DHHS comes under fire on 2 fronts over damning findings in federal report

By Eric Russell Staff Writer and Noel K. Gallagher Staff Writer

Maine’s Department of Health and Human Services came under fire from two sides Wednesday, with a top Democrat demanding more information about a scathing federal audit that said the state failed to protect adults with developmental disabilities, including some who died under unexplained circumstances, and an advocacy group saying caretakers are being squeezed financially, putting lives at risk.

Rep. Patty Hymanson, a York physician and co-chair of the Health and Human Services Committee, said she was “very troubled” by a federal audit released last week by the U.S. Office of Inspector General, and the possibility Maine could lose federal funding.

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“The fact that so many incidents of concern, including untimely and unexplained deaths, went unreported, uninvestigated, and lacked response from the Maine’s Department of Health and Human Services is atrocious,” Hymanson said in a statement. “The Committee on Health and Human Services will be working with the department to better understand how these incidents were allowed to happen without investigation, what will be done in the future to bring justice to these patients and their families, and significantly improve oversight of group homes.”

Hymanson said her committee would submit questions to DHHS in writing to learn more about what she called, “egregious lapses in oversight and management,” from DHHS, specifically the Office of Aging and Disability Services, which until recently was led by Acting DHHS Commissioner Ricker Hamilton.

Also Wednesday, an advocacy group representing providers who care for the developmentally disabled said the problems with the system fall squarely on the DHHS for failing to adequately fund caretakers and provide clear guidance and training.
“I am here to tell you the system is broken and the consequences are devastating,” said Lydia Paquette, executive director of the Maine Association for Community Service Providers. Parents and providers joined her at the news conference held at the Augusta Civic Center. “It’s been breaking for a very long time.”

Paquette described a system of providers under financial pressure, with caretakers paid “pennies above minimum wage,” which leads to a “revolving door” of caretakers. That means providers spend more money to train new people, and the turnover can be upsetting for clients who need consistency, and some clients are “shuffled from placement to placement.”

“We have collectively made multiple overtures to (DHHS) to address the crisis laid bare by (the audit),” she said. “Our phone calls go unanswered, our emails go unreturned.”

To fix the problems outlined in the audit, she said, “we must have clear standards, consistent and accessible training and quality assurance measures which hold providers and the Department accountable when care falls below those standards.”

“Currently we have none of these,” Paquette said.
If they can’t work with the department, she said, they will consider a lawsuit or some other “judicial or legislative intervention.”

In an email Wednesday, DHHS spokeswoman Samantha Edwards denied the group’s claims and said DHHS staff said had met as recently as Monday with some of the people at the news conference and they didn’t raise these issues.

“Furthermore, if the key is to work together, why would a press conference criticizing the department be the road they choose, rather than meeting with the commissioner or our staff?” she said in an email. “It appears that this group is using the media as a stage to drive their own agendas rather than focusing on the individuals they are meant to serve.”

Edwards also disagreed with the association’s characterization of an “impending collapse of services.”

“The system is not on the verge of collapse,” she wrote. “While eight agencies closed 14 group-home locations over the past year, these 23 individuals all transitioned to other homes and continued to receive Section 21 services. In addition, the data shows that from May of 2016 to May of 2017, the number of approved group home providers has gone from 161 to 163.”

The federal Office of Inspector General, in a 77-page report released last week, concluded that Maine health officials failed to adequately protect developmentally disabled Medicaid patients in Maine, failed to properly report critical incidents including sexual assault, suicidal acts and serious injuries, and neglected to investigate 133 deaths over a 2½-year period.

Federal investigators reviewed medical records and incident reports from January 2013 to June 2015 and found that DHHS did not comply with requirements for reporting and monitoring critical incidents for the 2,640 Medicaid beneficiaries being cared for by community-based providers during that time, including about 1,800 adults with
intellectual disabilities who live in group homes.

The people being cared for have intellectual and mental health disabilities, such as autism or very low intelligence, and can't care for themselves.

In a statement last week, DHHS acknowledged the federal report but downplayed the details, attributing any problem to “significant transition,” within the department.

“The department recognizes that issues identified by OIG did exist during this transitional phase, many of which were discovered prior to the time of this audit and have been addressed by the department,” the statement said. “We are proud that we have successfully made improvements since the audit period.”

DHHS did not include any data with its statement that would show how the system has improved, and it would not respond to any follow-up questions from reporters.

Paquette and others say funding is at the heart of the issue. In the last legislative session, the association backed a bill, L.D. 967, that would have hiked the reimbursement rate paid to providers. The rate, currently slightly above the minimum wage, was established in 2007 and has since been decreased 17 percent, while inflation has increased 17 percent. The bill would have restored it to the 2007 rate and adjusted it for inflation, costing the state about $50 million, according to the fiscal note.

Providers say the reimbursement rate cuts over the past decade have made it hard to hire people and have caused waiting lists to balloon from about 100 people in 2007 to about 1,200 currently. Some beds go empty, despite the waiting list, because providers can’t find caretakers.

The bill died, and the final budget deal included $11.25 million in one-time funding to pay for nine months of reimbursement rate increases.

Former DHHS Commissioner Mary Mayhew, who stepped down in May to run as a Republican candidate for governor, blamed the problems outlined in the Inspector General’s report entirely on previous administrations.

“There is nothing more important than the health and well being of our most vulnerable citizens. That’s why I fought for and prioritized $100 million extra for our disabled adults while I was at DHHS,” Mayhew said in a statement. “Today the department is prioritizing our most vulnerable, there is financial discipline and stability, and a commitment to accountability and quality results.”

Mayhew refused to answer follow up questions about the audit and her role in department shortcomings described in the report.

One parent at Wednesday’s news conference called out Mayhew’s response.

“I ask today that DHHS apologize for its failures and take immediate steps to correct them. (Mayhew’s) response to the Office of Inspector General’s report didn’t cut it,” said Elizabeth Mahoney, who has a 26-year-old son with intellectual disabilities who lives with a community based provider.
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