STATE OF MAINE
127th LEGISLATURE
FIRST REGULAR SESSION

Commission to Study Difficult-to-Place Patients

December 2015

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Sen. Roger J. Katz, Chair
Sen. Anne M. Haskell
Rep. Andrew M. Gattine, Chair
Rep. Richard S. Malaby
Rep. Peter C. Stuckey
Jeffrey A. Austin
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Executive Summary

The Commission to Study Difficult-to-place Patients (hereinafter "the Commission") was created during the First Regular Session of 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 (for a copy of that resolve, see Appendix A) and was composed of two members of the Senate, three members of the House of Representatives and nine public members.[1] 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 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 distributed at Commission meetings, are available at: www.maine.gov/legis/opla/difficulttoplacepatients.htm.

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

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[1] 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 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 through the establishment of the Commission To Continue the Study of Difficult-to-place Patients (for proposed legislation establishing this new commission, see Appendix C). Specific recommendations, supported by 11 of 12 Commission members,[2] are as follows:

1. Expand geropsychiatric facility capacity in the State

At present, there are only 3 facilities in Maine that specialize in the long-term residential care of geropsychiatric[3] patients. Hawthorne House in Freeport and Gorham House in Gorham provide geropsychiatric services in a nursing facility setting, while Mount Saint Joseph in Waterville provides similar services in a private non-medical institution (PNMI)[4] setting. In total at these 3 facilities, there are 51 geropsychiatric beds. Testimony received by the Commission indicated that these beds are in high demand and rarely vacant, suggesting an immediate need for additional capacity in the State. Moreover, the Commission understands that there has been no expansion of geropsychiatric facility capacity in Maine in the last 25 years.

Under the existing State Certificate of Need (CON) statutory provisions, CON unit approval from the Department of Health and Human Services (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 a CON application are established in 22 M.R.S.A. §335 as well as in DHHS' 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. Additionally, the Commission understands that DHHS currently interprets its statutory and regulatory authority to require so-called MaineCare neutrality fulfillment for any addition of facility capacity in the State.[5]

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[2] All Commission members except Ricker Hamilton voted to accept the final report and recommendations as a single package. Mr. Hamilton supported some proposals in the report and described his opposition to the other proposals at the final meeting. For more detail regarding his positions, see fifth Commission meeting summary.

[3] Geriatric psychiatry or geropsychiatry involves the study, prevention and treatment of mental illness in elderly and aging populations.

[4] DHHS defines a PNMI as "...an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides food, shelter, personal care, and treatment services to four or more residents in single or multiple facilities or scattered site facilities...." 10-144-101 ME. CODE R. §97.01-9 (MaineCare Benefits Manual, Chapter II, section 97). There are five categories of PNMIs in Maine, each based upon a different appendix to the MaineCare Benefits Manual, chapter II, section 97: Appendix B (substance abuse treatment facilities), C (medical and remedial services facilities), D (child care facilities/intensive temporary residential treatment services facilities), E (community residences for persons with mental illness) and F (non-case mixed medical and remedial facilities). *Id.*

[5] To put it another way, DHHS requires that an expanding facility acquire MaineCare revenue stream resources by purchasing these from another facility or relocating resources within its own system; i.e., you can't add a MaineCare bed without removing another MaineCare bed (or equivalent MaineCare resources) elsewhere in the State.

The Commission's recommendation to address current unmet demand for geropsychiatric facility care is to expand available geropsychiatric facility capacity in the State. We recognize that this proposal, if resulting in additional geropsychiatric nursing facility beds, will require an exemption from the CON statutory requirements. The Commission further recognizes that regardless of whether additional nursing facility or PNMI geropsychiatric beds, or a combination thereof, are added, this proposal will also require an exemption from so-called MaineCare neutrality fulfillment requirements.

While the Commission will not speculate as to whether this expansion would be best accomplished in the nursing facility or PNMI context, or both, the Commission does recommend that total approved expansion not exceed a maximum of 25 new geropsychiatric beds. This expansion need not be restricted to a single new or expanded facility but could represent expansion of capacity in multiple facilities and/or locations around the State. This Commission also recognizes that with existing geropsychiatric facilities located in Gorham, Freeport and Waterville, there is a specific lack of geropsychiatric capacity in Northern and Down East Maine. As such, we recommend that any expansion of geropsychiatric facility capacity give highest priority to proposals to add new beds located north and/or east of Waterville.

The Commission recognizes that expansion of geropsychiatric capacity will result in additional fiscal costs for the State. Testimony received by the Commission indicated that existing nursing facility geropsychiatric beds receive daily reimbursement rates averaging $328 to $344 per day, a rate that includes the cost for a private room, while existing PNMI geropsychiatric beds receive a rate of $227 per day. If the Commission assumes an expansion of 25 beds, with all new beds located in nursing facilities and uses a high estimated reimbursement rate of $350 per bed per day, the total cost for this proposed expansion would be $3,193,750 ($350 per bed per day x 365 days per year x 25 new beds). Accordingly, consistent with the Medicaid cost-sharing Federal Medicaid Assistance Percentage (FMAP),[6] the State's share of that cost would be $1,192,227, and this Commission recommends approval of State funding in that amount to support the above-described expansion of geropsychiatric facility capacity in Maine.

2. Expand the State's 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, as the program currently has no staff specifically dedicated to provide these services. The Ombudsman estimated that the total cost of adding these two additional staff to her office would be roughly $150,000. That total would include staff salaries, as well as all applicable taxes, benefits, mileage reimbursements and other costs.

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[6] For the current fiscal year (federal FY2016, which is October 1, 2015 through September 30, 2016), the FMAP for Maine is 62.67%. In other words, for eligible Medicaid costs, the State's share of the total cost is 37.33%. *See* FY2016 Federal Medical Assistance Percentages, United States Department of Health & Human Services, Office of the Assistant Secretary For Planning and Evaluation (December 2, 2014), *available at* https://aspe.hhs.gov/basic-report/fy2015-federal-medical-assistance-percentages.

The Commission's recommendation on this matter is to provide sufficient funding, estimated at $150,000, to support two additional full-time equivalent (FTE) staff for the Ombudsman program to provide assistance in placement of patients with complex medical conditions, including assistance to facilities post-placement.

The Commission also recommends that the Ombudsman's statutory authority set forth at 22 M.R.S.A. §5107-A be amended to reflect these additional duties relating to assistance in the placement of patients with complex medical conditions.

See Appendix D for draft legislation relating to the proposed statutory changes.

3. Expand resources provided by the Department of Health and Human Services

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 meet with staff to consult on and make recommendations for patient care as well as assist in medication changes. Information provided by DHHS indicated that the estimated total costs of an additional nurse education consultant position would include $57,304 in salary, $30,888 in benefits and $6,278 all other costs, for a total cost of $94,470. According to DHHS, costs for this position are split 50/50 with Medicaid.

As such, the Commission's recommendation on this matter is to provide State funding in the amount of $47,235 (based on a 50% cost-share of this position with Medicaid) to support one additional FTE nurse education consultant position at DHHS.

4. Examine feasibility of providing enhanced rates for home care services

Testimony received by the Commission indicated that a major barrier to community placement of patients with complex (and non-complex) medical conditions is lack of home care 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 each patient's particular needs.

The Commission's recommendation on this matter is to direct DHHS, Office of Aging and Disability Services to develop and implement a demonstration project to allow enhanced rates for home care services, with participation limited to patients with complex medical needs currently enrolled in the Homeward Bound program. These enhanced rates must provide additional reimbursement for services provided by Personal Support Specialists (PSS) and for on-site training of PSS staff prior to the commencement of services to promote quality of care and retention of staff. DHHS should be directed, following the completion of the demonstration project, to report back to the Legislature regarding its findings and recommendations regarding the expansion of enhanced rates for home care services.

See Appendix E for draft legislation directing this demonstration project.

5. Review adequacy of home care services

As stated in the previous recommendation, a major barrier to community placement is lack or inadequacy of available home care services. To ensure a complete understanding of the current state of home care services available in Maine, the Commission recommends that DHHS, Office of Aging and Disability Services, Home Care Quality Review Committee review the adequacy of home care services provided for individuals with complex needs under the MaineCare Benefits Manual, Chapter II, section 19, Home and Community Benefits for the Elderly and Adults with Disabilities. This review shall include, at a minimum, consideration of quality of care, emergency department visits and hospital admissions by individuals receiving services under section 19. In conducting this review, the Home Care Quality Review Committee should be directed to request input, at a minimum, from consumers, care coordination agencies, patient advocacy organizations and home care agencies. DHHS should be directed, following the completion of this review, to report back to the Legislature regarding its findings and recommendations regarding the adequacy of home care services provided under section 19.

See Appendix F for draft legislation directing this review.

6. Facilitate reporting of data regarding facility refusal of placement

When a patient with complex medical conditions is refused placement at a medical care facility, that facility's basis for refusing placement is often not communicated to the patient, the patient's providers or the State. The reasons a facility may refuse placement of 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 the basis for refusal of placement is critical to identifying and removing barriers to placement for patients with complex medical conditions.

Following Commission discussions on these matters, several commission members volunteered to work together to identify a process for the Office of the Long-term Care Ombudsman to receive and track information relating to a facility's decision to deny placement to a patient with complex medical needs, as well as a method for appropriately maintaining and distributing this collected data to interested agencies, organizations, individuals and the Legislature. The parties that have agreed to work on further development of this proposal include the State's Long-term Care Ombudsman, the Maine Health Care Association, the Maine Hospital Association, DHHS, the Consumer Council System of Maine and Disability Rights Maine. The Commission appreciates the initiative taken by these parties and requests that stakeholders submit any recommendations relating to these matters to the Joint Standing Committee on Health and Human Services (HHS Committee) during the Second Regular Session of the 127th Legislature.

7. Support financial exploitation prosecutions

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.[7] This financial exploitation by family members or relatives can often be prosecuted as elder abuse; however, for a number of reasons, including unwillingness on the part of many victims to support prosecution of a family member or relative, these cases are often not prosecuted.

The Commission understands that DHHS, Office of Aging and Disability Services is in the process of creating a Financial Abuse Specialist Team (FAST), which will be operational in the very near future. This team will be dedicated to working with community partners to increase prosecution of financial crimes against older persons and persons with disabilities, with primary goals of increasing 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.

The Commission's recommendation on this matter is to direct DHHS, Office of Aging and Disability Services, FAST to convene a stakeholder group to review the State's criminal statutes, the Maine Adult Protective Services Act (Title 22, Chapter 958-A) and any other relevant State statutes to identify amendments to enable and support criminal prosecution of crimes against the elderly and persons with disabilities, including enhancement of penalties for such crimes. FAST should be directed to invite as participants in the stakeholder group the Office of the Attorney General, including representatives of the Healthcare Crimes Unit; the Maine Sheriffs' Association; the Maine Chiefs of Police Association; the Maine State Police; the Maine Prosecutors' Association; the Maine Health Care Association; the State's Long-term Care Ombudsman; Legal Services for the Elderly; and the Maine Office of Securities. DHHS should be directed, following completion of the stakeholder group review, to report to the Legislature regarding its findings and recommendations regarding changes to the State's laws to enable and support criminal prosecution of crimes against the elderly and persons with disabilities.

See Appendix G for draft legislation directing the formation of this stakeholder group.

8. Pay hospitals a "days awaiting placement" rate

Throughout its meetings, the Commission heard testimony regarding hospitalized patients who meet all medical criteria for hospital 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 eligible for 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 Benefits Manual, critical access hospitals are paid a "days awaiting placement" rate under very similar circumstances.[8]

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[7] Depending on a MaineCare applicant's circumstances, different asset limits/tests will apply. *See generally* 10-144-332 ME. CODE R. (MaineCare Eligibility Manual). Generally speaking, if an applicant's assets have been transferred out of their control within a 60-month "look back period," a transfer penalty will be imposed, delaying MaineCare eligibility. *See id.* pt. 15.

[8] Under the MaineCare Benefits Manual, Chapter III, section 45, critical access hospitals are eligible for prospective reimbursement of care costs provided to a patient awaiting placement at a nursing facility. Reimbursement is based on the statewide average daily rate for nursing facility services. *See* 10-144-101 ME. CODE R. §45.04.

The Commission's recommendation on this matter is to implement a "days awaiting placement" reimbursement rate for prospective payment system (PPS)[9] hospitals for Medicaid-eligible patients awaiting discharge after meeting applicable hospital discharge criteria. For Medicaid-eligible patients, the State's cost share, as based on the FMAP, is 37.33% of eligible care costs; the federal Medicaid program covers the remainder of the costs. This "days awaiting placement rate" would be the same that is currently paid to critical access hospitals under the MaineCare Benefits Manual, which is the statewide average nursing facility rate (currently just under $200 per day). DHHS should be directed to amend its rules relating to hospital reimbursements to implement this rate and should be directed to provide for reimbursement of this new rate for a period of time not to exceed 5 years.[10] For the fiscal year in which this new rate is first implemented, total reimbursements to all eligible hospitals should be capped at $500,000, resulting in a total cost to the State of $186,650.[11] This Commission accordingly recommends continued funding in the amount of $186,650 per fiscal year for a 5-year period to fund provision of this new days awaiting placement rate by DHHS.

See Appendix H for draft legislation directing implementation of this new reimbursement rate.

9. Establish 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 and care of medically complex patients but recognized that solutions to these particular problems would require further study and consideration than the Commission could accomplish during its short existence. To solve these additional complex issues, input from various stakeholder groups is necessary and the Commission recommends continuation of its work through the creation of a Commission To Continue the Study of Difficult-to-place Patients.

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

- With input from the Department of Labor, identification of medical staffing needs in the State and the barriers to and solutions for increasing the availability of trained staff across the spectrum of care;

- With input from DHHS and the Board of Nursing, an examination of the feasibility of implementing in-house staff certification programs by medical providers, such as a certified nursing assistant training program;

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[9] According to the federal Centers for Medicare and Medicaid Services, a PPS "...is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service...." Prospective Payment Systems – General Information, Centers for Medicare and Medicaid Services, *available at* https://www.cms.gov/medicare/medicare-fee-for-service-payment/prospmedicarefeesvcpmtgen/index.html.

[10] In other words, it is the Commission's intent that DHHS implement rules on this matter in a manner that would terminate reimbursement of this rate after a 5-year period of eligibility.

[11] Consistent with the FMAP state cost share of 37.33%.

- Determination of existing capacity and demand for additional capacity in appendix C PNMIs[12] in the State and options for expanding or reconfiguring 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 DHHS;

- With input from DHHS, identification of efficiencies that can be implemented to expedite the MaineCare application process for patients currently being cared for in a facility;

- 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 DHHS placement process for open geropsychiatric beds, including a review of the application of the Preadmission Screening and Resident Review (PASRR)[13] process within the geropsychiatric placement process and the application of the geropsychiatric placement criterion that a patient have a long history of mental illness;

- 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;

- Evaluation of the feasibility of facilitating and funding long-term care contracts for behavioral health support at long-term care facilities for care plan consults, treatment and staff education; and

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[12] Under the MaineCare Benefits Manual, appendix C PNMIs are medical and remedial services facilities providing long-term care services at a lower level of care than nursing facilities, primarily for frail, elderly patients. These facilities constitute a less restrictive setting than nursing facilities and allow aging-in-place in a more home-like setting. *See* 10-144-101 ME. CODE R. §97.01-9 (MaineCare Benefits Manual, chapter II, section 97); PNMI Presentation to Maine State Legislature-Appropriations and Health and Human Services Committees, 7 (January 3, 2012), *available at* http://www.maine.gov/dhhs/oms/pdfs_doc/pnmi/pnmi_presnt_010312.pdf.

[13] According to Medicaid.gov, PASRR "…is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings…." Preadmission Screening and Resident Review (PASRR), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html.

- Review of DHHS' adult protective services and public guardianship processes to identify efficiencies that can be implemented to facilitate more expedient resolutions, and to evaluate, with input from representatives of the State's judiciary, the feasibility of implementing a temporary guardianship process to facilitate hospital discharge for patients awaiting guardianship.

I. INTRODUCTION

The Commission to Study Difficult-to-place Patients was created during the First Regular Session of 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 (for a copy of that resolve, 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's 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 distributed at Commission meetings, are available at: www.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 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 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, Commission 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 a hospital primarily due to the lack of a facility to discharge that patient to with the care resources they require (e.g., 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 (i.e., no bed available). 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 next 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 recognized 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 one-to-one staffing and can become physically violent at times, which is challenging to address in the nursing facility context. Other barriers noted by Mr. Erb include the prohibition against nursing facilities 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 posited 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 (see also Appendix I for a document outlining that requested information).

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. Mel Clarrage also recognized that accessibility is a problem, 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 it 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 State's Long-term Care Ombudsman.

- Commission staff – research if other states have taken action with respect to similar issues and provide to members a related study, recently published by New Hampshire.

The Commission determined that its second meeting would be held on November 5 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 geropsychiatric 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 payment for services.

Michelle Bellhumeur stated that Gorham House has 17 geropsychiatric 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[14]

[14] To be eligible for MaineCare nursing facility benefits, a patient must meet certain eligibility criteria set forth by DHHS. For the purposes of assessing a patient's MaineCare eligibility for nursing care, DHHS has contracted with a private company, Goold Health Systems. Goold Health Systems' Community Assessment Program is comprised

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 in or remain at a geropsychiatric facility, their psychiatric diagnosis must be the primary diagnosis. If a reassessment 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 rather than 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 level 4 residential care or PNMI facilities[15] need to be considered for providing geropsychiatric services and whether the 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 geropsychiatric 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, PNMIs 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 geropsychiatric facilities. Ms. Bellhumeur noted that Gorham House is fortunate to finally have a physician assistant and psychiatrist to manage residents at their facility and that

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of more than 30 nurses, who reportedly conduct over 1,500 so-called GOOLD assessments monthly in the State. *See* Clinical Assessment Programs, Goold Health Systems, *available at* http://www.ghsinc.com/services/clinical-assessment-programs.

[15] Under DHHS' regulations governing the licensing and functioning of assisted housing programs, a residential care facility, which is "...a house or other place that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services...," is assigned a licensing level based on the number of residents and staffing. A level I facility is licensed for 1-2 residents, a level II facility for 3-6 residents, a level III facility for 3-6 residents that also employs 3 or more persons who are not the owner of the facility and a level IV facility is licensed for more than 6 residents. 10-144-113 ME. CODE R. §2 (Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level IV Residential Care Facilities). Nearly identical licensing criteria based on the number of residents and staff is also used to categorize PNMI facilities into levels I to IV. *See* 10-144-113 ME. CODE R. §2 (Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Level IV Private Non-Medical Institutions).

because of this, they no longer need to call the police as frequently to assist with physically violent patients. However, as a result, DHHS, through its utilization review (UR) process 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 DHHS 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 geropsychiatric 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 geropsychiatric 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 geropsychiatric bed, a licensed clinical social worker 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 geropsychiatric 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 asked panelists how the State determines the cost of adding new additional private, for-profit geropsychiatric facilities, who 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 noted that the State has relied upon the 3 existing geropsychiatric 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 geropsychiatric beds in the State has remained unchanged over the last 25 years. Ms. Moody also recognized that even if the State opens up more geropsychiatric beds, they will still find it challenging to secure 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 geropsychiatric 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 geropsychiatric 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 geropsychiatric 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 PNMIs 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 PNMIs is nearly half of the nursing facility rate and their staff generally have less than a third of the training as those in geropsychiatric facilities. As such, patients may not be best served by expansion of geropsychiatric services in the appendix C PNMI context. Mr. Erb noted, however, that he was surprised to hear that Mount Saint Joseph has a successful geropsychiatric 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 geropsychiatric 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 for discussion. 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 geropsychiatric 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 losing a significant amount of revenue 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 assessments at hospitals and informing placement facilities of individual patient 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 has done great work helping to place individual patients, which is time-intensive, and her 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 geropsychiatric 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) to establish a geropsychiatric 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 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 geropsychiatric 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. Geropsychiatric 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 in house, such as for a certified nursing assistant (CNA), to address staffing deficiencies and barriers to education.

As a result of discussions at this meeting, the Commission requested its staff develop a spreadsheet with proposed recommendations identified to date for consideration at the next meeting. A number of information requests, described below, were also made at the meeting.

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

- Can MHCA provide information on the rates that the 3 geropsychiatric facilities are receiving from the State through SAMHS for holding open beds for geropsychiatric patients beyond the 7 day federal limit when they have to be hospitalized?

- What suggestions does MHCA have for expanding or improving/reconfiguring Appendix C PNMI facilities to better serve these patient populations?

- What is MHCA's position on the feasibility of implementing a presumptive eligibility standard/option?

- What is MHCA's position on the proposal to implement a basic reporting requirement for facilities refusing patient placement?

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, when would the rate kick in; would there be a cap on the rate, etc.?

- What approaches have other states taken in terms of hospital reimbursement under similar circumstances?

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 geropsychiatric 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 geropsychiatric 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 facility in Waterville, which has 16 PNMI geropsychiatric beds at a rate of $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 geropsychiatric beds has been put forward in recent years.

The second question asked of MHCA was what suggestions they had for expanding, improving or reconfiguring Appendix C PNMI facilities to better serve these complex patient populations. Mr. Erb noted the geropsychiatric 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 geropsychiatric 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 and that, once that amount is exhausted, no more reimbursement will be paid to any eligible 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 geropsychiatric 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 fiscal year 2016 through fiscal year 2020 and that no additional funds can be requested. He noted, however, that the number of individuals available to transition under the program 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 geropsychiatric 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 M.R.S.A. §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.

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

Problem/issue	Identified/proposed solution	Voting information
Patients awaiting discharge remain hospitalized due to lack of appropriate/ available placement.	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). DHHS address guardianship and APS processes contributing to unnecessary extended hospital stays; develop "temporary guardianship process."	10-1 in favor of implementing immediate legislative solution. 11-0 in favor of DHHS addressing with relevant parties, including hospitals and the judiciary.
Insufficient trained staff to serve complex patients (as well as general staffing problems for all patient populations).	Address costs of education/ barriers to entry into field (work with DOL). Further examine certain facilities possibly implementing in-house staff certification programs, such as CNA (work with DOE).	10-1 in favor of further study of proposal in a stakeholder group format.
Insufficient resources to assist in placement of patients with complex medical conditions.	Add 2 FTE staff to Long-term Care Ombudsman program to assist in placement. May need statutory changes to expand Ombudsman's authority. Add 1 FTE nurse education consultant to DHHS. 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. 7-3 in favor of immediate legislative solution. 11-0 in favor of immediate legislative solution.

Insufficient capacity across facility spectrum (NFs, SNFs, PNMIs, 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.	Amend 22 MRSA §7948 regarding unlawful discharges. Additional statutory/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 (patient may 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 MaineCare eligibility. Work with DHHS to specifically expedite application process for hospitalized patients awaiting placement. Amend MaineCare application process to better account for financial exploitation situations.	10-1 in favor of further study of proposal in a stakeholder group format. 10-1 in favor of further study of proposal in a stakeholder group format. 12-0 in favor of further study of proposal in a stakeholder group format.

Insufficient data is collected regarding basis for facility refusal of placement.	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.	10-2 in favor of immediate legislative solution.
Theft of patient assets by family member or other persons complicates patient's MaineCare eligibility and delays provision of services.	Increase efforts for prosecution of these types of cases (specifics TBD; DHHS will provide suggestions).	12-0 in favor of immediate legislative solution.
Currently insufficient geropsychiatric capacity in Maine (usually most beds full).	Provide statutory authority to waive CON to facilitate the expansion of geropsychiatric beds in State (NF and/or PNMI expansion) and implement all other necessary statutory or regulatory changes to accomplish this.	11-1 in favor of immediate legislative solution. Note DHHS testimony that RFI will issue in December 2015 to solicit responses for medical/psychiatric needs patients, special medical needs patients and neuro-behavioral needs patients.
Despite immediate needs, geropsychiatric placement process for open bed takes too long (often 6 weeks).	Implement options for improving/speeding up placement process, including addressing application of criterion that patient has "long history of mental illness" and challenges in applying PASRR process to geropsychiatric patients.	11-0 in favor of further study of proposal in a stakeholder group format.
Insufficient capacity/ placement options ("step-down") for geropsychiatric patients who no longer require that level or type of care.	Increase facility options to address geropsychiatric patients developing dementia, including residential care options at geropsychiatric facilities and address problems with	11-0 in favor of further study of proposal in a stakeholder group format.

	assessment criteria for both admission and discharge (PASRR v. GOOLD).	

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

The fourth meeting of the Commission was held on December 2. After calling the meeting to order and introducing the members, Commission staff introduced the draft Commission report. The first recommendation in the report ("Recommendation A") related to implementation of a "days awaiting placement" rate, whereby PPS hospitals would be paid a daily rate for care of patients who have met all medical criteria for discharge, but who remain hospitalized due to lack of an appropriate or available placement to which the patient can be discharged. Commission staff noted the vote at the last meeting on this proposal was 10-1 in favor.

Representative Malaby voiced his concern that he did not want this proposal to overshadow the proposal to expand geropsychiatric facility capacity. He recommended that perhaps, instead of listing this proposal as the first recommendation, it be moved to the end of the recommendations list. Kim Moody stated her opposition to this recommendation, arguing that it was not part of the solution to the actual problem faced by patients. Jeff Austin responded that this proposal is significantly restricted in terms of actual reimbursement in that it would only be available for Medicaid-eligible patients. He also stated that it seems fundamentally unfair that the hospitals should have to be the current solution to the problem yet receive no compensation for their actual costs. Mr. Austin also recommended that this proposal include a statement regarding the State's cost share of these payments (1/3 of cost paid by State; 2/3 paid by federal government), note that the payment only applies to Medicaid-eligible patients and to provide an estimated $500,000 total cost per year, only 1/3 of which would be paid by the State.

Senator Haskell suggested that the Commission consider a sunset on this proposal. Mel Clarrage noted that with the limited resources available to address the many problems the Commission has identified, he has difficulty supporting funding this proposal over others that are more patient-focused. Richard Erb questioned whether the rate would have a trigger, i.e., would the rate be available immediately for a patient once they became eligible for discharge. He noted even once a patient meets discharge criteria and has a placement lined up, it often takes a number of days before they can actually be placed. Mr. Austin responded there is no such trigger for the similar rate currently paid to critical access hospitals, and as such he would recommend the same for this rate. He also noted that because eligibility for the rate is significantly restricted and total reimbursements are capped, that cap might not even be reached in any given year.

For the purposes of review at the final meeting, Commission members informally agreed to add Mr. Austin's language recommendations to this proposal, include a 5 year "sunset" provision to the reimbursement and to move this proposal to later on in the recommendations list.

Commission staff next described "Recommendation B," which proposes to expand the role of the Long-term Care Ombudsman program by adding two additional staff to that office and amending the Ombudsman's statutory authority, which was supported by an 11-0 vote at the last meeting. Brenda Gallant, the Long-term Care Ombudsman, provided additional details on this proposal, noting these two staff would be focused solely on outreach, patient consults and facility or home care consults relating to the placement of patients with complex medical conditions. Currently, there are no staff in her office who are tasked with this role; instead, it is something she herself has taken on as time allows. She estimated that the total cost for these two positions, including wages, taxes, benefits, mileage reimbursement and other incidentals would be roughly $150,000.

For the purposes of review at the final meeting, Commission members informally agreed to add details of Ms. Gallant's position cost estimates to the recommendation.

"Recommendation C" pertains to expansion of certain DHHS resources. As Commission staff noted, one recommendation adds an additional nurse education consultant position at DHHS, which was supported by a 7-3 vote at the last meeting. This position, which is reportedly in high demand at facilities across the State, engages in facility outreach and assistance, provides care consults, medication changes, etc. The other recommendation here would require DHHS to fund long-term care contract for behavioral health support at long-term care facilities for care plan consults, treatment and staff education, and was supported by an 11-0 vote at the last meeting.

Senator Katz questioned why the nurse education consultant position was even needed as every nursing facility must have nursing staff. Mr. Erb responded that although every nursing facility does in fact have nursing staff, they often lack the resources, especially in small facilities, to provide the type of specialized supportive and consultative services this DHHS position provides. Having that additional support, he noted, often helps facilities in being able to accept medically complex patients. Ms. Gallant echoed that this position is a frequently-utilized resource and reportedly provides necessary and appreciated assistance to facility staff around the State. Ricker Hamilton, when asked about the cost of this position, estimated the total cost to add another nurse education consultant would be roughly $75,000 to $100,000, but stated that he would confirm that figure by the next meeting.

For the purposes of review at the final meeting, Commission members informally agreed to clarify and include details of the cost estimates of this position to the recommendation.

Turning to the second part of this recommendation, Mr. Austin questioned whether the proposal would be to have DHHS fund multiple contracts between long-term care facilities and local behavioral health service providers, or whether it would be a single contract between the State and behavioral health providers to provide services to facilities across the State. Mr. Hamilton stated he cannot support the proposal if the intention for DHHS to fund within existing resources.

Commission members generally agreed this proposal would require more information and development before full consideration and, for purposes of review at the final meeting, informally agreed to move the proposal to the list of directives for the new commission.

Commission staff next described "Recommendation D," which proposes to expand community placement options in the State, focusing on the lack of staffing support and low, flat reimbursement for home care services and was supported by a 10-2 vote at the last meeting. Mr. Clarrage and Ms. Gallant presented two proposals to address these issues that they had worked together to develop. First, they recommended that DHHS conduct a demonstration project to explore the feasibility of implementing an enhanced reimbursement rate for home care services. Participants would be limited to those patients currently receiving services through the Homeward Bound program. Second, they recommend that the Home Care Quality Review Committee at DHHS conduct a review into the adequacy of home care services provided under section 19 of the MaineCare Benefits Manual. Both proposals would include a requirement that DHHS report their respective findings and recommendations to the Legislature.

Representative Gattine noted the difficulty in developing an acuity scale to apply for home care services and questioned whether the State would have the ability to do this. Ms. Gallant responded that, in the home care services context, this could be accomplished by just providing supplemental payments for actual costs relating to the patient's acuity. Ms. Gallant also noted, in response to a Commission member's question, that these proposals would not be aimed at increasing the number of placements under the Homeward Bound program, but would hopefully improve the likelihood of successful community placements through that program.

For the purposes of review at the final meeting, Commission members informally agreed to incorporate both of these proposals as recommendations in the report.

"Recommendation E" recognizes that data relating to the basis for a facility's refusal to accept placement of a patient may be crucial to understanding and addressing barriers to placement and proposes to implement a method to collect and analyze this data. At the last meeting, although this recommendation was supported by a 10-2 vote, no specific details as to how to accomplish this proposal were suggested. Ms. Gallant and Mr. Erb described discussions they had had since the last meeting and proposed to, in conjunction with other interested parties, develop an appropriate method for collecting, maintaining, analyzing and reporting on this data without the need to create an additional regulatory burden for long-term care facilities. They stated their intention to work with providers, hospitals and facilities to develop recommendations to bring to the Legislature in the spring. Ms. Maline recommended that Consumer Council System of Maine be included in the conversation to provide input on mental health facilities.

For the purposes of review at the final meeting, Commission members informally agreed to include information in this recommendation relating to the work to be undertaken by these groups in developing a method for collecting and maintaining this data.

Commission staff next described "Recommendation F," which addresses financial exploitation of individuals by family members or other relatives and its impact on MaineCare application processing and eligibility. Commission members voted 12-0 at the last meeting in support of implementing an immediate solution to this problem, with specific details to be provided by DHHS. Mr. Hamilton provided a draft proposal outlining the creation of a stakeholder group, hosted by the new financial abuse specialist team (FAST) at DHHS, to review Maine criminal laws, the Maine Adult Protective Services Act and other applicable laws with the intent of

facilitating greater prosecutions of elder abuse and financial exploitation cases. He noted that FAST staff were being hired at present and would be available to conduct this review should the Legislature direct it next session.

For the purposes of review at the final meeting, Commission members informally agreed to incorporate this proposal as a recommendation in the report.

"Recommendation G" proposes to expand geropsychiatric bed capacity in the State and was supported by an 11-1 vote at the last meeting. Mr. Hamilton started out this discussion by providing additional information on the Request for Information (RFI) that DHHS is preparing to put out. This RFI would seek input on the development of a 12-20 bed neurobehavioral treatment center, a 12-20 bed specialty medical treatment center and a 12-20 bed medical/psychiatric specialty treatment center (see also Appendix I for a copy of this document). Commission members generally agreed that, while there may be some overlap in patient populations addressed by this proposal and in the RFI, expansion of geropsychiatric capacity should be considered independently of the RFI. Representative Gattine asked Mr. Hamilton about the timeline of the RFI and subsequent actions to be taken. Mr. Hamilton responded that after receiving the responses to the RFI, DHHS would assess that information, which could potentially inform legislative action and a Request for Proposals (RFP) to actually develop one or all of these facilities described in the RFI.

Turning to the recommendation to expand the number of geropsychiatric beds, Mr. Austin suggested that the report explicitly state that Maine has not expanded the number of geropsychiatric beds in Maine in 25 years. He also recommended that a rough estimate of State costs of expansion be included and that a requirement be added to give priority to expansion of capacity in Northern Maine. He estimated that based on a cost per bed of $350 per day and an expansion of 25 beds, the State's cost share would be roughly $1 million of a $3 million total cost. Ms. Moody questioned whether there was actual data demonstrating a need for more geropsychiatric beds in the State and stated she could not support expansion without such data. Mr. Austin reiterated, and Mr. Erb agreed, that there was a great need for these beds, and that such data would certainly be provided should the proposal reach a public hearing format in the HHS Committee.

For the purposes of review at the final meeting, Commission members informally agreed to include Mr. Austin's recommended language additions and cost estimate.

"Recommendation H" proposes to review DHHS' APS/guardianship processes and explore the feasibility of implementing a temporary guardianship process to facilitate the placement of hospitalized patients at long-term care or other facilities. At the last meeting, there had been an 11-0 vote in favor of recommending further consideration of these matters by DHHS with input from the judiciary and other interested parties. Mr. Hamilton noted that this is a probate code issue and as such is within the purview of the judiciary, not DHHS. Mr. Austin suggested that this seems a more appropriate proposal for further consideration by the new commission.

For the purposes of review at the final meeting, Commission members informally agreed to move this proposal to the list of directives for the new commission.

Commission staff lastly provided an overview of "Recommendation I," which creates a new Commission To Continue the Study of Difficult-to-place Patients. Staff highlighted draft legislation creating this new commission, noting the various proposals flagged for inclusion at the last meeting to be included as directives for the new commission. At the last meeting, three of the directives had been voted for further study by the new commission by a 10-1 vote; the rest had been voted unanimously for inclusion.

For the purposes of review at the final meeting, Commission members informally agreed to recommend a number of minor language and formatting changes to the listed study directives.

The Commission next opened the floor up for public comment. Lisa Harvey-McPherson (EMHS) responded to an earlier statement questioning the actual need for geropsychiatric capacity expansion. She noted that EMHS generally has around 12 patients at all times requiring placement in a facility with geropsychiatric services, noting that even small hospitals in their system typically place a number of patients per year in geropsychiatric care. She agreed with Mr. Austin and Mr. Erb that there was a distinct and immediate need for these additional geropsychiatric beds and committed to providing all necessary data to the HHS Committee support this proposal.

The Commission determined that its fifth and final meeting would be held on Monday, December 7 and adjourned for the day.

E. Fifth meeting – December 7, 2015

The fifth meeting of the Commission was held on December 7. After calling the meeting to order and introducing the members, the Commission provided members of the public with an opportunity to comment on the draft Commission report; however, there were no members of the public present who wished to testify.

Commission staff assisted members in reviewing its draft report and questioned members as to how they would like to review and vote on the report and the included recommendations. Representative Gattine expressed his preference to view and vote on the report as an entire package rather than on each individual proposal. Senator Haskell agreed, noting that given the straw votes previously taken and the inclusion of detailed meeting summaries outlining members' preferences and concerns, it would be best to vote on the entire proposed package. Jeff Austin also noted that this was a group recommendation, generally supported by the entire Commission, although certain members might have different sets of priorities or concerns about specific proposals. Ultimately, Commission members decided to consider the report and its proposed recommendations in a single vote.

Commission staff also questioned members as to their preference for inclusion of meeting summaries in the report, noting that these summaries do significantly increase the length of the report, that some commissions or studies choose not to include meeting summaries for this and other reasons and that the summaries and all materials distributed in conjunction with the Commission are already available via the Office of Policy and Legal Analysis webpage. Representative Gattine expressed his preference that, for historical and accessibility purposes,

the summaries be included in the report. Commission members agreed and opted to include the summaries in the final report.

Turning to the report, the Commission decided that rather than formally go back through each recommendation, especially as each proposal was not being voted on individually, it would just provide any member the opportunity to comment specifically or generally on the draft report under consideration. Mr. Austin was the first to comment, noting a few errors or clarifications to be made to certain recommendations in the report. He also suggested that the document provided by DHHS at the prior meeting outlining its upcoming RFI be included in the report. Representative Gattine noted an additional oversight to be corrected in the report. Commission members generally agreed to accept Mr. Austin's and Representative Gattine's changes and to include the RFI document as an appendix to the report.

Representative Gattine next entertained a motion from Senator Haskell, seconded by Mr. Austin, to accept the draft report as written, including the minor changes discussed at the current meeting. With two members absent (Katz, Malaby), the vote was 9-1 in favor of the motion, with Ricker Hamilton voting against accepting the report as written.[16] In describing the basis for his opposition, Mr. Hamilton noted that he would have preferred to vote individually on each recommendation as there were a number of them he would have supported. Specifically, Mr. Hamilton described his opposition to the following proposals: expansion of geropsychiatric beds (concern about current system and lack of information; would have supported obtaining more information through a RFI); demonstration project for enhanced home care services rates (additional costs to DHHS for conducting study); paying hospitals a "days awaiting placement" rate; and establishment of the Commission To Continue the Study of Difficult-to-place Patients (additional costs to DHHS associated with its involvement).

Mel Clarrage noted that, while he did ultimately support the overall package, he was concerned over the lack of attention paid to home-based and community placements and care and the focus on institutional services. He hoped that future discussions and proposals on these matters addressed problems specific to home-based and community placements and care. Mr. Austin, noting that Maine Hospital Association was the primary supporter of this study, thanked members for their participation and expressed his desire that meaningful action will occur this session as a result of the Commission's work. Kim Moody reiterated her position that she is not convinced that there is a specific need for expansion of geropsychiatric beds in the State and stated that she will be opposing that proposal before the Legislature.

Representative Gattine noted that, given the size and scope of the problems facing the Commission, it has made more progress on these issues than he might have expected. He thanked all members for their participation, complimented the quality of discussion and participation throughout the Commission's meetings and expressed his hope that additional work on these matters will continue in the future. Senator Haskell additionally noted that these issues cannot always sufficiently be addressed in the legislative study context and expressed her hope that all parties continue to engage one another in discussions on the issues reviewed by the

[16] Neither Senator Katz nor Representative Malaby were present at the final Commission meeting, but Commission members agreed to allow them to record their respective votes on the report after the meeting. Both members subsequently voted to accept the report as presented.

Commission and work together to solve the many problems relating to the care of medically complex patients in Maine. After completing its work for the day and for the interim, the Commission adjourned for the final time.

IV. RECOMMENDATIONS

Early on in the Commission's meetings, it became clear to its members that the issues raised by 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 fully address. Accordingly, the Commission determined that its recommendations would include a number of proposals for immediate legislative action as well as the establishment of the Commission To Continue the Study of Difficult-to-place Patients to further discuss other complex, but equally important issues raised and considered by the Commission during its interim work but not fully addressed in its specific legislative recommendations. The Commission's specific recommendations, supported by 11 of 12 members,[17] are as follows.

1. Expand geropsychiatric facility capacity in the State

At present, there are only 3 facilities in Maine that specialize in the long-term residential care of geropsychiatric[18] patients. Hawthorne House in Freeport and Gorham House in Gorham provide geropsychiatric services in a nursing facility setting, while Mount Saint Joseph in Waterville provides similar services in a private non-medical institution (PNMI)[19] setting. In total at these 3 facilities, there are 51 geropsychiatric beds. Testimony received by the Commission indicated that these beds are in high demand and rarely vacant, suggesting an immediate need for additional capacity in the State. Moreover, the Commission understands that there has been no expansion of geropsychiatric facility capacity in Maine in the last 25 years.

Under the existing State Certificate of Need (CON) statutory provisions, CON unit approval from the Department of Health and Human Services (DHHS) is required for new nursing facility services including expansion of capacity, relocation of beds from one nursing facility to another,

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[17] All Commission members except Ricker Hamilton voted to accept the final report and recommendations as a single package. Mr. Hamilton supported some of the proposals in the report and described his opposition to the other proposals at the final meeting. For more detail regarding his position, see fifth meeting summary.

[18] Geriatric psychiatry or geropsychiatry involves the study, prevention and treatment of mental illness in elderly and aging populations.

[19] DHHS defines a PNMI as "...an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides food, shelter, personal care, and treatment services to four or more residents in single or multiple facilities or scattered site facilities...." 10-144-101 ME. CODE R. §97.01-9 (MaineCare Benefits Manual, Chapter II, section 97). There are five categories of PNMIs in Maine, each based upon a different appendix to the MaineCare Benefits Manual, chapter II, section 97: Appendix B (substance abuse treatment facilities), C (medical and remedial services facilities), D (child care facilities/intensive temporary residential treatment services facilities), E (community residences for persons with mental illness) and F (non-case mixed medical and remedial facilities). *Id.*

replacement nursing facilities, changes in ownership and control of nursing facilities and building modifications and capital expenditures by nursing facilities. Criteria for a CON application are established in 22 M.R.S.A. §335 as well as in DHHS' 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. Additionally, the Commission understands that DHHS currently interprets its statutory and regulatory authority to require so-called MaineCare neutrality fulfillment for any addition of facility capacity in the State.[20]

The Commission's recommendation to address current unmet demand for geropsychiatric facility care is to expand available geropsychiatric facility capacity in the State. We recognize that this proposal, if resulting in additional geropsychiatric nursing facility beds, will require an exemption from the CON statutory requirements. The Commission further recognizes that regardless of whether additional nursing facility or PNMI geropsychiatric beds, or a combination thereof, are added, this proposal will also require an exemption from so-called MaineCare neutrality fulfillment requirements.

While the Commission will not speculate as to whether this expansion would be best accomplished in the nursing facility or PNMI context, or both, the Commission does recommend that total approved expansion not exceed a maximum of 25 new geropsychiatric beds. This expansion need not be restricted to a single new or expanded facility but could represent expansion of capacity in multiple facilities and/or locations around the State. This Commission also recognizes that with existing geropsychiatric facilities located in Gorham, Freeport and Waterville, there is a specific lack of geropsychiatric capacity in Northern and Down East Maine. As such, we recommend that any expansion of geropsychiatric facility capacity give highest priority to proposals to add new beds located north and/or east of Waterville.

The Commission recognizes that expansion of geropsychiatric capacity will result in additional fiscal costs for the State. Testimony received by the Commission indicated that existing nursing facility geropsychiatric beds receive daily reimbursement rates averaging $328 to $344 per day, a rate that includes the cost for a private room, while existing PNMI geropsychiatric beds receive a rate of $227 per day. If the Commission assumes an expansion of 25 beds, with all new beds located in nursing facilities and uses a high estimated reimbursement rate of $350 per bed per day, the total cost for this proposed expansion would be $3,193,750 ($350 per bed per day x 365 days per year x 25 new beds). Accordingly, consistent with the Medicaid cost-sharing Federal Medicaid Assistance Percentage (FMAP),[21] the State's share of that cost would be $1,192,227, and this Commission recommends approval of State funding in that amount to support the above-described expansion of geropsychiatric facility capacity in Maine.

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[20] To put it another way, DHHS requires that an expanding facility acquire MaineCare revenue stream resources by purchasing these from another facility or relocating resources within its own system; i.e., you can't add a MaineCare bed without removing another MaineCare bed (or equivalent MaineCare resources) elsewhere in the State.

[21] For the current fiscal year (federal FY2016, which is October 1, 2015 through September 30, 2016), the FMAP for Maine is 62.67%. In other words, for eligible Medicaid costs, the State's share of the total cost is 37.33%. *See* FY2016 Federal Medical Assistance Percentages, United States Department of Health & Human Services, Office of the Assistant Secretary For Planning and Evaluation (December 2, 2014), *available at* https://aspe.hhs.gov/basic-report/fy2015-federal-medical-assistance-percentages.

2. Expand the State's 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, as the program currently has no staff specifically dedicated to provide these services. The Ombudsman estimated that the total cost of adding these two additional staff to her office would be roughly $150,000. That total would include staff salaries, as well as all applicable taxes, benefits, mileage reimbursements and other costs.

The Commission's recommendation on this matter is to provide sufficient funding, estimated at $150,000, to support two additional full-time equivalent (FTE) staff for the Ombudsman program to provide assistance in placement of patients with complex medical conditions, including assistance to facilities post-placement.

The Commission also recommends that the Ombudsman's statutory authority set forth at 22 M.R.S.A. §5107-A be amended to reflect these additional duties relating to assistance in the placement of patients with complex medical conditions.

See Appendix D for draft legislation relating to the proposed statutory changes.

3. Expand resources provided by the Department of Health and Human Services

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 meet with staff to consult on and make recommendations for patient care as well as assist in medication changes. Information provided by DHHS indicated that the estimated total costs of an additional nurse education consultant position would include $57,304 in salary, $30,888 in benefits and $6,278 all other costs, for a total cost of $94,470. According to DHHS, costs for this position are split 50/50 with Medicaid.

As such, the Commission's recommendation on this matter is to provide State funding in the amount of $47,235 (based on a 50% cost-share of this position with Medicaid) to support one additional FTE nurse education consultant position at DHHS.

4. Examine feasibility of providing enhanced rates for home care services

Testimony received by the Commission indicated that a major barrier to community placement of patients with complex (and non-complex) medical conditions is lack of home care 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 each patient's particular needs.

The Commission's recommendation on this matter is to direct DHHS, Office of Aging and Disability Services to develop and implement a demonstration project to allow enhanced rates for home care services, with participation limited to patients with complex medical needs

currently enrolled in the Homeward Bound program. These enhanced rates must provide additional reimbursement for services provided by Personal Support Specialists (PSS) and for on-site training of PSS staff prior to the commencement of services to promote quality of care and retention of staff. DHHS should be directed, following the completion of the demonstration project, to report back to the Legislature regarding its findings and recommendations regarding the expansion of enhanced rates for home care services.

See Appendix E for draft legislation directing this demonstration project.

5. Review adequacy of home care services

As stated in the previous recommendation, a major barrier to community placement is lack or inadequacy of available home care services. To ensure a complete understanding of the current state of home care services available in Maine, the Commission recommends that DHHS, Office of Aging and Disability Services, Home Care Quality Review Committee review the adequacy of home care services provided for individuals with complex needs under the MaineCare Benefits Manual, Chapter II, section 19, Home and Community Benefits for the Elderly and Adults with Disabilities. This review shall include, at a minimum, consideration of quality of care, emergency department visits and hospital admissions by individuals receiving services under section 19. In conducting this review, the Home Care Quality Review Committee should be directed to request input, at a minimum, from consumers, care coordination agencies, patient advocacy organizations and home care agencies. DHHS should be directed, following the completion of this review, to report back to the Legislature regarding its findings and recommendations regarding the adequacy of home care services provided under section 19.

See Appendix F for draft legislation directing this review.

6. Facilitate reporting of data regarding facility refusal of placement

When a patient with complex medical conditions is refused placement at a medical care facility, that facility's basis for refusing placement is often not communicated to the patient, the patient's providers or the State. The reasons a facility may refuse placement of 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 the basis for refusal of placement is critical to identifying and removing barriers to placement for patients with complex medical conditions.

Following Commission discussions on these matters, several commission members volunteered to work together to identify a process for the Office of the Long-term Care Ombudsman to receive and track information relating to a facility's decision to deny placement to a patient with complex medical needs, as well as a method for appropriately maintaining and distributing this collected data to interested agencies, organizations, individuals and the Legislature. The parties that have agreed to work on further development of this proposal include the State's Long-term Care Ombudsman, the Maine Health Care Association, the Maine Hospital Association, DHHS, the Consumer Council System of Maine and Disability Rights Maine. The Commission appreciates the initiative taken by these parties and requests that stakeholders submit any

recommendations relating to these matters to the Joint Standing Committee on Health and Human Services (HHS Committee) during the Second Regular Session of the 127th Legislature.

7. Support financial exploitation prosecutions

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.[22] This financial exploitation by family members or relatives can often be prosecuted as elder abuse; however, for a number of reasons, including unwillingness on the part of many victims to support prosecution of a family member or relative, these cases are often not prosecuted.

The Commission understands that DHHS, Office of Aging and Disability Services is in the process of creating a Financial Abuse Specialist Team (FAST), which will be operational in the very near future. This team will be dedicated to working with community partners to increase prosecution of financial crimes against older persons and persons with disabilities, with primary goals of increasing 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.

The Commission's recommendation on this matter is to direct DHHS, Office of Aging and Disability Services, FAST to convene a stakeholder group to review the State's criminal statutes, the Maine Adult Protective Services Act (Title 22, Chapter 958-A) and any other relevant State statutes to identify amendments to enable and support criminal prosecution of crimes against the elderly and persons with disabilities, including enhancement of penalties for such crimes. FAST should be directed to invite as participants in the stakeholder group the Office of the Attorney General, including representatives of the Healthcare Crimes Unit; the Maine Sheriffs' Association; the Maine Chiefs of Police Association; the Maine State Police; the Maine Prosecutors' Association; the Maine Health Care Association; the State's Long-term Care Ombudsman; Legal Services for the Elderly; and the Maine Office of Securities. DHHS should be directed, following completion of the stakeholder group review, to report to the Legislature regarding its findings and recommendations regarding changes to the State's laws to enable and support criminal prosecution of crimes against the elderly and persons with disabilities.

See Appendix G for draft legislation directing the formation of this stakeholder group.

8. Pay hospitals a "days awaiting placement" rate

Throughout its meetings, the Commission heard testimony regarding hospitalized patients who meet all medical criteria for hospital discharge, but remain hospitalized due to the lack of an

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[22] Depending on a MaineCare applicant's circumstances, different asset limits/tests will apply. *See generally* 10-144-332 ME. CODE R. (MaineCare Eligibility Manual). Generally speaking, if an applicant's assets have been transferred out of their control within a 60-month "look back period," a transfer penalty will be imposed, delaying MaineCare eligibility. *See id.* pt. 15.

appropriate or available placement to which the patient can be discharged. Once discharge criteria are met, hospitals are no longer eligible for 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 Benefits Manual, critical access hospitals are paid a "days awaiting placement" rate under very similar circumstances.[23] The Commission's recommendation on this matter is to implement a "days awaiting placement" reimbursement rate for prospective payment system (PPS)[24] hospitals for Medicaid-eligible patients awaiting discharge after meeting applicable hospital discharge criteria. For Medicaid-eligible patients, the State's cost share, as based on the FMAP, is 37.33% of eligible care costs; the federal Medicaid program covers the remainder of the costs. This "days awaiting placement rate" would be the same that is currently paid to critical access hospitals under the MaineCare Benefits Manual, which is the statewide average nursing facility rate (currently just under $200 per day). DHHS should be directed to amend its rules relating to hospital reimbursements to implement this rate and should be directed to provide for reimbursement of this new rate for a period of time not to exceed 5 years.[25] For the fiscal year in which this new rate is first implemented, total reimbursements to all eligible hospitals should be capped at $500,000, resulting in a total cost to the State of $186,650.[26] This Commission accordingly recommends continued funding in the amount of $186,650 per fiscal year for a 5-year period to fund provision of this new days awaiting placement rate by DHHS.

See Appendix H for draft legislation directing implementation of this new reimbursement rate.

9. Establish 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 and care of medically complex patients but recognized that solutions to these particular problems would require further study and consideration than the Commission could accomplish during its short existence. To solve these additional complex issues, input from various stakeholder groups is necessary and the Commission recommends continuation of its work through the creation of a Commission To Continue the Study of Difficult-to-place Patients.

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

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[23] Under the MaineCare Benefits Manual, Chapter III, section 45, critical access hospitals are eligible for prospective reimbursement of care costs provided to a patient awaiting placement at a nursing facility. Reimbursement is based on the statewide average daily rate for nursing facility services. *See* 10-144-101 ME. CODE R. §45.04.

[24] According to the federal Centers for Medicare and Medicaid Services, a PPS "...is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service...." Prospective Payment Systems – General Information, Centers for Medicare and Medicaid Services, *available at* https://www.cms.gov/medicare/medicare-fee-for-service-payment/prospmedicarefeesvcpmtgen/index.html.

[25] In other words, it is the Commission's intent that DHHS implement rules on this matter in a manner that would terminate reimbursement of this rate after a 5-year period of eligibility.

[26] Consistent with the FMAP state cost share of 37.33%.

- With input from the Department of Labor, identification of medical staffing needs in the State and the barriers to and solutions for increasing the availability of trained staff across the spectrum of care;

- With input from DHHS and the Board of Nursing, an examination of the feasibility of implementing in-house staff certification programs by medical providers, such as a certified nursing assistant training program;

- Determination of existing capacity and demand for additional capacity in appendix C PNMIs[27] in the State and options for expanding or reconfiguring 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 DHHS;

- With input from DHHS, identification of efficiencies that can be implemented to expedite the MaineCare application process for patients currently being cared for in a facility;

- 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 DHHS placement process for open geropsychiatric beds, including a review of the application of the Preadmission Screening and Resident Review (PASRR)[28] process within the geropsychiatric placement process and the application of the geropsychiatric placement criterion that a patient have a long history of mental illness;

- 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

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[27] Under the MaineCare Benefits Manual, appendix C PNMIs are medical and remedial services facilities providing long-term care services at a lower level of care than nursing facilities, primarily for frail, elderly patients. These facilities constitute a less restrictive setting than nursing facilities and allow aging-in-place in a more home-like setting. *See* 10-144-101 ME. CODE R. §97.01-9 (MaineCare Benefits Manual, chapter II, section 97); PNMI Presentation to Maine State Legislature-Appropriations and Health and Human Services Committees, 7 (January 3, 2012), *available at* http://www.maine.gov/dhhs/oms/pdfs_doc/pnmi/pnmi_presnt_010312.pdf.

[28] According to Medicaid.gov, PASRR "...is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings...." Preadmission Screening and Resident Review (PASRR), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html.

geropsychiatric services and a discussion of applicable assessment criteria for admission and discharge at geropsychiatric facilities;

- Evaluation of the feasibility of facilitating and funding long-term care contracts for behavioral health support at long-term care facilities for care plan consults, treatment and staff education; and

- Review of DHHS' adult protective services and public guardianship processes to identify efficiencies that can be implemented to facilitate more expedient resolutions, and to evaluate, with input from representatives of the State's judiciary, the feasibility of implementing a temporary guardianship process to facilitate hospital discharge for patients awaiting guardianship.

APPENDIX A

Authorizing legislation, Resolve 2015, Chapter 44

LAW WITHOUT GOVERNOR'S SIGNATURE (Originals not returned by Governor) JULY 12, 2015

CHAPTER 44 RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND AND FIFTEEN

H.P. 113 - L.D. 155

Resolve, To Establish the Commission To Study 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, this resolve establishes the Commission To Study Difficult-to-place Patients to study certain 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, immediate enactment of this resolve is necessary to provide the commission 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 Study 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; and

4. Seven members appointed by the Governor 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 long-term care facilities;

C. An individual representing a statewide association of hospitals;

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

E. An individual representing a statewide organization advocating for people with mental illness;

F. An individual representing an organization promoting independent living for individuals with disabilities; and

G. An individual or a family member of an individual with a complex medical condition; 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 First 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 categories of patients with complex medical and mental health conditions who are unable to be discharged from hospitals because there are no facilities or providers who are able to care for them or to accept them for care;

2. A description of how patients with complex medical and mental health conditions are placed currently, including the involvement of staff from the Department of Health and Human Services;

3. Identification of primary barriers to placement of patients with complex medical and mental health conditions currently;

4. A description of facilities in which patients with complex medical and mental health conditions are currently placed, including whether the facilities are in-state and the costs associated with the patients' care;

5. Options for increasing availability of residential care and long-term care facilities, including conversion of existing facilities such as hospitals, nursing homes and the Dorothea Dix Psychiatric Center to long-term care facilities for specialized populations that are difficult to place for care, such as ventilator-dependent patients, geropsychiatric patients and bariatric patients;

6. Rates of reimbursement necessary to operate facilities to manage patients with complex medical conditions, including psychiatric conditions and neurodegenerative diseases; and

7. 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 2, 2015, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the Joint Standing Committee on Health and Human Services.

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

APPENDIX B

Commission membership list

Commission to Study Difficult-to-Place Patients

Resolve 2015, c. 44

Appointment(s) by the Governor

Jeffrey A. Austin Maine Hospital Association 33 Fuller Road Augusta, ME 04330	An individual representing a statewide association of hospitals
Melvin Clarrage 221 Longfellow St., Unit 2 Westbrook, ME 04092	An individual representing an organization promoting independent living for individuals with disabilities
Richard A. Erb 35 Melden Drive Brunswick, ME 04011	An individual representing a statewide association of long-term care facilities
Brenda C. Gallant Long-Term Care Ombudsman 61 Winthrop Street Augusta, ME 04330	Director of the long-term care ombudsman program (MRS Title 22, Section 5106, subsection 11-C)
Michael Lemieux* Seaside Healthcare 850 Baxter Blvd. Portland, ME 04103	An individual or a family member of an individual with a complex medical condition
Simonne Maline Consumer Council System of ME 55 Middle St., Suite 2 Augusta, ME 04330	An individual representing statewide organization advocating for people with mental illness
Kim Moody 24 Stone Street, Suite 204 Augusta, ME 04330	An individual representing an organization that represents people with disabilities

Appointment(s) by the President

Sen. Roger J. Katz – Chair 3Westview Street Augusta, ME 043330	Senate members from each of the two parties holding the largest number of seats in the legislature
Sen. Anne. M. Haskell 31 Higgins Street Portland, ME 04103	Senate members from each of the two parties holding the largest number of seats in the legislature

* Resigned

Appointment(s) by the Speaker

Rep. Andrew M. Gattine - Chair
529 Stroudwater Street
Westbrook, ME 04092

Members of the House of Representatives from each of the two parties holding the largest number of seats in the legislature

Rep. Richard Malaby
52 Cross Road
Hancock, ME 04640

Members of the House of Representatives from each of the two parties holding the largest number of seats in the legislature

Rep. Peter C. Stuckey
20 Vaill Street
Portland, ME 04103

Members of the House of Representatives from each of the two parties holding the largest number of seats in the legislature

Commissioner, Department of Health and Human Services

Ricker Hamilton
11 State House Station
Augusta, ME 04333-0011

Commissioner of Health and Human Services or Commissioner's Designee

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Staff:
Dan Tartakoff
Natalie Haynes
Office of Policy and Legal Analysis

APPENDIX C

Draft legislation, establishing Commission To Continue the Study of Difficult-to-place Patients

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 the organization that represents people with disabilities designated pursuant to the Maine Revised Statutes, Title 5, chapter 511; 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. With input from the Department of Labor, identification of medical staffing needs in the State and the barriers to and solutions for increasing the availability of trained staff across the spectrum of care;

2. 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 by medical providers, such as a certified nursing assistant training program;

3. Determination of existing capacity and demand for additional capacity in appendix C private non-medical institutions in the State and options to expand or reconfigure the State's appendix C private non-medical institution system to better meet identified demands;

4. 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;

5. With input from the Department of Health and Human Services, identification of efficiencies that can be implemented to expedite the MaineCare application process for patients currently being cared for in a facility;

6. 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;

7. 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;

8. 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;

9. Evaluation of the feasibility of facilitating and funding long-term care contracts for behavioral health support at long-term care facilities for care plan consults, treatment and staff education;

10. Review of the Department of Health and Human Services' adult protective services and public guardianship processes to identify efficiencies that can be implemented to facilitate more expedient resolutions, and to evaluate, with input from representatives of the State's judiciary, the feasibility of implementing a temporary guardianship process to facilitate hospital discharge for patients awaiting guardianship; and

11. 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 draft legislation establishes by resolve 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. With input from the Department of Labor, identification of medical staffing needs in the State and the barriers to and solutions for increasing the availability of trained staff across the spectrum of care;

2. 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 by medical providers, such as a certified nursing assistant training program;

3. Determination of existing capacity and demand for additional capacity in appendix C private non-medical institutions in the State and options to expand or reconfigure the State's appendix C private non-medical institution system to better meet identified demands;

4. 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;

5. With input from the Department of Health and Human Services, identification of efficiencies that can be implemented to expedite the MaineCare application process for patients currently being cared for in a facility;

6. 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;

7. 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;

8. 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;

9. Evaluation of the feasibility of facilitating and funding long-term care contracts for behavioral health support at long-term care facilities for care plan consults, treatment and staff education;

10. Review of the Department of Health and Human Services' adult protective services and public guardianship processes to identify efficiencies that can be implemented to facilitate more expedient resolutions, and to evaluate, with input from representatives of the State's judiciary, the feasibility of implementing a temporary guardianship process to facilitate hospital discharge for patients awaiting guardianship; and

11. Any other issue identified by the commission.

No later than December 15, 2016, the Commission shall submit a report containing 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.

APPENDIX D

Draft legislation, Long-term Care Ombudsman statutory amendment

DRAFT LEGISLATION

Sec. 1. 22 MRSA §5107-A, second ¶ is amended to read:

The ombudsman and volunteers shall visit, talk with and make personal, social and legal services available to residents; inform residents of their rights, entitlements and obligations under federal and state laws by distributing education materials and meeting with groups or individuals; assist residents in asserting their legal rights regarding claims for public assistance, medical care and social security benefits or in actions against agencies responsible for those programs, as well as in all other matters in which residents are aggrieved, including, but not limited to, advising residents to litigate; investigate complaints received from residents or concerned parties regarding care or other matters concerning residents; and participate as observer and resource in any on-site survey or other regulatory review performed by state agencies pursuant to state or federal law. In addition, the ombudsman may act as a resource during the hospital discharge process to assist patients with complex medical needs who experience significant barriers to admission in a residential care facility, assisted living facility or program or nursing facility and provide assistance to such facilities subsequent to the placement of patients with complex medical needs.

SUMMARY

This draft legislation amends the section of law governing the long-term care ombudsman program. It clarifies that the Ombudsman has the authority to act as a resource during the hospital discharge process to assist patients with complex medical needs who experience significant barriers to admission in a residential care facility, assisted living facility or program or nursing facility.

APPENDIX E

Draft legislation, Department of Health and Human Services demonstration project for enhanced rates for home care services

DRAFT LEGISLATION

Sec. 1. Department of Health and Human Services; enhanced rates for home care services. The Department of Health and Human Services, Office of Aging and Disability Services, shall, by October 15, 2016, implement a demonstration project to provide enhanced rates for home care services, with participation limited to patients with complex medical needs who are enrolled in the State's Homeward Bound program, a demonstration project funded by the federal Centers for Medicaid and Medicare Services. The demonstration project shall allow for enhanced rates that will provide additional reimbursement for services provided by personal support specialists, as well as on-site training of personal support specialist staff before services are provided to patients with complex medical needs, in order to promote quality of care and retention of staff serving patient populations with complex medical needs. The department shall, by January 15, 2018, submit a report to the joint standing committee of the Legislature having jurisdiction over health and human services matters detailing its findings and recommendations regarding the expansion of enhanced rates for home care services in the State. The joint standing committee of the Legislature having jurisdiction over health and human services matters is authorized to report out a bill relating to the report to the Second Regular Session of the 128th Legislature.

SUMMARY

This draft legislation contains an unallocated section directing the Department of Health and Human Services, Office of Aging and Disability Services, to implement, by October 15, 2016, a demonstration project that will provide enhanced rates for home care services, with participation limited to patients with complex medical needs who are enrolled in the State's Homeward Bound Program, a demonstration project funded by the federal Centers for Medicaid and Medicare Services. The department is directed, by January 15, 2018, to submit a report to the joint standing committee of the Legislature having jurisdiction over health and human services matters detailing its findings and any recommendations for legislation regarding the expansion of enhanced rates for home care services in the State and the committee may report out a bill relating to the report.

APPENDIX F

Draft legislation, Department of Health and Human Services review of adequacy of home care services

DRAFT LEGISLATION

Sec. 1. Department of Health and Human Services; home care services review. The Department of Health and Human Services, Office of Aging and Disability Services, Home Care Quality Review Committee shall conduct a review of the adequacy of home care services provided to individuals with complex needs under the MaineCare Benefits Manual, Chapter II, section 19, Home and Community Benefits for the Elderly and Adults with Disabilities. The department's review shall include, at a minimum, consideration of quality of care, emergency department visits and hospital admissions by individuals receiving services under section 19. In conducting this review, the department shall request input, at a minimum, from consumers, care coordination agencies, patient advocacy organizations and home care agencies. The department shall, by January 15, 2017, submit a report to the joint standing committee of the Legislature having jurisdiction over health and human services matters detailing its findings and any recommendations for legislation regarding the adequacy of home care services provided under section 19. After reviewing the report, the joint standing committee of the Legislature having jurisdiction over health and human services matters may report out a bill relating to the report to the First Regular Session of the 128th Legislature.

SUMMARY

This draft legislation contains an unallocated section directing the Department of Health and Human Services, Office of Aging and Disability Services, Home Care Quality Review Committee to conduct a review of the adequacy of home care services provided to individuals with complex needs under the MaineCare Benefits Manual, Chapter II, section 19, Home and Community Benefits for the Elderly and Adults with Disabilities. The department is directed, by January 15, 2017, to submit a report to the joint standing committee of the Legislature having jurisdiction over health and human services matters detailing its findings and any recommendations for legislation regarding the adequacy of home care services provided under section 19 and the committee may report out a bill relating to the report.

APPENDIX G

Draft legislation, Department of Health and Human Services stakeholder group on financial exploitation

DRAFT LEGISLATION

Sec. 1. Department of Health and Human Services; financial exploitation stakeholder group. The Department of Health and Human Services, Office of Aging and Disability Services, Financial Abuse Specialist Team shall convene a stakeholder group to review the State's criminal statutes, the Maine Adult Protective Services Act, the Maine Revised Statutes, Title 22, chapter 958-A and any other relevant State statutes to identify potential statutory changes to enable and support criminal prosecution of crimes against the elderly and persons with disabilities, including the enhancement of penalties for such crimes. The department shall invite as participants in the stakeholder group, at a minimum, the Office of the Attorney General, including representatives of the Healthcare Crimes Unit; the Maine Sheriffs' Association; the Maine Chiefs of Police Association; the Maine State Police; the Maine Prosecutors' Association; the Maine Health Care Association; the State's Long-term Care Ombudsman; Legal Services for the Elderly; and the Maine Office of Securities. The department shall, by January 15, 2017, submit a report to the joint standing committee of the Legislature having jurisdiction over health and human services matters detailing the stakeholder group's findings and any recommendations for legislation regarding changes to the State's laws to enable and support criminal prosecution of crimes against the elderly and persons with disabilities. After reviewing the report, the joint standing committee of the Legislature having jurisdiction over health and human services matters may report out a bill relating to the report to the First Regular Session of the 128th Legislature.

SUMMARY

This draft legislation contains an unallocated section directing the Department of Health and Human Services, Office of Aging and Disability Services, Financial Abuse Specialist Team to convene a stakeholder group to review the State's criminal statutes, the Maine Adult Protective Services Act, the Maine Revised Statutes, Title 22, chapter 958-A and any other relevant State statutes to identify potential statutory changes to enable and support criminal prosecution of crimes against the elderly and persons with disabilities, including the enhancement of penalties for such crimes. The department is directed, by January 15, 2017, to submit a report to the joint standing committee of the Legislature having jurisdiction over health and human services matters detailing the stakeholder group's findings and any recommendations for legislation regarding changes to the State's laws to enable and support criminal prosecution of crimes against the elderly and persons with disabilities and the committee may report out a bill relating to the report.

APPENDIX H

Draft legislation, Department of Health and Human Services implement "days awaiting placement" rate for hospitals

DRAFT LEGISLATION

Sec. 1. Department of Health and Human Services; days awaiting placement reimbursement for acute care non-critical access hospitals. The Department of Health and Human Services shall, as soon as practicable, amend its existing MaineCare Benefits Manual, Chapter III, section 45, Hospital Services, to provide daily reimbursement to acute care non-critical access hospitals for nursing facility services, as specified in the MaineCare Benefits Manual, Chapter III, section 67, that are provided to a MaineCare eligible individual in an acute care non-critical access hospital's care who is awaiting placement at a nursing facility. The department shall reimburse acute care non-critical access hospitals prospectively at the statewide average rate per member day for nursing facility services. The department shall compute the average statewide rate per member day based on the simple average of the nursing facility rate per member day for the applicable State fiscal year(s) and prorated for the hospital's fiscal year. The department shall ensure that the reimbursement for acute care non-critical access hospitals for days awaiting placement described in this section is implemented for a period of not more than 5 years. The department is authorized to implement any additional changes to its existing rules necessary to implement the regulatory changes described in this section.

SUMMARY

This draft legislation contains an unallocated section directing the Department of Health and Human Services to amend its existing MaineCare Benefits Manual, Chapter III, section 45, Hospital Services, to provide daily reimbursement to acute care non-critical access hospitals for nursing facility services that are provided to a MaineCare eligible individual in an acute care non-critical access hospital's care who is awaiting placement at a nursing facility. The reimbursement is to be paid prospectively at the statewide average rate per member day for nursing facility services. The department is directed to implement this reimbursement for days awaiting placement for a period of not more than 5 years.

APPENDIX I

Information regarding Department of Health and Human Services request for information (RFI)

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