

Commission to Study Difficult-to-place Patients
October 26, 2015
Meeting Summary

Convened 12:00 p.m., Room 216, Cross State Office Building, Augusta

Present:
Sen. Roger Katz
Rep. Drew Gattine
Rep. Richard Malaby
Rep. Peter Stuckey
Jeff Austin
Melvin Clarrage
Richard Erb
Brenda Gallant
Ricker Hamilton
Simonne Maline

Absent:
Sen. Anne Haskell
Michael Lemieux

Also:
Peter Rice (on behalf of Kim Moody)

Staff:
Natalie Haynes
Dan Tartakoff

Introductions

Commission Chair Roger Katz called the meeting to order and the members introduced themselves. Commission Chair Drew Gattine provided some background on the legislative history of LD 155 and its background in the HHS Committee during the previous session.

Overview of enabling legislation

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. Depending on the Commission’s recommendations, the HHS Committee has the option of using LD 966 as a vehicle for adoption of any proposed legislation relating to the Commission’s findings.

Presentation by Jeff Austin

Jeff Austin provided the Commission with a briefing on behalf of the Maine Hospital Association. Mr. Austin acknowledged that the problems the Commission is facing 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) or the lack of availability at a facility that would otherwise meet the patient's needs. Mr. Austin noted that at the time of the study, 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.

Presentation by Richard Erb

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 the 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 – requires 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. These 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 such 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.

Presentation by Brenda Gallant

Brenda Gallant provided the Commission with a briefing in her capacity as the State Long-Term Care Ombudsman. Ms. Gallant noted that in the last 6 months, she 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.

Presentation by Peter Rice and Simonne Maline

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.

Commission discussion

The Commission next opened up the floor for discussion amongst its members. Members first discussed the expenses to hospitals for caring with patients eligible for discharge but for whom there was no facility to discharge to. Mr. Austin acknowledged that this may be a significant cost, but since it is not reimbursed, it's not something that is 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, or lack thereof, 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 with the State establishing public guardianship. He noted that even where family members of the 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 to a large degree 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 RUG (Resource Utilization Group) 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 that certainty over

the reimbursement rate would help encourage more providers to make available the services these complex patient populations require, and questioned whether the reimbursement rate process for ventilator care services could be replicated for other populations, such as geropsychiatric.

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 by the end of November and be put out shortly thereafter. The Commission asked Mr. Hamilton to provide at future meetings whatever information on this RFI that he can share.

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 that 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 that 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.

Public comment

Jill Lufkin Robinson testified 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.

Information requests

As a result of its discussions at the first meeting, the Commission has 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.

Future Meetings

The second meeting of the Commission will be held on Thursday, November 5, 2015, at 10:00 am. The third meeting will be held on Wednesday, November 18, 2015, at 10:00 am. The final meeting will be held on Wednesday, December 2, at 10:00 am. Unless otherwise noted, all meetings will be held in Room 216 of the Cross State Office Building.

The meeting was adjourned at 3:00 p.m.