



Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

Testimony of the Maine Hospital Association

LD 960 - An Act Facilitating The Discharge Of Hospitalized Patients To Nursing Facilities

March 24, 2025

Senator Ingwersen, Representative Meyer and members of the Health and Human Services Committee, my name is Jeffrey Austin and I am presenting testimony in support of LD 960 on behalf of the Maine Hospital Association.

Patients stuck in hospitals remains a concern all across Maine. My colleague Sally Weiss worked with the Roux Institute to produce a report on the extent of the problem.

In August 2024, MHA conducted a survey of its members, receiving 22 responses. The results revealed that 325 patients were no longer meeting the criteria for inpatient care and were awaiting placement in post-acute care settings. In other words, 12% of all licensed hospital beds in the state—excluding staffed beds—are currently occupied by patients waiting for transfer to another care setting.

Total Number of Patients Awaiting Discharge to the Following Settings:

- Skilled Nursing Facility (SNF): 129
- Long-Term Care (LTC): 78
- Residential Care Facility (RCF): 43
- Home Health: 75

Among those waiting for discharge to SNF/LTC facilities: (I can res care too, if you want?)

- 48 patients had been waiting for 7-13 days.
- 36 patients had been waiting for 14-29 days.
- 64 patients had been waiting for 30 days or more.

These delays present a significant burden for hospitals, but perhaps more critically, they delay necessary care for patients who would benefit from post-acute care settings. Additionally, the delays impact those who are critically ill and need access to inpatient beds or require transfer from Critical Access Hospitals to tertiary care centers.

With my allotted time, I would like to speak to just one of the three items in the bill.

Section 1 of the bill seeks to overturn what we understand to be current Department policy related to patients in need of guardianship.

Some patients get to a point where they lack capacity to make decisions for themselves. In these situations a proxy decisionmaker, like a family member, is important. When such a proxy is not available, DHHS has a process to secure guardianship and become the decisionmaker.

Guardianship is not to be entered into lightly because it transfers decisionmaking authority away from the patient and to the guardian. As such, there is pretty extensive due process requirements that can take a long time to complete.

When the patient needs a residential placement, they languish in the hospital while the guardianship process plays out. **Nursing facilities, understandably, will not accept a patient who lacks a decisionmaker like a guardian.**

For years, hospitals were frustrated that DHHS would not seek guardianship for many patients that our clinicians had determined needed one. The legislature created a stakeholder group and the Legislature agreed with us that the more expedited "emergency" guardianship process was appropriate for patients who are stuck in hospitals.

Following is the section of the emergency guardianship statute we are now seeking further amendment:

§5-312. Emergency guardian

1. Basis for emergency guardianship. *On petition by a person interested in an adult's welfare or on its own after a petition has been filed under section 5-302, the court may appoint an emergency guardian for the adult if the court finds:*

A. Appointment of an emergency guardian is likely to prevent substantial harm to the adult's physical health, safety or welfare.

For purposes of this paragraph, the delay of discharge of a patient in a hospital until the appointment of a guardian constitutes substantial harm;

B. No other person appears to have authority and willingness to act in the circumstances; and

C. There is reason to believe that a basis for appointment of a guardian under section 5-301 may exist.

In a simplified way, an emergency guardianship has a three-part test.

- First, does the situation cause **substantial harm** to the individual.
- Second, is there someone else who can act on behalf of the patient.
- Third, does the person qualify for guardianship.

Prior to 2021, hospitals were repeatedly told by DHHS that Probate Courts would not grant an emergency guardian for patients who were safe in a hospital because there was no “substantial harm.” So you changed the law to say, correctly, that being stuck does constitute substantial harm.

Following enactment of the change, DHHS raised a new barrier to emergency guardianship that we had not heard before. DHHS adopted a policy that they had not told us they would be adopting. **They said they would not seek emergency guardianship for a patient stuck in a hospital who needs a long-term care bed UNLESS there was a long-term care bed available for the patient.**

We have conveyed to DHHS that this is an impossibility; yet, DHHS will not change their policy.

So this bill asks you to do it.

Long-term care beds are in short supply and high demand. **As such, LTC facilities, either nursing homes or residential care facilities, can not hold a bed for the months it takes to secure a full guardian.**

So, the DHHS policy has rendered the statutory change we secured four years ago functionally worthless. We can't get an emergency guardian until we secure a bed; we can't secure a bed without a guardian.

Complex Problem. There are many issues why patients get stuck; guardianship is but one of the reasons. This bill does not address all of the reasons. No bill can address every issue that contributes to patients getting stuck. You may hear that the guardianship issue is not the “real” issue or the “primary” issue. That is not a legitimate objection to this bill.

There is no single primary or underlying issue that if solved, would resolve all placement challenges. There are many discreet issues and we are trying to tackle each of those issues.

For some patients, however, guardianship is the reason for delay.

Please adopt this change and remove this unreasonable DHHS policy.

With respect to the other issues – the 60 mile rule and the length of time it takes to get Medicaid LTC approval – my colleague's survey also had some qualitative questions:

We also asked members to identify verbally the top three barriers they face in placing patients. Here are some of their responses:

- *"The closure of nursing homes has made it extremely difficult to place LTC patients. Residential care facilities often accept patients they cannot adequately care for and then*

discharge them to the ED, refusing to accept them back. This only clogs the ED with patients, resulting in extended lengths of stay."

- *"In our region, there are no SNF beds within a two-hour radius, and no LTC beds are available. Safe discharge planning is severely limited due to the lack of beds and community resources. We have only one home health agency available to service most of our patients."*
- *"The lack of long-term care facilities in the state, the lengthy process for establishing MaineCare benefits, and the time it takes to obtain APS guardianship are among the top barriers we face."*
- *"The shortage of long-term care facilities in the state, coupled with facilities' reluctance to accept long-term MaineCare patients due to low state reimbursement rates, and the lengthy process for obtaining APS guardianship (which can take 4-10 months in some cases), significantly hinder placement."*

Please help us help some of our most vulnerable patients get the right care in the right setting.

Thank you.

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner



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Augusta, Maine 04333-0011
Tel; (207) 287-9200; Toll Free: (800) 262-2232
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TTY: Dial 711 (Maine Relay)

MEMORANDUM

TO: Maine Hospital Association
FROM: Erin Salvo, Associate Director – Adult Protective Services
DATE: November 19, 2021
RE: *LD 366 – An Act Regarding Emergency Guardianship*

In light of the passage of LD 366, An Act Regarding Emergency Guardianship, this memo is intended to communicate the Department's approach to applying the law during the public guardianship petition process.

As you know, LD 366 was enacted during the first special session of the 130th Legislature and went into effect October 18, 2021. Accordingly, 18-C MRSA § 5-312 is amended to include that "delay of discharge of a patient in a hospital until the appointment of a guardian constitutes substantial harm" for purposes of establishing grounds for appointment of an emergency guardian.

The Maine Department of Health and Human Services (Department), through the Adult Protective Services program, has the authority to petition for guardianship when an adult is being abused, neglected or exploited (or at risk thereof) and lacks the capacity to consent to protective services, and all less restrictive alternatives have been tried and have failed. In other words, the Department petitions for public guardianship as a last resort when an adult requires a substitute decision-maker, no alternatives to guardianship are sufficient to meet the individual's needs, and no private party is able and willing to serve as a guardian or surrogate decision-maker.

The Department recognizes that there are several factors that may impact an individual's ability to discharge from the hospital unrelated to an individual's guardianship status, and probate courts may have differing responses to the language established by LD 366. In order to maintain consistent expectations statewide, the Department will rely on some key basic guidelines when making decisions on the type of petition to file. Accordingly, the need for appointment of a guardian will generally be considered the reason for delay of discharge for purposes of filing an emergency public guardianship petition when the following conditions exist:

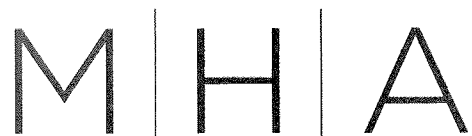
1. The individual has been medically cleared for discharge from a hospital; AND
2. A Petition for Appointment of Guardian for Adult requesting permanent guardianship over the individual has been or is being filed in the appropriate Probate Court; AND
3. A placement outside the hospital has been identified that will meet the individual's level of care needs and such placement is reasonably expected to be available to the individual only upon appointment of a guardian; AND
4. Appointment of an emergency guardian is reasonably expected to result in the individual's discharge from the hospital to an appropriate placement outside the hospital prior to the final guardianship hearing.

These guidelines are intended to provide a general framework regarding the Department's plans pursuant to LD 366 and may not encompass every factor relevant to a specific individual's situation. If you have any questions on a particular public guardianship study, please contact the Adult Protective Services

Investigation Supervisor based on the districts listed below. If you have any questions on this policy generally, please contact the Associate Director of Adult Protective Services, Erin Salvo (erin.salvo@maine.gov). To initiate APS involvement with an adult in need of a guardian or in a situation involving abuse, neglect, or exploitation of an incapacitated or dependent adult, please contact APS Intake: 1-800-624-8404 (available 24/7).

District	County	APS Supervisor	Email
1	York	Jessica Gagne	Jessica.L.Gagne@maine.gov
2	Cumberland	Sarah Bennett	Sarah.Bennett@maine.gov
3	Androscoggin	Benjamin Bergeron	Benjamin.A.Bergeron@maine.gov
	Oxford		
	Franklin		
4	Sagadahoc	Joanne Cookson	Joanne.Cookson@maine.gov
	Lincoln		
	Knox		
	Waldo		
5	Kennebec	Heather Pease	Heather.Pease@maine.gov
	Somerset		
6	Penobscot	Janice Archer	Janice.Archer@maine.gov
	Piscataquis		
7	Hancock	Michael Libby	Michael.Libby@maine.gov
	Washington		
8	Aroostook	Annie Torres	Annie.Torres@maine.gov

cc: Paul Saucier, Director – DHHS Office of Aging and Disability Services
Molly Bogart, DHHS Government Relations Director
Cody Hopkins, Assistant Attorney General



Maine Hospital Association

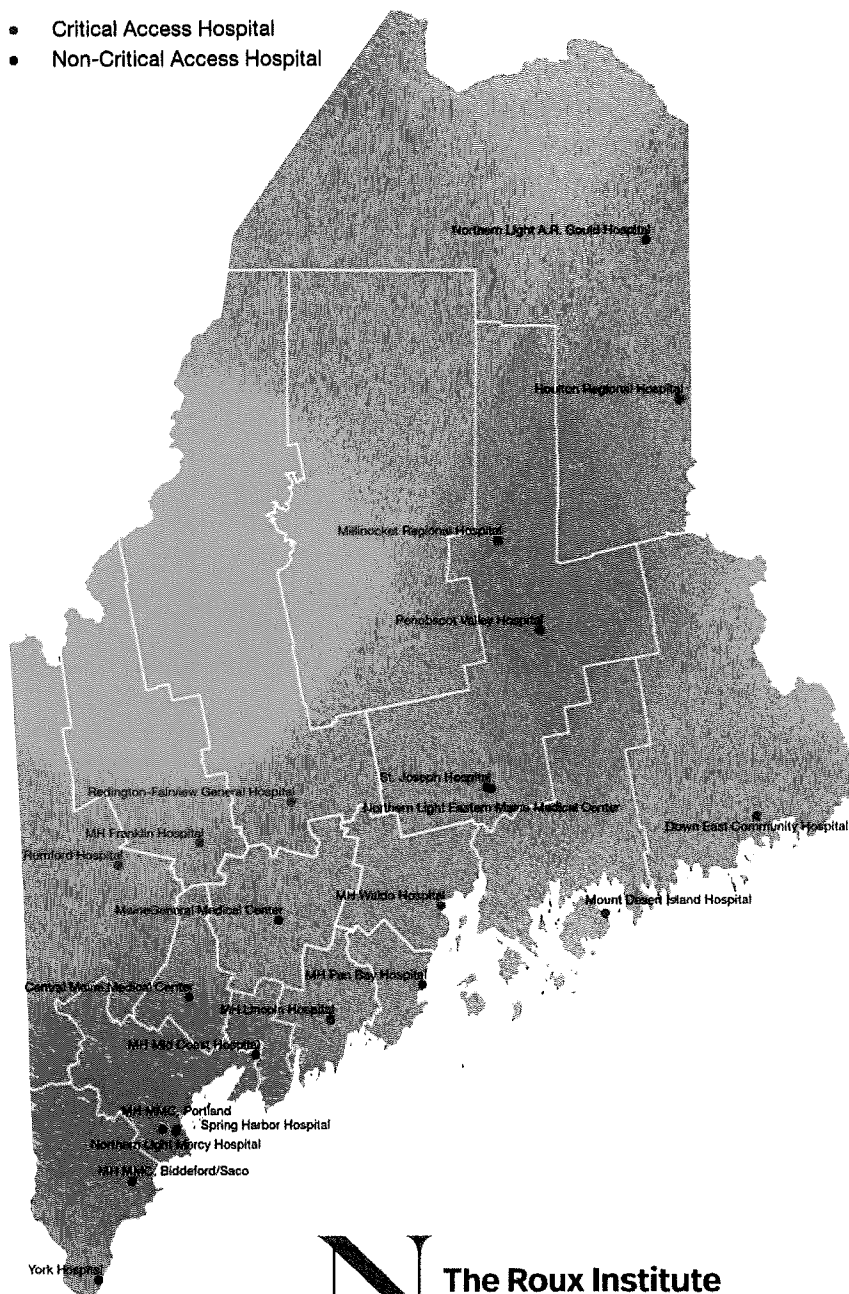
2025

A Clogged System of Care

Respondent Hospitals

22 of 36 Hospitals in Maine Reporting

- Critical Access Hospital
- Non-Critical Access Hospital



N **The Roux Institute**
Northeastern University

Understanding the drivers and impacts of delayed care within the Maine healthcare system.

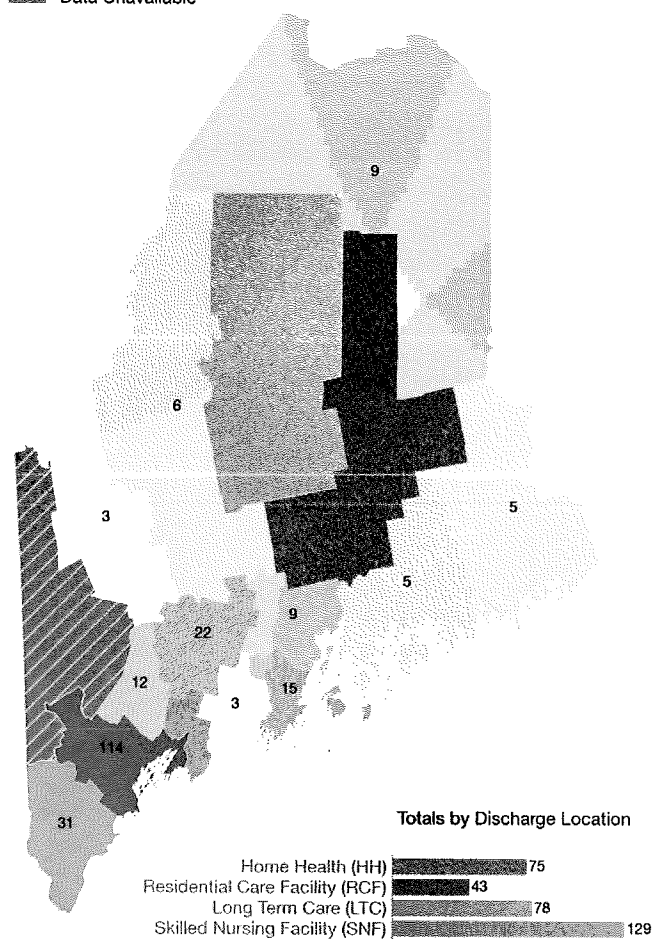
Our direct care workforce shortage combined with insufficient reimbursement rates from public payers has led to an unprecedented number of long-term care facility closures, unstaffed residential and skilled nursing beds, and limited home health and behavioral health capacity. As a result, Maine hospitals, on any given day, have over 300 patients* who are ready for discharge and awaiting placement in another setting. Many of these patients wait weeks to months.

Delayed discharges prevent hospitals from admitting new patients who need acute care and payers do not universally compensate for patients' prolonged hospital stays. A recent AHA analysis noted that the average length of stay across all patients in hospitals increased by 19% in 2022 compared to 2019. Additionally, the average length of stay for patients being discharged from acute care hospitals to home health agencies grew 12.6%, while those discharged to skilled nursing facilities saw a 20% increase.

Patients Awaiting Discharge by County

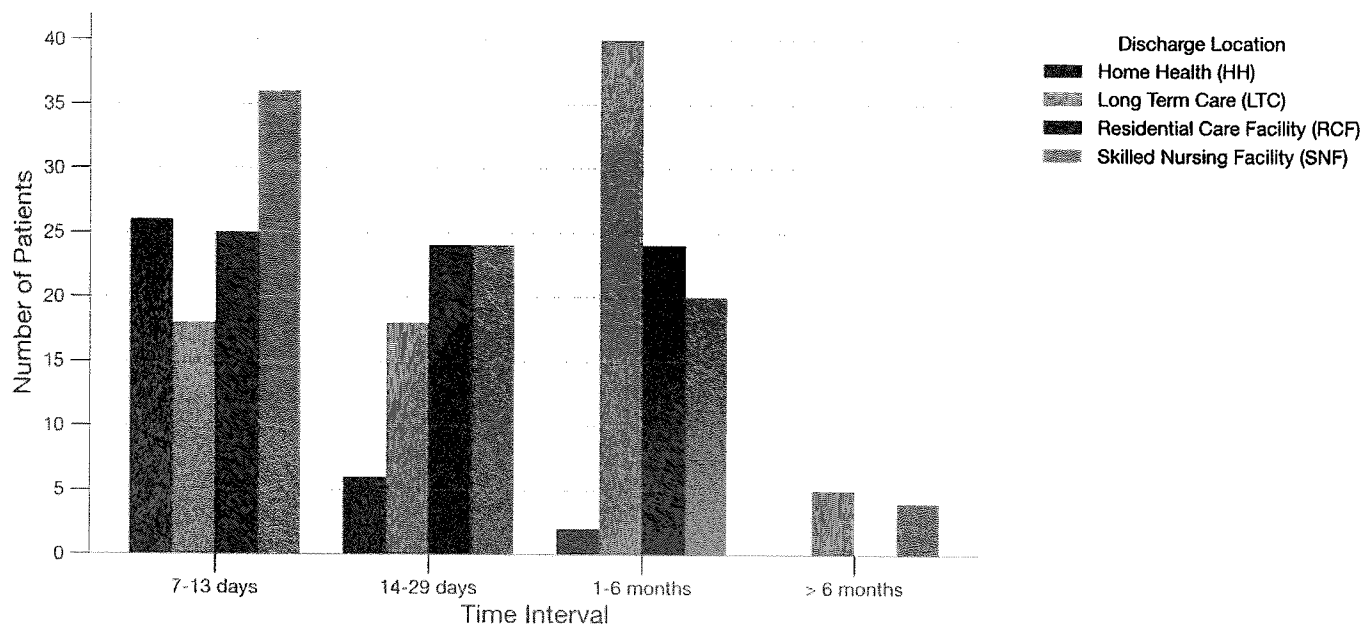
Statewide Total: 325*

▨ Data Reported with Androscoggin County
▨ Data Unavailable



* 22 of 36 Hospitals in Maine Reporting

Patients Awaiting Discharge by Time Interval and Location



One study found the average duration for a delayed discharge was 17 days and came at a cost of more than \$31,000.[1]

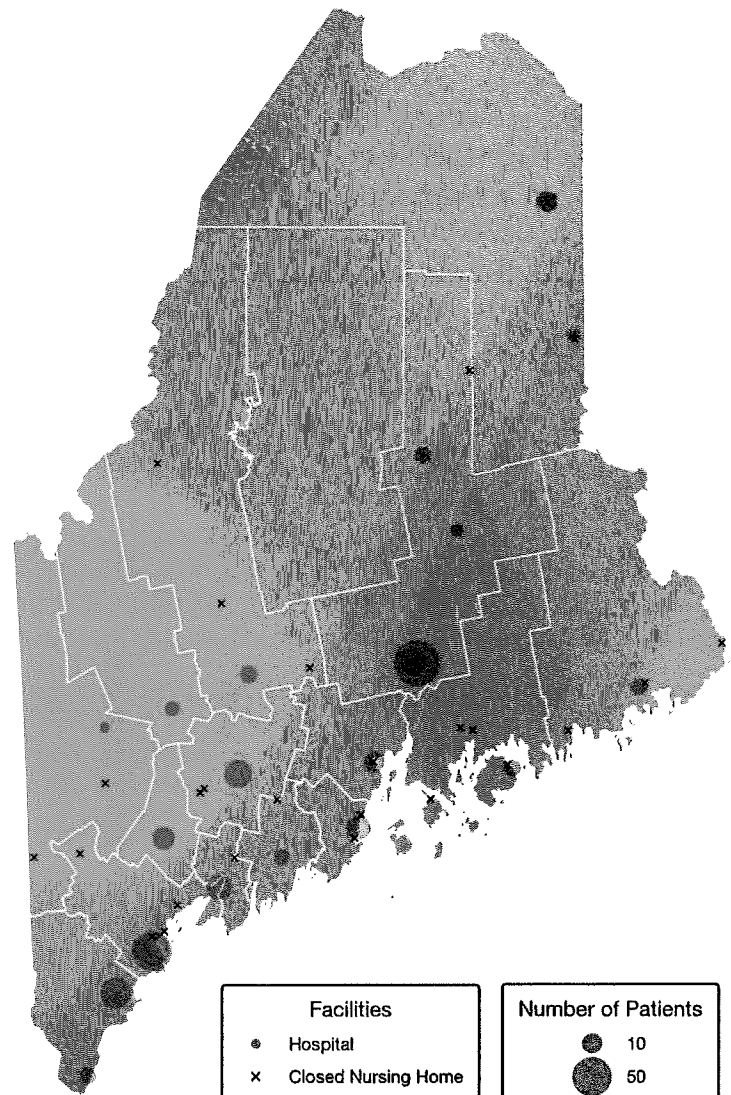
In addition to the increased cost burden, patients and their families suffer and health outcomes are negatively impacted when individuals cannot access the appropriate level of care close to home.

MHA with the support of the Roux Institute at Northeastern University developed a survey tool and surveyed all Maine hospitals in August of 2024, with 22 of 36 hospitals responding. This report will delve into some of the factors contributing to these delayed discharges to post-acute care settings and briefly examine the ongoing challenges associated with boarding patients in emergency departments. The report reflects data from 22 hospitals; however, Maine has 36 hospitals across the state. Thus, we can conclude that there are over 300 patients on any given day.

[1] [Issue-Brief-Patients-and-Providers-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf \(aha.org\)](#)

Patients Awaiting Discharge by Hospital: Nursing Home Closures Overlay

Number of Closed Nursing Homes: 28



22 of 36 Hospitals in Maine Reporting

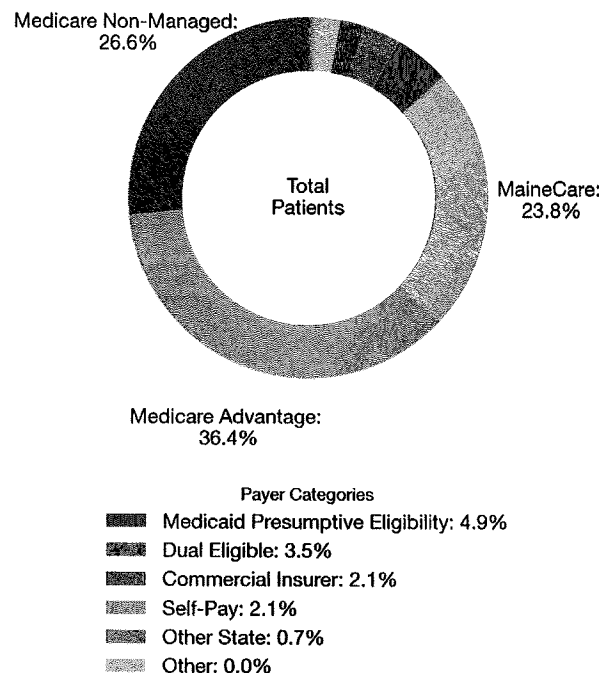
Top Right: Nursing homes, including long-term care and skilled nursing facilities, have been hit particularly hard by a combination of workforce shortages and low reimbursement rates. Since 2014, 28 nursing facilities have been closed, with 54% of those, or 15, closing in the past three years (2021 to 2024). The distribution of closures impacts all geographic parts of the state and all hospitals and their ability to move patients to post-acute care settings. To highlight the impact of these closures, one hospital noted in the survey that there were no skilled nursing facilities within a two-hour radius of their hospital, further demonstrating the impact these closures have had on families as they seek placement for their loved ones.

Most Common Reasons for Delay by Rank

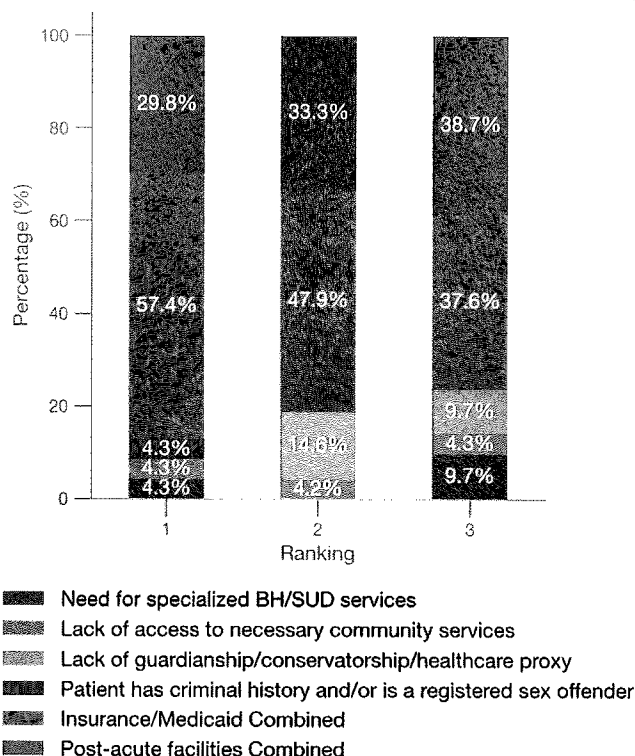
- | Ranking | Reason |
|---------|--|
| 1 | Waiting for LTC MaineCare (Medicaid) approval |
| 2 | Denial of request for authorization from insurer |
| 3 | Delayed response from insurer |
| 4 | Staffing/capacity constraints at post-acute care facilities |
| 4 | Lack of facility within patients desired geographic area. |
| 5 | Inadequate post-acute network |
| 6 | Lack of guardianship/conservatorship/healthcare proxy |
| 7 | Lack of access to necessary community services |
| 8 | Need Behavioral Health (BH) and Substance Use (SUD) Services |
| 9 | Insurer does not provide post-acute coverage |
| 10 | Transportation unavailable |
| 11 | COVID+ status |
| 12 | Lack of secondary insurance |
| 13 | COVID recovered status |
| 14 | Patient has criminal history and/or is a registered sex offender |
| 15 | Unvaccinated status |

The aggregated ranking of most common reasons for a patients discharge being delayed, with one being the most commonly cited and 15 being the least.

Number of Patients Awaiting Placement by Payer



Most Commonly Ranked Causes of Delay (Ranks 1-3)



Breakdown of causes of delayed discharge by most commonly ranked within the top 3 by survey respondents.

Many patients experiencing a delay in care are those covered by Medicare and Medicare Advantage with a combined percentage of 63%, demonstrating that those Mainers 65 years of age and older are most likely to experience a delay in care as they transition from an acute care setting to a postacute care setting. The second largest group are those covered by Maine's state Medicaid program.

Survey Responses

"We are unable to place [Medicaid] patients requiring LTC as facilities report the reimbursement is too low. [SNF] patients are declined for same reasons compared to commercial and Medicare."

"[We] don't have a Psychiatric Residential Treatment Facility (PRTF) or Intensive Developmental Disorder Residential Program, and there are no intellectual developmental disorder residential beds available."

"In our region there are no SNF beds within a 2 hour radius, there are no LTC beds available. Safe discharge planning is severely limited due to lack of beds and community resources."

Boarding in the Emergency Department (ED):

Since the pandemic, Maine hospitals have reported a growing number of patients that are boarding, or sitting, in emergency departments across the state.

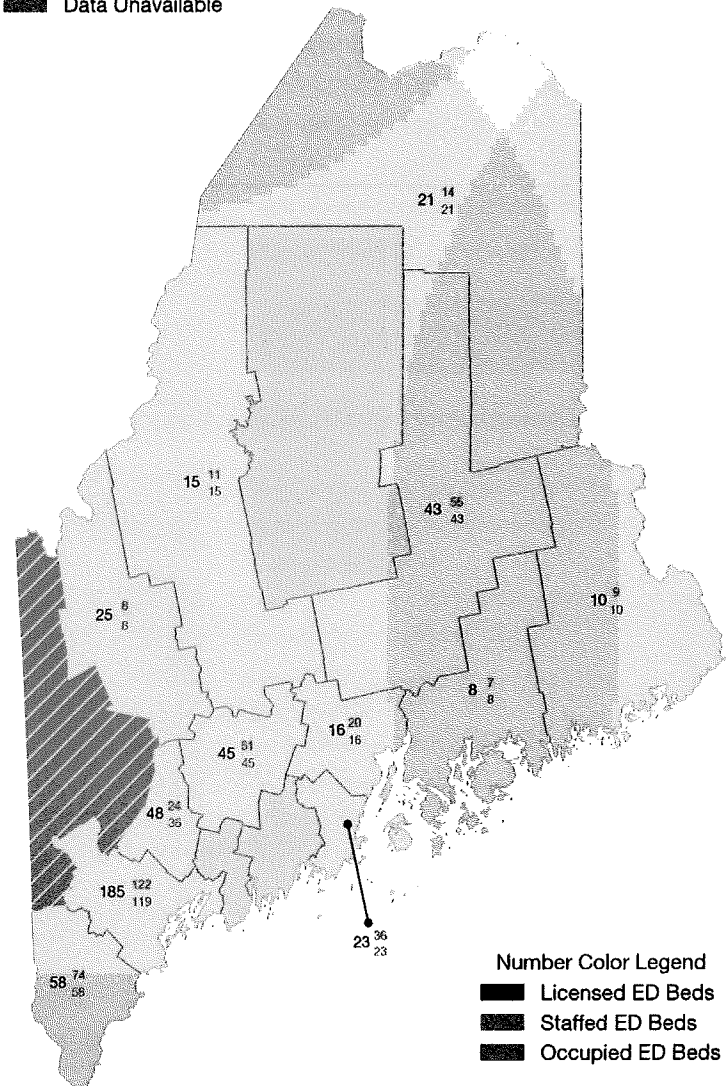
Many of these patients are waiting for an inpatient bed, either within the same hospital or at another facility, such as a tertiary care center or residential care facility, where specialized care is required. However, due to the unavailability of inpatient or residential treatment beds, these patients often remain in limbo for days, waiting for a bed to become available. This shortage contributes to Maine's emergency departments operating at over 93% capacity on average, with some counties exceeding 100% capacity.

Boarding patients in the emergency department leads to delayed care and an increase in violence as agitated patients sit for prolonged periods not receiving the care they need (Table 1). Ultimately, this hampers the state's emergency preparedness as hospitals struggle to respond to a surge in demand driven by a virus or mass casualty event.

Emergency Department Overview by County: Capacity & Occupancy

Statewide Occupancy Rate of Staffed ED Beds: 93.27%
Statewide Percentage of Licensed Beds Currently Staffed: 80.89%

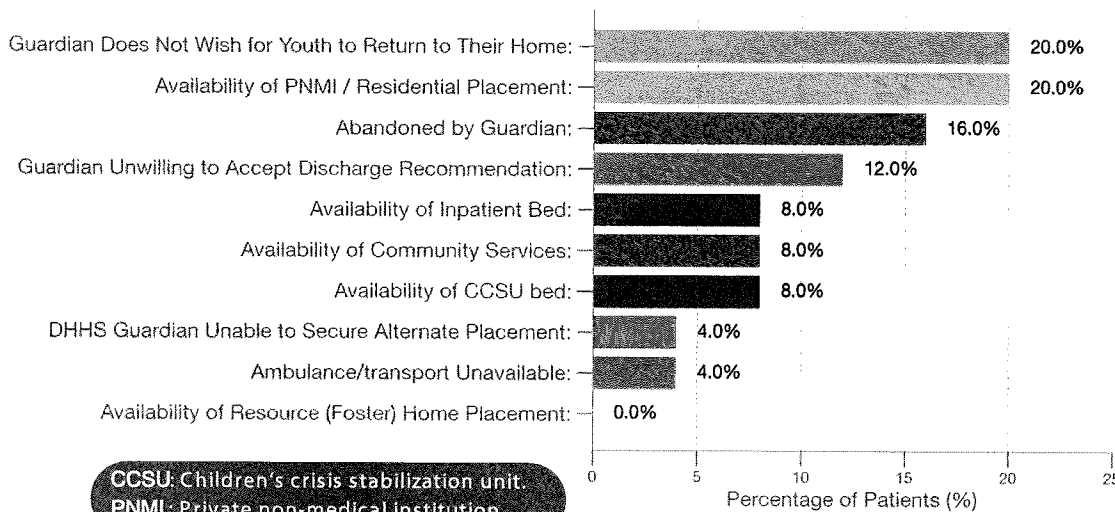
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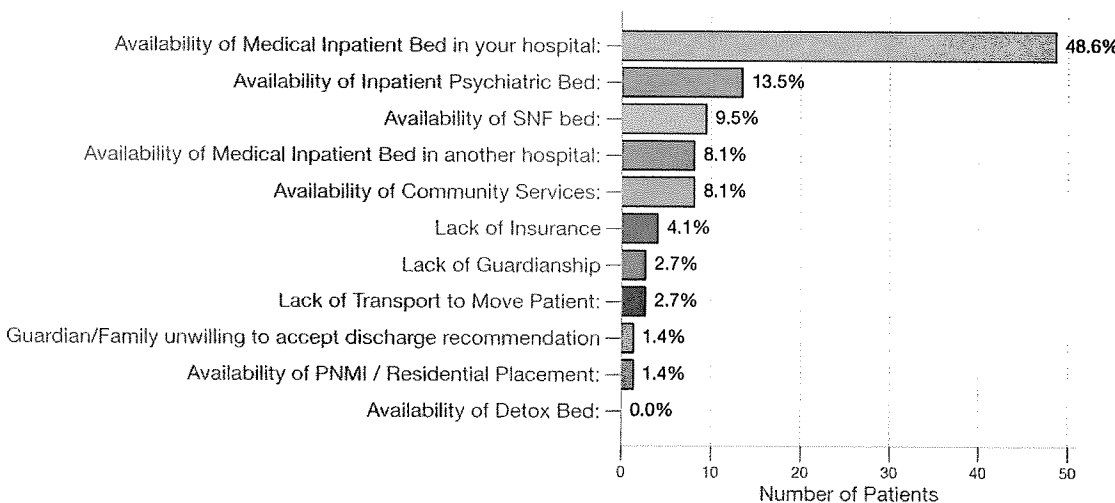
22 of 36 Hospitals in Maine Reporting

Top Right : Not all responding hospitals provided ED data, resulting in incomplete figures for some counties. In particular, no hospitals in Piscataquis or Lincoln counties reported ED data. Additionally, the only responding hospital in Oxford County submitted its data in conjunction with a hospital in Androscoggin County, and Sagadahoc County does not have a hospital.

Patients (<18) experiencing extended ED stays due to the following reasons:



Patients (18+) experiencing extended ED stays due to the following reasons:



Emergency Department Boarding Times

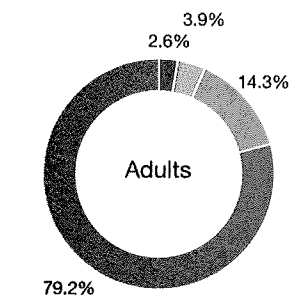
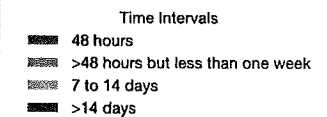
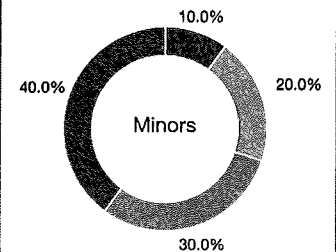


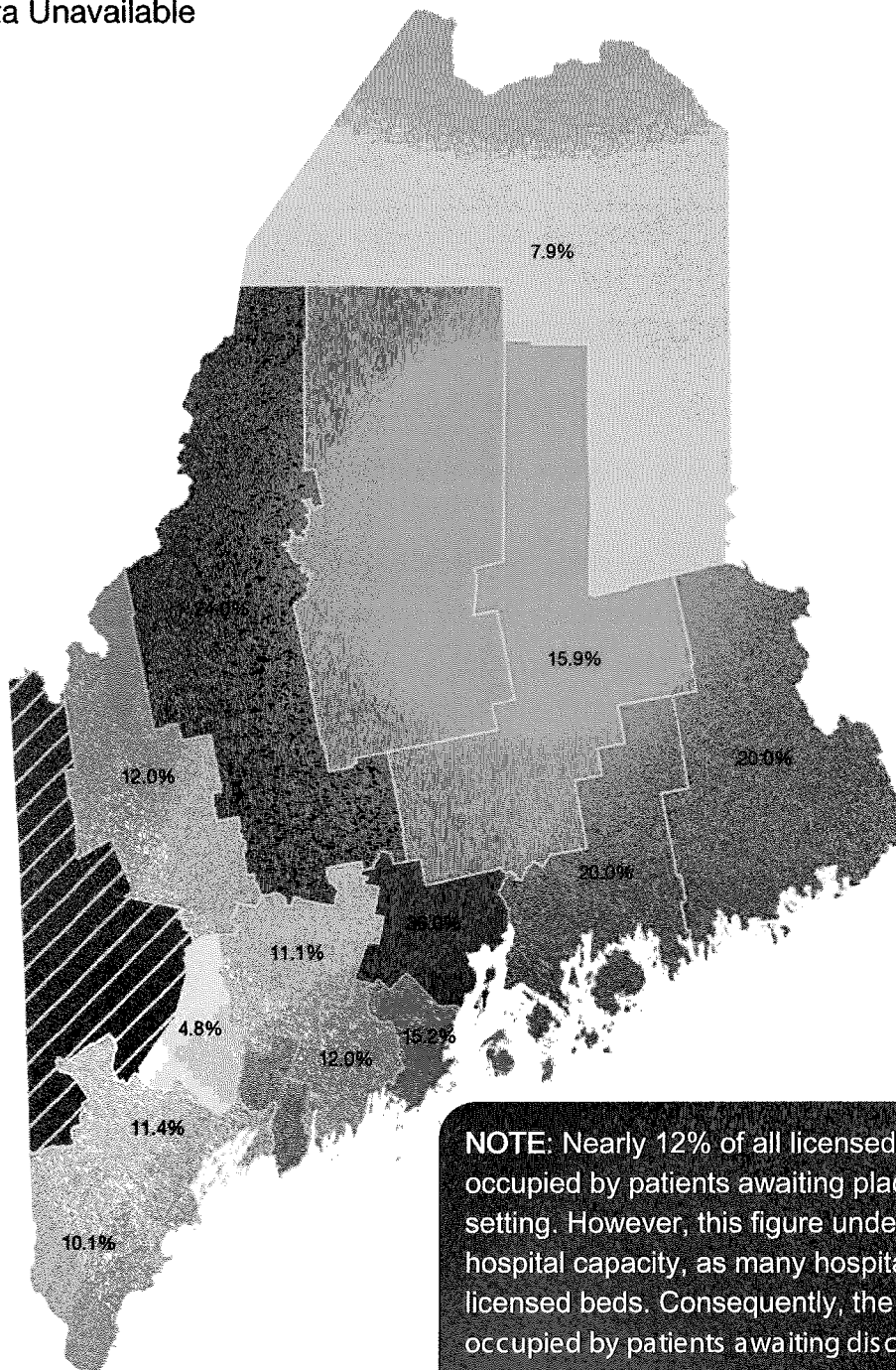
Table 1: Emergency Department Violence

Percent of hospitals reporting pediatric patients displaying violent behavior impacting healthcare staff?	60%
Number of staff that were injured or threatened, verbally or physically, by pediatric patients within the proceeding week.	41
Percent of hospitals reporting adult patients displaying violent behavior impacting healthcare staff?	48%
Number of staff that were injured or threatened, verbally or physically, by adult patients within the preceding week.	25

Licensed Beds Occupied by Patients Awaiting Transfer by County

Statewide Percentage: 11.95%

-  Data Reported with Androscoggin County
-  Data Unavailable



NOTE: Nearly 12% of all licensed beds in Maine are occupied by patients awaiting placement in another care setting. However, this figure understates the true impact on hospital capacity, as many hospitals cannot staff all their licensed beds. Consequently, the proportion of *staffed* beds occupied by patients awaiting discharge is significantly higher.

Table 2: Causes of Delayed Discharge

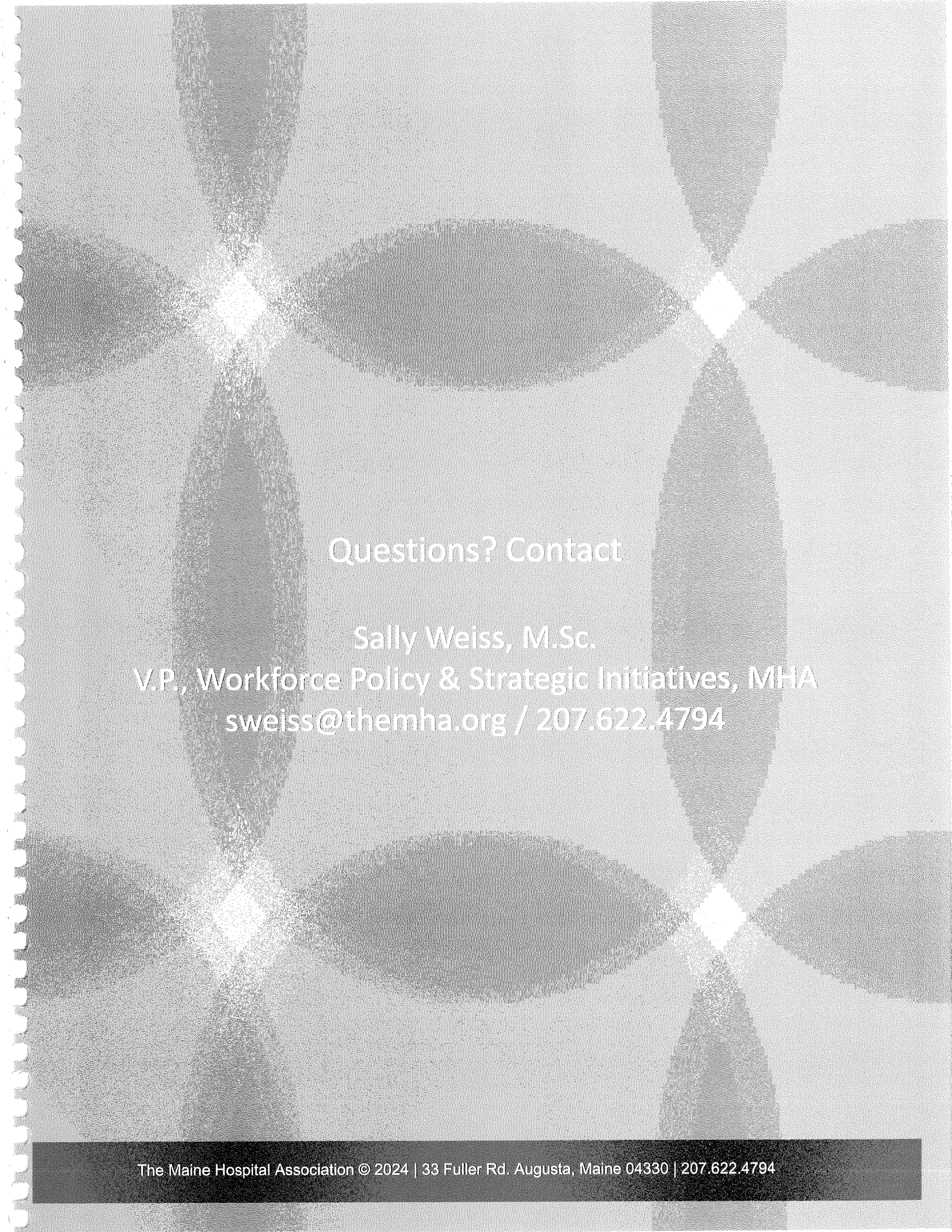
	Number of Patients
Homeless or housing unstable inpatients awaiting discharge to shelters.	27
Patients awaiting discharge to shelters for more than 7 days.	14
Homeless patients with behavioral health issues or SUD.	34
Awaiting discharge to SNF beds with geri -psych capabilities.	14
Patients with dementia diagnoses awaiting discharge who require SNF care in a secure facility.	28
Patients who are waiting for placement due to an inability to find an appropriate facility within their geographic area.	95

Policy Implications

- Invest in behavioral health and direct care workforce development to expand capacity at the community level.
- Reimburse long-term care and residential facilities for the true cost of care.
- Invest in long-term care and home health workforce to care for older and disabled Mainers to ensure that patients don't languish in hospitals while awaiting placement in their community.
- Reimburse hospitals for care provided as a result of delayed discharges to community settings, such as assisted living facilities, long-term care, skilled nursing, and behavioral health facilities.
- Prioritize hospitalized patients for MaineCare coverage approval and Guardianship process.

Survey & Report Methodology

This report represents a collaborative effort between the Maine Hospital Association (MHA) and Data for Social Good, a student-led organization at Northeastern University's Roux Institute in Portland, Maine, with contributions from Nelson Farrell, Michael Massone, and Peter Talpey. The data presented in this report was collected through a voluntary survey distributed to all 36 hospitals in Maine. Of these, 22 hospitals responded, resulting in a 61.1% response rate. The survey was distributed on July 31, 2024, and all responses were received by September 3, 2024. This survey and the subsequent report offer a snapshot of patient throughput across the state of Maine during this period.



Questions? Contact

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Maine Hospital Association

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FOR HEALTHCARE