

## **Community Connect memo 10/13/16**

### **Detailed Questions and Comments for Discussion with Stakeholders**

*Analysis of Section 21 Proposed Rule changes based on DHHS Five “Key Messages” highlights:*

#### **1) Ensuring individual choice-Highlights the Person Centered Planning Process (PCP)**

1. What happens if individuals getting off the waiting list are refused by providers?
2. How will individual choice be preserved?
3. If a member (or their designated guardian) is driving the Person Center Planning process, what happens if they do not have the capacity or interest to speak up for their needs and desires, or understand the full range of opportunities available to them? How can we ensure they know what their choices are in this case?
4. It is unclear and confusing at what point the agency providers will be invited to participate in the planning process. Please clarify this.
5. What if the member *wants* their agency provider at the pre-planning meeting? How do the rules ensure individual choice if providers are not allowed to participate?
6. The agency team providing daily care has the most up-to-date understanding of how an individual is currently functioning. If only the case manager and member do the pre-meeting planning, how can this be called “Person Centered Planning” when critical team members are excluded? Why not allow this decision to be decided among team members?
7. There are many new reporting requirements. Examples include the BMS99 assessment form required for the initial waiver application. This form will now be required yearly. \*(Recently learned that this was always done yearly by case managers.) Updated doctor reports are required every three months. How can we be assured that these bureaucratic requirements will not interfere with smooth implementation of an individual’s Person Centered Plan?
8. What if an individual wants to choose to be healthy throughout their life, but does not have the impulse control to resist food--or the understanding of how nutrition relates to short and long-term health consequences? If food must be available 24/7, then these individuals potentially could be losing their right and choice to maintain a healthy lifestyle.
9. If a housemate leaves (death, hospitalization, or other) and an agency cannot find a replacement within 6 months, the remaining member is forced to find a new placement. Couldn’t this represent a major barrier to ensuring individual choice?
10. It is unclear how the hours allowed and proposed staff payment compare to the current waiver. Please clarify with examples.
11. The PCP requires that services and supports be identified, even if they are not covered. Please clarify why this is being done. If this is to document unmet needs it should be stated. We support the idea of clearly stated unmet needs that can be tracked.
12. Thank you for moving behavioral, medical and communication back into the Personal Plan.

#### **2) Ensuring the right services are received-Highlights the Clinical Review Team (CRT)**

1. If the Clinical Review Team (CRT) is a fixed group, is designed to support and enhance quality, and provides medical and clinical oversight of services and supports, then how will the team have the necessary knowledge and expertise to assess

unique individuals by only looking at them on paper? Reviewing reports is very different from discussions with people who know and have personal experience with an individual. A PCP team representative would be most helpful at these meetings. Why wouldn't a representative be included in these meetings?

2. How will the crisis team interact and share information with the PCP team to ensure access to necessary information and help ensure that any intervention is successful?
3. What safeguards will be in place to assure that the CRT will not become backlogged?
4. If the CRT does become backlogged, won't the PCP process become subverted by preventing individuals from receiving the right services in a timely manner? Please give a detailed explanation of how the team will work, and what protections are in place to assure timely assessment of MaineCare member needs.
5. Crisis assessment is limited to no more than once every three years, but a member may need this service in order to return to a non-crisis status. Doesn't this policy potentially keep some members from receiving the right services? A crisis event is often characterized by a lack of predictability, and an insufficient response to a crisis is likely to escalate or prolong it, resulting in increased cost to the individual and the system as a whole.
6. According to the new policy, if DHHS deems that an agency cannot keep a member safe they will give the agency 30 days notice, then stop payment to the agency. The agency is forbidden to discharge the member unless there is a safe place to discharge them. This potentially leaves agencies at risk of their own viability to serve members with unsafe behaviors. It leaves all members with risky behaviors in jeopardy of ever being served by this HCBS waiver. How can the department anticipate that this proposal will ensure appropriate services, when it has the potential to destroy the service model for all individuals at risk of unsafe behaviors?
7. If the new proposal creates a business model that only works for the most easily served individuals, how will the department ensure appropriate services for the more health- or behaviorally-challenged members who are displaced?
8. How can the department ensure that the right amount of services are received by individuals while apparently cutting OT, PT and counseling services? What is the policy/health rationale for this change?
9. How were the limits determined for all services that have been cut? What consideration was given to determine if unique individuals are receiving the right services?
10. Could the department add a mechanism for obtaining additional hours if the service hours are determined to be absolutely critical for someone's health, safety and/or quality of life?
11. What is the difference between OT and PT consultation and maintenance?

### *3) Ensuring full staff support-Highlights aligning policy with payment*

1. In this proposal, providers will now only be reimbursed for services rendered. Currently there is flexibility for providers to be reimbursed 100% even if only 92.5% of hours are covered. This flexibility has been critical to agencies, enabling them to provide necessary care to individuals under a variety of circumstances.
2. Gaps in staffing are often not a failure of the agency provider but of unavoidable factors such as an insufficient DSP work-force, or a DSP that is sick. This flexibility also allows members to travel and be away from the home while keeping a reliable work force at the ready. We are all regularly reminded in the news and in our communities about qualified worker shortages. To ensure full staff support, will the depart-

ment do a rate study to make sure the proposal allows for a workable business model, and results in improved services for the members as intended?

#### *4) Ensuring members are safe-Highlights adding criminal background checks*

1. While it is great to have increased background checks every two years on all DSPs, this requirement is unfunded. Without a workable business model that supports providers' ability to provide quality services, it may be more difficult to keep members safe. Will the department complete a rate study to assure that the necessary new business model is compatible with the provision of quality services?
2. How have background check requirements been changed from the current waiver?
3. Is there evidence that background checks every two years is the best timeframe for detecting new criminal action?

#### *5) Providing opportunities for feedback-Highlights that the proposal has a public comment period*

1. The 5 highlights explaining the proposal sound ideal, but do not address the details of how these changes will be made. The details include sections II and III of Chapters 21 and 29, which total 169 pages. Reviewing the proposal under significant time constraints may result in inaccuracies in the way the rule is understood and interpreted, as neither members, their families and guardians, or providers have had any opportunity to discuss the details with DHHS. This inevitably diminishes the quality and accuracy of the feedback.
2. Details of the proposal impact directly on how an agency functions. Therefore, individuals and families will seek to have each agency/provider explain how they will be affected through informational forums, letters, and discussions with families and membership. For many, the present timeframe is inadequate for this to happen.
3. Stakeholders advocated strongly for the opportunity to work together (individuals, families, and providers) with DHHS as the new proposal was developed. Not revealing the rule until it was in the public comment period contributes to feelings of inadequate trust, transparency and collaboration with stakeholders.
4. When the department hosted the largest turnout ever at the hearing for the original proposal, it was clear that stakeholders care deeply about quality services that work. There was also a strong desire expressed by the legislature to have the opportunity to review proposals put forth by the Department. A vote was taken by the legislature to make such proposals Major Substantive, though this legislation was subsequently vetoed. Obtaining feedback via stakeholder discussion and thorough vetting could help this proposal be successful. It is unfortunate that the timing is such that the legislature isn't in session.
5. The five "Key Messages" highlights circulated, open discussions at forums, conference calls, and the PCP conference--all seemed evidence of genuine and positive efforts by the Department. As a result, individuals/families may not look closely at the details. If stakeholders testify without a deeper understanding of the details, their feedback may reflect only the general messages that were disseminated by the Department. The opportunity to gain more practical detailed feedback from stakeholders will be missed.