer require that level or type of care.	Increase facility options to address geropsych patients developing dementia, including residential care options at geropsych facilities and addressing problems with assessment criteria for both admission and discharge (PASRR v. GOOLD).	11-0 in favor of further study of proposal in a stakeholder group format.

The Commission determined that its fourth meeting would be held on Wednesday, December 2, decided to request approval for a fifth meeting and an extension of the reporting deadline and adjourned for the day.

**D. Fourth meeting – December 2, 2015**

INSERT FOURTH MEETING SUMMARY

**E. Fifth meeting – December 7, 2015**

INSERT FIFTH MEETING SUMMARY

**IV. RECOMMENDATIONS**

Early on in the Commission’s meetings, it became clear to its members that the issues raised through the duties described in the enacting legislation were broader than could be addressed in the relatively short period of time allotted. When developing recommendations, Commission members considered both those issues meriting immediate legislative action in the coming session as well as those issues for which future discussion by stakeholders would be necessary to adequately address. Accordingly, the Commission determined that its recommendations would include a number of proposals for immediate legislative action as well as the establishment of a Commission to Continue the Study of Difficult-to-place Patients to further discuss other complex but equally important issues raised and discussed by the Commission during its interim work but not fully addressed in its specific legislative recommendations. Specific recommendations, including the votes in favor of each recommendation, are as follows:

### **A. Pay hospitals a “days awaiting placement” rate**

Throughout its meetings, the Commission heard testimony on the issue of hospitalized patients who meet all medical criteria for discharge, but remain hospitalized due to the lack of an appropriate or available placement to which the patient can be discharged. Once discharge criteria are met, hospitals are no longer able to receive any reimbursement for medical care provided to the patient despite the patient having to be cared for by the hospital in the manner of a nursing facility (or specialized nursing facility). Under the current MaineCare manual, critical access hospitals are paid a “days awaiting placement” rate under the same circumstances.

The Commission’s recommendation on this matter is to implement a “days awaiting placement” reimbursement rate for PPS hospitals for patients awaiting discharge after meeting applicable discharge criteria. The rate would be the same that is currently paid to critical access hospitals under the MaineCare manual, which is the statewide average nursing facility rate (currently just under \$200 per day). For the fiscal year in which this new rate is first implemented, total reimbursements to all eligible hospitals would be capped at \$1,000,000/\$500,000.

See Appendix TBD for legislation.

### **B. Expand Long-term Care Ombudsman program**

Testimony received by the Commission indicated that the Long-term Care Ombudsman program provides invaluable assistance to patients, families and providers in facilitating the successful and appropriate placement of patients with complex medical conditions. The Ombudsman expressed an interest in expanding the program’s provision of these services, but indicated that additional staff would be necessary to accomplish this.

The Commission’s recommendation on this matter is to provide funding adequate to support two additional full-time equivalent (FTE) staff to the Ombudsman program to provide assistance in placement of patients with complex medical conditions, including assistance to facilities post-placement. The program’s statutory authority would be expanded to reflect these changes.

See Appendix TBD for legislation.

### **C. Expand resources provided by Maine DHHS**

Testimony received by the Commission indicated that the nurse education consultant position at DHHS is an important resource for many facilities in the State. This individual, who is a trained nurse, visits facilities to assess patients and meets with staff to consult on and make recommendations for patient care as well as to assist in medication changes.

The Commission’s recommendation on this matter is to provide funding adequate to support one additional FTE nurse education consultant position at DHHS.

Another related proposal concerns the demand for and lack of behavioral health support at long-term care facilities. To address these demands, the Commission recommends that DHHS fund

long-term care contracts for behavioral health support at long-term care facilities for care plan consults, treatment and staff education.

See Appendix TBD for legislation.

#### **D. Expand community placement options**

Testimony indicated that a major barrier to community placement of patients with complex (and non-complex) medical conditions is lack of staffing support, both in terms of staff training and staff availability. State reimbursement for home care services is currently a low, flat rate that does not account for the needs of the patient.

The Commission's recommendation on this matter is to implement an enhanced reimbursement rate for home care services that accounts for the needs of the patient.

See Appendix TBD for legislation.

#### **E. Facilitate reporting of data regarding facility refusal of placement**

When a patient with complex medical conditions is refused placement at a facility, that facility's basis for refusing placement is often not communicated to the patient, the patient's provider or the State. The reasons a facility may refuse placement of such a patient may relate to a lack of an available bed, but could also relate to a lack of appropriate staffing, specialized equipment or other resources. An understanding of these reasons for refusal of placement is critical to removing barriers to placement for patients with complex medical conditions.

The Commission's recommendation on this matter is to....

See Appendix TBD for legislation.

#### **F. Increase prosecution of financial exploitation cases**

A MaineCare eligibility determination involves a DHHS review of an applicant's financial assets. In most situations where an applicant's family members or relatives have improperly taken that applicant's assets prior to the filing of the application, the applicant will be denied for failing to meet MaineCare's asset limits. This financial exploitation by family members or relatives can often be prosecuted as elder abuse; however, for a number of reasons, these cases are often not prosecuted.

The Commission's recommendation on this matter is to....

See Appendix TBD for legislation.

#### **G. Provide authority for expansion of geropsychiatric facility capacity**

At present, there are only 3 facilities in Maine that specialize in the care of geropsychiatric patients. Hawthorne House in Freeport and Gorham House in Gorham provide geropsych services in a nursing facility setting, while Mount Saint Joseph in Waterville provides those services in a PNMI setting. In total at these 3 facilities, there are between 50 and 55 geropsych beds. Testimony before the Commission indicated that these beds are in high demand and rarely vacant, indicating an immediate need for additional capacity.

Under the existing Certificate of Need (CON) statutory provisions, CON unit approval from DHHS is required for new nursing facility services including expansion of capacity, relocation of beds from one nursing facility to another, replacement nursing facilities, changes in ownership and control of nursing facilities, and building modifications and capital expenditures by nursing facilities. Criteria for the CON application are established in 22 MRSA §335 as well as in the Department's applicable rules. The CON process and criteria focus only on the need in the area where the beds were previously located. In order to increase the overall number of beds, the nursing facility MaineCare funding pool would have to be increased.

As such, the Commission's recommendation on this matter is to exempt from the CON statutory requirements and, where applicable, budget neutrality cap provisions the creation of additional nursing facility or PNMI facility capacity for geropsych patients, with a maximum total capacity increase of 25 beds.

See Appendix TBD for legislation.

#### **H. Development of temporary guardianship process**

During its review of the factors contributing to the extended hospitalization of medically complex patients, the Commission recognized that DHHS's APS/public guardianship processes can often result in long delays in the appropriate placement of a hospitalized patient. Lisa Harvey-McPherson (EMHS) suggested that, in addition to reviewing these processes to remove unnecessary aspects that do not add value to the patient and unnecessarily extend the patient's hospitalization, the Commission consider supporting the development of a temporary guardianship status to facilitate hospital discharge while permanent guardianship is completed.

Because a resolution of these questions and proposals require input from both DHHS and the State's judiciary, the Commission's recommendation on this matter is to recommend to DHHS that it engage in discussions with representatives from hospitals and the judiciary to identify options for improving the efficiency of the APS/public guardianship process and to evaluate the feasibility of implementing a temporary guardianship process.

See Appendix TBD for letter to DHHS.

#### **I. Establishment of Commission to Continue the Study of Difficult-to-place Patients**

In its work, the Commission identified a number of additional important issues relating to the placement of medically complex patients, but recognized that solutions to these particular problems would require additional study and consideration than the Commission could

accomplish during its short existence. To solve these additional complex issues, input from various stakeholder groups will be necessary and the Commission recommends the continuation of its work by recommending the formation of a Commission to Continue the Study of Difficult-to-place Patients.

As set forth in the draft legislation contained in Appendix TBD, the issues and solutions to be considered by this new commission include the following:

- Identification of medical staffing needs in the State and the barriers to and, with input from the Department of Labor, solutions for increasing the availability of trained staff across the spectrum of care, including, with input from the Department of Health and Human Services and the Board of Nursing, an examination of the feasibility of implementing in-house staff certification programs, such as a certified nursing assistant training program, by licensed medical facilities;
- Determination of existing capacity and demand for additional capacity in appendix C PNMI facilities in the State and options to expand or reconfigure the State's appendix C PNMI system to better meet identified demands;
- Examination of the feasibility of implementing a presumptive eligibility option whereby a medical facility would be authorized to presume a patient's eligibility for MaineCare and receive reimbursement for the patient's eligible care costs prior to final approval of eligibility by the Department of Health and Human Services;
- With input from the Department of Health and Human Services, identification of efficiencies that can be implemented to expedite the MaineCare application process, and consideration of methods of prioritizing MaineCare application processing for hospitalized individuals eligible for discharge, but who are awaiting placement at an appropriate facility with available capacity;
- Review of options for amending the MaineCare application process to better address financial exploitation of an applicant by a family member or relative of the applicant;
- Examination of methods of expediting the Department of Health and Human Services' placement process for open geropsychiatric beds, including a review of the application of the Preadmission Screening and Resident Review process within the placement process and the application of the geropsychiatric placement criterion that a patient have a long history of mental illness; and
- Determination of existing need for medical facility "step-down" options for geropsychiatric and other patients who no longer require the level or type of care they are receiving at a specialized facility, as well as addressing issues relating to geropsychiatric patients that develop dementia, expansion of residential care options at facilities that offer geropsychiatric services and a discussion of applicable assessment criteria for admission and discharge at geropsychiatric facilities.



## **Commission to Study Difficult to Place Patients**

### **Proposals to Consider**

Submitted by: Mel Clarrage, Chair, Statewide Independent Living Council  
Brenda Gallant, Executive Director, Maine Long-Term Care Ombudsman Program

Recommendation #1: The Department of Health and Human Services, Office of Aging and Disability Services will plan and implement a demonstration project that will allow enhanced rates for home care services for participants in the Homeward Bound Program with complex needs. These rates must allow additional reimbursement for services provided by Personal Support Specialists (PSS). In addition, the rates must include a provision for on-site training of PSS staff prior to the start of services in the community to promote quality of care and retention of staff.

Recommendation #2: The Department of Health and Human Services, Office of Aging and Disability Services, Home Care Quality Review Committee will review the adequacy of home care services provided for individuals with complex needs under Section 19, Home and Community Benefits for the Elderly and Adults with Disabilities. In conducting this review, input from the following will be sought: consumers, agencies providing Care Coordination, agencies providing advocacy and home care agencies. This review will include consideration of quality of care, ED visits and hospital admissions.



**Treatment Approaches for Persons with Complex Needs**  
**Mission - Prevention of Individuals Getting Stuck in Hospitals or Sent Out of State for Care**

Estimated  
 Population 60-100  
 Individuals/year

**Request for Information (RFI)**

The RFI process is a nation-wide request of providers to determine the best practices for treatment, regulatory supports, needs, and costs.

**Neurobehavioral Treatment Center**

**Target Population** – Individuals with challenging behaviors that do not allow the assurance of health and welfare in a typical residential care setting and are related to a brain based disorder

**Need** – Short-term transitional setting (6-12 months) that utilizing a highly sophisticated approach to stabilize maladaptive behaviors and replacing those behaviors with socially effective behaviors

**Goal** - Assisting the Individual with return to a home and community based setting and maximizing independence and self-sufficiency

**Dedicated Staffing** – Neuropsychologist, Psychiatrist, Physician, Highly Skilled Direct Treatment Staff, Occupational Therapist, Speech Therapist, Speech Language Therapist, and Behavioral Psychologist

**Size** – 12-20 beds licensed as a specialty hospital or nursing facility

**Specialty Medical Treatment Center**

**Target Population** – Individuals with significant medical needs that are typically neurodegenerative in nature (such as ALS, Huntington's, Parkinson's, but also including ventilator care and bariatric care)

**Need** – A setting that may include short-term care (6-12 months) as well as end of life palliative care that has a well trained staff to handle complex medical needs

**Goal** - Addressing complex medical needs through state of the art evidenced medical and rehabilitative care

**Dedicated Staffing** – Physician, Respiratory Therapist, Behavioral Psychologist, Psychiatrist, Highly Trained Skilled Care Staff, and a Consultative Relationship with National Centers of Excellence

**Size** – 12-20 beds licensed as a specialty hospital or nursing facility

**Medical/ Psychiatric Specialty Treatment Center**

**Target Population** – Individuals with significant mental illness and significant medical needs that require nursing facility level of care

**Need** – A short-term transitional setting (6-12 months) that offers medical skilled care and also manages challenging behaviors

**Goal** - Addressing complex medical and psychiatric needs to allow a person to return to a home and community based setting and maximize independence and self-sufficiency

**Dedicated Staffing** – Physician, Psychiatrist, Behavioral Psychologist, Psychiatric Nurse, Highly Skilled Direct Treatment Staff

**Size** – 12-20 bed licensed as a specialty hospital or nursing facility



## Commission to Study Difficult to Place Patients

December 2, 2015

### Draft Proposal for the Commission's Consideration Regarding Financial Exploitation of Older Persons and Vulnerable Adults

#### Financial Abuse Specialist Team (FAST)

Two Caseworker positions within DHHS/Office of Aging and Disability Services will be dedicated to working with community partners to increase the prosecution of financial crimes against older persons and persons with disabilities. A primary goal is to increase the financial security of all older and vulnerable adults living in Maine by recovering assets that are stolen, mismanaged or misappropriated against the person's wishes; holding perpetrators of financial crimes accountable for their actions; and developing preventive options that will deter financial exploitation of Maine's older and vulnerable adult population.

#### Maine FAST PRIMARY OBJECTIVE

To improve and enhance the ability of professionals across multiple disciplines, including Adult Protective Services, Law Enforcement, Prosecutors, and others, to effectively investigate and prosecute financial crimes against older and vulnerable adults by convening a team of experts to consult on complex cases and cases that are not being effectively pursued for any reason, develop recommendations, and to access additional consultant resources to assist with these cases.

#### Tasks:

1. Membership: Office of the Attorney General; Department of Health and Human Services (OADS and OFI); Maine Sheriff's Association; Maine Chiefs of Police; Maine State Police; Maine Prosecutors Association, Maine Health Care association, Long Term Care Ombudsman Program, Legal Services for the Elderly; Security Commission; and other identified partners.
2. Review Maine Criminal Statutes and Maine's Adult Protective Services Act and suggest changes that would enable and support criminal prosecution of crimes against the elderly and persons with disabilities including review of other states relevant statutes to add enhanced penalties.
3. Report back with an overview of the issue and recommendations.

