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Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

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Office of Policy and Legal Analysis

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Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

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***See Appendix B**

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Executive Summary

The Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services (herein, "the commission") was established during the First Special Session of the 131st Legislature by Resolve 2023, chapter 98. The resolve directs the Commission to examine the organizational structure of the Department of Health and Human Services and the services provided by the Department. The Commission was charged to submit a report of its findings and recommendations, including suggested legislation, to the Joint Standing Committee of the Legislature having jurisdiction over health and human services matters by November 6, 2024. A copy of the Commission's authorizing legislation, Resolve 2023, chapter 98, is included as Appendix A.

The Commission was composed of 13 members, three members of the Senate, three members of the House of Representatives, four public members, and three representatives from the Department of Health and Human Services. Senator Jill Duson served as the Senate chair and Representative Margaret Craven served as the House chair. A complete list of the Commission's members is included as Appendix B.[1] Each representative from the Department who served on the Commission stated, at the outset, that they would act as a resource to the Commission providing information and responding to questions, but they would be abstaining from all votes on findings and recommendations.

The Commission was tasked with examining the following:

- The organizational structure of and service delivery by similar agencies in other states and in nongovernmental organizations;
- The strengths and weaknesses in the services provided with state and federal funding;
- Current proposals for improving the safety and well-being of children and strengthening families across all populations and geographical areas of the State;
- Barriers to accessing services, as well as system failures and additional needed resources; and
- Areas in which processes can be streamlined and efficiencies made within the Department.

The Commission was authorized to meet eight times over the interims of 2023 and 2024. The Commission met twice in 2023 and six times in 2024. Materials from the meetings are available on the Commission's website at: https://legislature.maine.gov/blue-ribbon-commission-to-study-the-organization-of-and-service-delivery-by-dhhs. Archived videos of the meetings are also available on the Maine Legislature's website.

Over the course of eight meetings, the commission developed the following recommendations:

[1] Membership changed over the course of the Commission's work.

Child Welfare and Child Protective Services

1. The Legislature should support the 30 recommendations of the Government Oversight Committee's investigation of the perspective of persons involved on the front-line of Maine's child protection system.

2. The Department should determine how better to communicate with persons who report suspected child abuse or neglect so that the reporter understands the process that will occur based on the report.

3. The Department should implement security standards for licensed child care facilities through rulemaking taking into consideration the costs provider will incur from new security standards.

Children and Youth with Special Health Care Needs

4. The Department should develop a continuum of care service model that serves children with any combination of physical, developmental, neurological, or other care needs that connect to behavioral needs as necessary to provide adequate and appropriate care in the least restrictive setting possible.

5. The Department should update the Health and Human Services Committee on the lawsuit filed by the Department of Justice against the State of Maine in the United States District Court, District of Maine, *United States of America v. State of Maine*.[2] The Health and Human Services Committee could also consider inviting the Government Oversight Committee to any presentations related to the lawsuit.

6. The Department should identify and expand, as appropriate, funds that should be targeted to Children and Youth with Serious Health Care Needs from the Maternal and Child Health Services Block Grant to support the Center for Disease Control and Prevention's Blueprint for Change.

7. If the percentage of the Title V Block Grant funds allocated for preventative and primary care services for Children and Youth with Serious Health Care Needs in the State's five-year State Plan for children's health needs is not at least 30% of the grant funds, the Department should reallocate funds to meet the 30% obligation.

8. The Department should study, and report to the Health and Human Services Committee, how the Department is meeting its obligations under the Medicaid Early and Periodic Screening, Diagnostic and Treatment benefit, including identifying gaps in the services offered or the accessibility of services. As part of this study, the Department should engage stakeholders in the process of identifying gaps.

9. The Department should conduct a compliance evaluation of whether the current statutes, State Plan and operations of the Centers of Disease Control and Prevention ensure the

[2] On November 25, 2024, prior to the completion of this report, this case was settled.

department meets its obligations with respect to Children and Youth with Special Health Care Needs.

Behavioral Health

10. The Department should identify the amount of funds needed to sustain Maine's Certified Community Behavioral Health Clinics, with fidelity to the model, and develop a plan to fully fund and expand them in the future.

11. The Department should develop a plan to increase accessibility to behavioral health crisis services, including mobile crisis services and crisis receiving centers.

Developmental Disabilities

12. The Legislature should increase funding to the behavioral health crisis centers in the counties of Penobscot and Aroostook and the City of Lewiston.

13. The Department should develop a plan to provide preventative, community-based behavioral health services in rural areas of the State.

14. The Department should investigate how children's behavioral health services will be coordinated with the lifespan waiver.

15. The Department should review the requirements of case management to improve versatility across different client populations, reduce duplication, and examine required credentials in order to improve employee retention and services for clients.

Elder Services

16. The Legislature should increase funding for the Meals on Wheels program administered by Maine's Area Agencies on Aging to eliminate waiting lists.

17. The Department should develop and implement a nonmedical transportation pilot program similar to the Majority Report of the Health and Human Services Committee to LD 17, Resolve, to Provide Nonmedical Transportation Services to the Elderly and Adults with Disabilities Receiving Home and Community Benefits under the MaineCare Program from the 130th Legislature.

Complex Cases

18. The Department should designate a person within the Commissioner's office with sufficient decision-making authority to coordinate services among the Department's offices to solve complex cases, such as individuals stuck in hospitals awaiting placement, or individuals institutionalized out-of-state due to lack of services and resources within the State. The designee should have decision-making authority including the authority to develop individualized plans of care for these complex cases.

Service Delivery Improvements

19. Whenever possible, the Department should enroll members of the public in all programs for which they are eligible at one time and provide applicants with information on all Department programs for which they may be eligible and all local or community programs offered.

20. The Health and Human Services Committee should schedule an update from the Department, including the Office of Financial Independence, during the Committee orientation, on the efforts of the Department to increase and improve language access of Department documents.

21. The Health and Human Services Committee should schedule an update from the Department, during the Committee orientation, on the Department's progress in adopting rules related to trauma-informed services required by the TANF statute, including the state entity contracted to provide ASPIRE services, Fedcap.

22. The Health and Human Services Committee should schedule an update from the Department, during the Committee orientation, on the Department's progress in providing training to all Department employees and contractors (including Fedcap staff) in the culture of respect and empathy.

23. The Health and Human Services Committee should schedule an update from the Department on its progress to increase and standardize communication to TANF/ASPIRE recipients on services available, requests for fair hearings, and access to plain language descriptions of Department programs.

Legislative Oversight

24. The Health and Human Services Committee should follow the current statutory schedule and conduct a GEA review of the Department during the 132nd Legislature. The Committee could consider requiring the Department to submit additional information in the report to allow the Committee to better determine whether the Department is meeting its obligations.

25. The Health and Human Services Committee should require the Department to submit a report to the Committee on the use of all federal block grant funds and review the specifics of how the funds are allocated among the programs and consider ways to increase flexibility in the use of these funds. (Please note, this is in addition to earlier recommendations about the use of Maternal and Child Health Services block grant funds for Children and Youth with Special Health Care Needs program.)

I. INTRODUCTION

The Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services (herein, "the Commission") was established during the First Special Session of the 131st Legislature by Resolve 2023, chapter 98. The resolve is included as Appendix A. In terms of the number of people employed, the Department of Health and Human Services is the largest department in Maine State government. Expenditures by the Department account for just over 50% of the state budget (in all funds) in each year or just over $6,100,000 in FY2023-24. Many people in Maine rely on services provided by the Department of Health and Human Services and their expressed intent is to always deliver high quality services efficiently and within budgeted resources.

The Commission was composed of three members of the Senate, three members of the House of Representatives, four public members, and three representatives from the Department of Health and Human Services. A list of the Commission's members is included as Appendix B. A number of members changed between 2023 and 2024. Each representative from the Department who served on the Commission stated, at the outset, that they would act as a resource to the Commission providing information and responding to questions but they would be abstaining from all votes on findings and recommendations.

The Commission was tasked with examining:

- The organizational structure of and service delivery by similar agencies in other states and in nongovernmental organizations;
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- Barriers to accessing services, as well as system failures and additional needed resources; and
- Areas in which processes can be streamlined and efficiencies made within the Department.

The Commission was authorized to meet eight times in 2023 and 2024. The Commission met twice in 2023 and six times in 2024. Materials from the meetings are available on the Commission's website at: https://legislature.maine.gov/blue-ribbon-commission-to-study-the-organization-of-and-service-delivery-by-dhhs. Archived videos of the meetings are available on the Maine Legislature's website.

II. BACKGROUND

In pursuit of their charge, members of the Commission identified overarching goals, or principles, for the Department of Health and Human Services in providing services to individuals and families within the State. The following overview is provided on the Department's website, and has been used in its orientation to the Health and Human Services Committee:

The Maine Department of Health and Human Services is dedicated to promoting health, safety, resilience, and opportunity for Maine people. The Department provides health and social services to approximately a third of the State's population, including children, families, older Mainers, and individuals with disabilities, mental illness, and substance use disorders.

The Department also promotes public health through the Maine Center for Disease Control and Prevention, operates two state psychiatric hospitals, and provides oversight to health care providers through the licensing division. DHHS is the largest executive branch department in Maine, employing over 3,000 people across the state.

The Department also lists the following as its goals:

- That Maine children grow up in safe, healthy, and supportive environments, allowing them to thrive throughout their lives.
- That all adults have the opportunity to work, live with independence, and have good health.
- That older Mainers live with dignity in the place that balances their needs and preferences.

Throughout the course of their work, Commission members repeatedly referred back to a summarized objective that individuals and families who need services from the Department are able to access all the services to which they are entitled. In order for people to receive all the services they are entitled to and need, the Commission acknowledges that there are several obstacles that must be overcome.

- **Eligibility.** Although the department strives to improve interoperability of computer systems and centralize eligibility through the Office of Family Independence, there are still instances in which systems do not talk to each other, and federal requirements, including confidentiality provisions, necessitate multiple applications
- **Stigma.** Commission members stated that there are still many situations in which individuals and families do not ask the department for help, especially if there exists concern that the request might bring additional and unwarranted scrutiny to the family generating fears that children in the home could be removed. Such fears may cause parents to be reluctant to ask for behavioral health or substance use disorder treatment services or access parenting programs that could be beneficial.
- **Availability.** Even when individuals or families are approved for services, they may not be available due to workforce shortages, budgetary waitlists, or other reasons. This is an issue with department programs across the board, including community and residential behavioral health services for both children and adults, as well as home and community-based services for the elderly, individuals with disabilities and individuals with developmental disabilities or autism. In addition, there are waitlists for state-funded home and community-based services, the homemaker program, Meals on Wheels, and Head Start. Waitlists are created when an individual is eligible financially and/or categorically but because of budget limits, not all those eligible individuals can be served.

- **Complexity.** There are concerns that when individuals or families have issues that require services from different offices within the Department of Health and Human Services, or across different departments in state government, navigating access to those services can become complex and accountability for effective service delivery may not be transparent. A repeated theme throughout Commission discussions was a desire to have a dedicated person in the Department of Health and Human Services, Commissioner's office who has the responsibility and authority to solve complex problems and negotiate solutions, particularly for individuals who have unique issues complicating their requirements for services.
- **Holistic focus.** Related to the above concern about complexity, Commission members noted that the fee-for-service or transactional focus of many services can act at cross-purposes to a more holistic or a preferred public health focus on service provision.

Each of the findings and recommendations contained in this report, in some way, relates to the Commission's overarching goal that individuals and families who need services from the Department are able to access all the services to which they are entitled and the Department provides those services in a way that promotes health, safety, resilience, and opportunity for Maine people.

Historical Framework for the Department of Health and Human Services

At its first meeting in October 2023, Molly Bogart, Director of Government Relations in the Department of Health and Human Services[3] provided a brief overview of the department's structure and recent history of reorganization, to the Commission. She began her presentation noting that those who could provide more of a first-hand account of the history or organizational changes and what drove those changes are no longer with the Department. Director Bogart thanked Kristin Brawn, Legislative Researcher in the Office of Policy and Legal Analysis for her memorandum describing a legislative history of significant changes to the Department that was previously provided to the Health and Human Services Committee that she used to inform her presentation. This memorandum is included as Appendix C.

The State Board of Health was formed in Maine in 1885 as the first iteration of what is now the Maine Department of Health and Human Services. The name was changed to the Department of Health in 1917 and then to the Department of Health and Welfare in 1931. Organization was largely static until 1975 when it became the Department of Human Services with five bureaus (health, child and family services, family independence, medical services, and elder and adult services). A major reorganization began in 1993 with the passage of Resolve 1993, chapter 36. The law required the abolition of the Department of Human Services and the Department of Mental Health and Mental Retardation and the reorganization of functions into a newly created Department of Children and Families and Department of Health. The resolve also established the Health and Social Services Transition Team to develop legislation to implement the reorganization of services, reallocate funds and govern the transition. The Transition Team offered alternative ways to organize the Department of Health and also recommended a later

[3] Molly Bogart was the Director of Government Relations during the period this Commission was meeting but became a Deputy Commissioner within the Department of Health and Human Services prior to the completion of this report.

implementation date for the reorganization. The Transition Team introduced a bill in 1994 with its recommendations. In the end, the Legislature enacted Public Law 1993, chapter 738 which did not abolish or create any department but rather established policy principles for the existing Department and created several studies and task forces. Governor King's Productivity Realization Task Force made some changes within the department including some consolidations of service delivery areas, functions and management (along with office name changes).

The 122nd Legislature enacted Public Law 2003, chapter 20 (biennial budget) which included a required merger of the Department of Human Services (DHS) and the Department of Behavioral and Developmental Services (formerly the Department of Mental Health, Mental Retardation and Substance Abuse) with a plan for the merger to be submitted in 2004. The goals of the directive were to improve services, increase program and fiscal efficiency and improve relations with consumers and community organizations. The merger plan was enacted as Public Law 2003, chapter 689, creating the new Department of Health and Human Services. Further transitional legislation was enacted in 2005 which established the specific functions within each bureau or office of the Department along with many technical aspects related to the merger. More recent changes to the department have included reorganizations within the department (for example, long-term care services, including the administering of long-term care accounts as one account with one budget), the outsourcing of the Office of Advocacy to a third-party contract, the consolidation of accounting functions, and the establishment of the Office of Behavioral Health. Commission member and Director of the Office of Aging and Disability Services, Paul Saucier, was involved in the merger in the early 2000s and he noted that clarity of goals is critical to any restructuring and the purpose of the reorganization is to develop a structure that encompasses those goals. He noted that one core reason for having a single department for health and human services is to ensure accountability and to encourage collaboration.[4]

Commission member (and sponsor of the bill establishing this Commission), Representative Dan Shagoury, contacted the National Conference of State Legislatures requesting a 50-state scan of state health and human services department structures by main responsibilities and services. NCSL research noted that some states have one agency that oversees health and human services, including public health, while other states have two or more agencies for this purpose.[5] Related, the Health and Human Services Committee considered LD 779 in 2024, a bill that proposed to restructure the department into two separate departments. The Committee voted Ought Not to Pass on LD 779 but wrote a letter to this Commission asking it to consider the possibility of restructuring the department into two separate departments. The Commission made no recommendations related to the topic.

How to Measure Success?

The Legislature enacted Resolve 2023, chapter 98, to explore possibilities for improving the performance of the Department. In a similar sense to Director Saucier's comment that restructuring follows the development of clear goals, judging the performance of the Department requires a determination of what the measures of success should be. Director Bogart's first presentation to the Commission highlighted the challenges of how to define success for such a

[4] Paul Saucier was a member of the Commission only in 2023.
[5] This memo is located on the Commission's web page with materials for the October 24, 2023 meeting.

large agency that provides a wide array of services. The goals, as identified by the Department, are noted above. Director Bogart stated that the Department's current approach to metrics is to ensure a transparency of data so that constituencies can draw their own conclusions and encourage a shared understanding of successes and opportunities. In 2022, the department launched the "DHHS By the Numbers" Dashboard[6]. The dashboard posts multiple service data points and charts across offices within the Department. A small number of examples include the following:

- Monthly enrollment data since 2020 for MaineCare, SNAP and TANF (Office of Financial Independence).
- The number of students currently enrolled in the Higher Opportunities to Pathways to Employment (HOPE) program and the number of credentials that have been awarded as of August 2023 (also OFI).
- Medicaid expansion tracking and Medicaid claims for emergency room visits over time (Office of MaineCare Services).
- The number of Maine callers to national suicide hotlines and the number of callers to Maine crisis hotlines (Office of Behavioral Health).
- A count of the number of people served by Meals on Wheels (Office of Aging and Disability Services).
- Data on child care providers licenses and children's behavioral health waitlists (Office of Child and Family Services).
- The number of new enrollees and reenrollees in the CoverME.gov insurance plans (Office of the Health Insurance Marketplace).

Director Bogart presented an overview of the Department's efforts to improve services and where the Department continues to experience challenges at the November 2023 meeting.[7] The initiatives and challenges illustrate the difficulty of measuring success. Workforce challenges, budgetary restraints, federal and state laws and rules will always be present, and any definition of success depends on which numbers, statistics, and outcomes are used as measures.

To further illustrate the challenges of measuring success, Director Bogart presented data on health insurance coverage in Maine. She noted that between 2019 and 2021, Maine had the largest drop in the nation of the state's uninsured rate. She stated that it was largely due to expanding Medicaid, but in addition the department launched a State-based Marketplace, CoverME.gov, for private coverage, and also worked with the Bureau of Insurance to implement a State Innovation Waiver that reduced the average health insurance premium for small businesses for the first time in over 20 years. However, Director Bogart also noted the "unwinding" of pandemic Medicaid continuous coverage counteracts the progress in coverage. The unwinding requires that an individual's eligibility must be assessed or reassessed, and the enhanced federal Medicaid matching funds ends. Not all individuals who continued to be covered by MaineCare during the pandemic will still be eligible and while the federal government has extended the special enrollment period for insurance purchased on the exchange, there is an expectation that health insurance coverage will drop with the unwinding.

[6] https://public.tableau.com/app/profile/dhhs.commissioner.s.office/viz/DHHSbytheNumbers_17079272307690/DHHSbytheNumbers

[7] This memo is located on the Commission's web page with materials for the November 14, 2023 meeting.

In addition to the impact on health insurance coverage rates, the unwinding has increased the number of calls to call centers straining the ability of eligibility specialists to cope with demand and consequently wait times have lengthened. In response, the Department created the Wilton Call Center, contracted with additional staff, used a CoverME.gov call center vendor to make outbound calls to MaineCare members to update their contact information during the open enrollment period, and redesigned the mymaineconnection.gov website. Director Bogart said that the Department had not yet solved the problem but they were trying hard.

Director Bogart discussed examples of work in progress including the MaineCare rate reform law and its accompanying ongoing process to update MaineCare rates with the input of interested parties and providers. The National Association of Medicaid Directors awarded the Office of MaineCare Services its Spotlight Award in 2022 for the rate reform law that is intended to create a rate setting system that ensures regularly updated, evidence-based payments that support high-quality health care and fair and sustainable reimbursement to Maine's providers. Another example of work in progress was the opening of a crisis center "living room" in Portland run by Spurwink as an alternative to jail or an emergency department for those experiencing a crisis.

Director Bogart presented the work that is going on in the Department around services for older youth and adults with developmental disabilities and autism. Although there have been significant increases in reimbursement for direct care workers, the industry is subject to the workforce shortages impacting every sector of the workforce in the State. There are budget limits for Section 21, the waiver program that provides comprehensive services for adults with developmental disabilities and autism, and waiting lists have grown. A particular challenge for families with children who receive services at school, is the "cliff" which is when services end upon adulthood. These young people can become isolated and lose ground without services. The Department has been working on a new way of delivering services to older youth and adults with developmental disabilities and autism to strengthen the entire system, prevent disruptions, and tailor services to individual needs. The Office of Aging and Disability Services, within the Department, has been developing a new Lifespan Waiver, with stakeholder input, that is proposed to begin in 2025. The new waiver would enroll eligible individuals at 14 years of age and facilitate a seamless transition to adult services, allow supports to change over time, assess needs, and expand self-direction within the program. In the meantime, individuals on the Section 21 waiver can choose to remain covered under the current program. The Department has been providing regular updates to the Health and Human Services Committee and the Committee will review the major substantive rule that is required for the waiver to be implemented and expected during the 132nd Legislature.

The Department has made structural changes to the Office of Child and Family Services as it reacts to increasing need, concerns about service gaps, and implements the Family First Preventative Services Act and the Child Safety and Family Well-Being Plan. The Office hired a third associate director, increased the number of caseworkers including overnight and weekend staff and auxiliary paralegal staff, and worked to improve the hiring and retention of caseworkers. More restructuring occurred in 2024 after recommendations from the Public Consulting Group in its Child Welfare Organizational Structure and Support Assessment of the

Office of Child and Family Services.[8] The restructuring took place in management structure, professional development, communication and retention, engagement and culture. During the period that the Commission was meeting, the Maine children's behavioral health system was the subject of a Department of Justice investigation and lawsuit related to compliance with the Americans with Disabilities Act for unnecessarily segregating children with behavioral health disabilities in psychiatric hospitals, residential facilities and a state-operated juvenile detention facility, as well as out of state. In late November 2024, the case was settled, but the lawsuit and the activities of the Government Oversight Committee reviewing the deaths of four children both acted as a backdrop to the Commission's examination of the Department's child welfare work and delivery of children's behavioral health services.

Director Bogart presented data related to the timeliness of constituent services responses within the Department. In the third quarter of 2023, the Commissioner's Office tracked 869 inquiries. Inquiries come from constituents, legislators, Maine's congressional delegation, organizations and other departments or offices. According to the data presented, over 80% of the issues were resolved within two days. The constituent services coordinator acts as a clearing house and sends more complicated questions to her counterparts and the program experts in the other offices within the department.

III. DISCUSSIONS AND RECOMMENDATIONS

A. Child Welfare and Child Protective Services

The Commission spent a considerable amount of time, at multiple meetings, discussing issues related to child welfare. Commission members are aware that the child welfare issue has been, and still is, a serious topic of discussion in the Health and Human Services Committee and the Government Oversight Committee (GOC). The focus is a natural response to the recent deaths of several children in Maine at the hands of family members or caregivers when there was, or had been, a report to the Department of suspected child abuse or neglect. All legislators serving on this Commission also served on either the Health and Human Services Committee or the Government Oversight Committee in the 131st Legislature.

The Commission requested a summary of budget initiatives that related to improving child welfare services and to providing preventative services to vulnerable families. The biennial and supplemental budgets enacted in the 131st Legislature (Public Law 2023, chapter 412 and Public Law 2023, chapter 643, respectively), included over $6,000,000 in general funds allocated to address staffing shortages and staff turnover within the child protective program as well as one-time funds as incentives to behavioral health providers to provide services to families in the child welfare system. Details of these budget initiatives are summarized in Appendix D

The Commission also discussed two bills considered by the Health and Human Services Committee in the 131st Legislature, LD 799 and LD 1788, and the two letters related to these bills from the Committee to the Commission. These letters, dated April 9, 2024 and May 13, 2024, asked the Commission to consider the policy proposals outlined in these two bills, LD

[8] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/03292024%20PCG%20Org%20Assessment%20FINAL.pdf

1788, An Act to Establish the Office of the Inspector General of Child Protection[9] and LD 799 An Act to Create a Separate Department of Child and Family Services[10]. These letters are in Appendix E.

LD 1788, as drafted, would have established the Office of the Inspector General (OIG), based on the model from the State of Nebraska, to investigate: suspicious deaths or serious injuries at child care facilities, residential care facilities, foster homes, Long Creek Youth Development Center, as well as allegations or incidents of misconduct and other violations of law, rules or protocols by the Department of Health and Human Services' employees and contractors. The sponsor presented an amendment to the Committee proposing to establish an Office of the Child Advocate (OCA), based on the model from the State of New Hampshire, that would provide oversight of executive agencies to: ensure children served by the child welfare or juvenile justice systems have their interests protected and ensure children receive services; provide recommendations to improve services; and advise the public, governor, commissioners, presiding officers and committees of jurisdiction on how the State may improve services. LD 1788 was unanimously voted out of committee with a report of "ought not to pass." The Commission's discussion on this proposal was also informed by a memorandum from Kristin Brawn, Office of Policy and Legal Analysis, on OIG/OCA offices in other states. This memorandum is included as Appendix F.

LD 779 proposed to separate the Office of Child and Family Services from the rest of the Department of Health and Human Services. LD 799 had a majority report of "ought not to pass" and a two-person minority report in favor of the bill. The minority report was passed to be engrossed in the Senate, but tabled in the House and then carried over when the 131st Legislature adjourned on May 1, 2024.

The Commission makes no recommendations relating to establishing an OIG or OCA, changing the authority of the Child Welfare Ombudsman, or separating out the Office of Child and Family Services from the Department as a separate department with a cabinet-level Commissioner. The Commission is aware that there will be future bills introduced to the 132nd Legislature related to these options.

At the May 29, 2024 meeting, the Commission had several briefings to get a full picture of the system of oversight around the child welfare system. Bobbi Johnson, Director of Office of Child and Family Services (OCFS), briefed the Commission on the reorganization within the Office, recruitment and retention initiatives, collaboration efforts across offices and departments to improve services, and the procedure of a case through the child welfare system. Peter Schleck, Director of the Office of Program Evaluation and Government Accountability (OPEGA) provided the Commission with background information on the GOC's current investigations into the Department's child protective services system that began in the 130th Legislature. A detailed report on the initial work of OPEGA is found in the January 2022 *Information Brief: Oversight of Maine's Child Protective Services* report shared with the commission.[11]

[9] https://legislature.maine.gov/billtracker/#Paper/1788?legislature=131
[10] https://legislature.maine.gov/billtracker/#Paper/779?legislature=131
[11] https://legislature.maine.gov/doc/7924

1. Government Oversight Committee Recommendations

The GOC released its draft report on February 2024, *Report of the Government Oversight Committee: Frontline Perspectives in Child Protection as Catalysts for Reform*[12] that contains recommendations from the GOC to the Department of Health and Human Services on internal department reform initiatives intended to improve the child protective services system.

A detailed update on the Department's response to the GOC recommendations was provided to the Commission during Director Johnson's presentation in May and by Molly Bogart, Director of Government Relations in June. Among the department's efforts in response to the report's recommendations are the following:

- A position of Associate Director was added to OCFS to enhance accountability for child care and children's behavioral health services;
- Additional caseworkers and supervisors were hired and efforts made, such as increased pay, to combat high turnover of these staff;
- A dedicated hotel and emergency department coordinator was hired to assist in finding appropriate behavioral health treatment options for youth, including youth in State custody;
- The Child Safety and Family Well-Being Plan[13] was implemented to intervene earlier upstream with children and their families to minimize or eliminate the risk of child abuse and neglect and to reduce the need for child protective services;
- The Department joined the National Partnership for Child Safety which is a collaborative focused on improving child safety and preventing child maltreatment fatalities[14];
- A formal agreement with the National Center for Fatality Review and Prevention to make use of the National Fatality Review Case Reporting System which allows participating state and local entities to systematically collect data and report findings from cases over time is in the works; and
- OCFS partnered with the Collaborative Safety LLC to develop and implement the Maine Safety Science Model[15] into the Department's critical incident review process. Safety science applies an evidence-based approach to inform preventative and responsive actions through the application of scientific methods, tools and resource to assess, understand and manage safety

A list of the GOC's recommendations and full details of the Department's progress implementing these recommendations, as of September 14, 2024, is in Appendix G.

[12] https://legislature.maine.gov/backend/app/services/getDocument.aspx?documentId=107569
[13] Version 1.0 of the plan and information on updates to the plan may be found at: https://www.maine.gov/dhhs/programs-services/human-services/child-safety-and-wellbeing-plan
[14] For more information on NPCS visit: https://www.prnewswire.com/news-releases/national-partnership-for-child-safety-provides-year-end-updates-on-collaborative-efforts-to-improve-child-safety-and-prevent-child-maltreatment-fatalities-302022852.html
[15] A department report on this model is available at: https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Maine%20Safety%20Science%20Model%202022%20Report.pdf

Commission members reached consensus that the work of the GOC and the Department identifying the necessary steps to improve the child welfare and child protective services, the Department's ongoing work implementing those steps and the continued oversight of these matters by the GOC and the Health and Human Services Committee, rendered additional recommendations in this area by the Commission unnecessary. The Commission did vote, unanimously of those present and voting, to make the following recommendation to highlight the importance of continued work in this area:

> **Recommendation**: The Legislature should support the 30 recommendations of the Government Oversight Committee's investigation of the perspective of persons involved on the front-line of Maine's child protection system.

2. The Maine Safety Science Model and Child Safety and Family Well-Being Plan

Christine Alberi, the Child Welfare Ombudsman, also presented to the Commission stressing the benefits of full implementation by OCFS of the Safety Science Model which integrates behavior analysis science to improve how staff make decisions and how managers and supervisors affect employee performance to achieve successful outcomes. OCFS has stated that it is using the Safety Science Model to improve staff's ability to make decisions in a way that eliminates hindsight bias and blaming or shaming of staff. In response to Ombudsman Alberi's presentation, the Commission spent time discussing the need for more transparency in the work of child protective services and the need for the department to better consider the opinions of outside stakeholders. The Commission also learned about and discussed Maine's Child Safety and Family Well-Being Plan which expands early intervention and services to reduce the need for child protective services.

The commission voted unanimously of those present and voting, to make the following finding:

> **Finding**: The Commission supports the Maine's Child Safety and Family Well-Being Plan developed by Department and implementation of the Plan. The Health and Human Services Committee has received several presentations on the Plan including Version 1.0 and continuing work to update the Plan.

3. Upstream Initiatives and Reducing Stigma

The Commission discussed the importance of upstream efforts to strengthen families in order to prevent involvement with the child welfare system. Commission member, Allina Diaz reiterated the importance of financial assistance to meet a family's basic needs for food, shelter, clothing and health – services that help families maintain a safe and healthy home. She stressed that financial assistance needed to be sufficient to pay for family needs and that families know best what services they need. Allina Diaz also mentioned the public perception that child welfare services are punitive rather than preventative and that the involvement of child protective staff often leads to the breakup of the family unit in some way. This perception brings fear and can cause families to be reluctant to seek help from the department even for services that are intended to be helpful and build success in creating and maintaining stable and health families.

The Commission did not make recommendations related to this discussion but did vote, unanimously of those present and voting, to make the following findings:

Finding: More opportunities for families to provide input to the Department on the availability and delivery of services and programs, with special attention to soliciting input from immigrant families, families of color and other underserved groups, should be created.

Finding: The message to the public that involvement with Office and Child and Family Services, child protective services includes information and services to support families remaining together and does not automatically result in removal of children from the home must be clearly and continually communicated.

Finding: Increasing funds available to families to meet their basic needs reduces stress on families.

4. Mandated Reporters

Commission member, Senator Marianne Moore stated that she has repeatedly heard concerns from members of the public that mandated reporters who have made reports of suspected child abuse or neglect receive no feedback regarding their report, including whether it is being investigated or if the report was even received. This concern was repeated by other legislative members of the Commission.

Recommendation: The Department should determine how better to communicate with persons who report suspected child abuse or neglect so that the reporter understands the process that will occur based on the report.

5. Child Care Security

Commission member, Senator Marianne Moore expressed concern that child care facilities are not required to have security standards. Commission member, Bill Montejo, Director of Licensing and Certification in the Department, confirmed that there are no security requirements in the Department's child care licensing rules.

Recommendation: The Department should implement security standards for licensed child care facilities through rulemaking taking into consideration the costs providers will incur from new security standards.

B. Children and Youth with Special Health Care Needs

The Commission developed recommendations regarding Children and Youth with Special Health Care Needs (CYSHCN)[16] and children with behavioral health issues through twin lenses.

[16] The federal government identifies CYSHCN as children who have, or at increased risk for having, chronic physical, developmental, behavioral, or emotional conditions. They have conditions such as asthma, sickle cell disease, epilepsy, anxiety, autism, and learning disorders. They may require more specialized health and educational

The first lens is around the requirements for CYSHCN within the Maternal and Child Health Services Block Grant, as well as a need for care coordination. The second lens is around the programmatic shortages of behavioral health services provided to children with disabilities that led to the lawsuit filed by the Department of Justice against the State of Maine in the United States District Court, District of Maine, *United States of America v. State of Maine.*[17]

1. Title V, Children and Youth with Special Health Care Needs

Commission member, Nancy Cronin, organized presentations from Dr. Amy Houtrow on the Title V Maternal and Child Health Services Block Grant, and the National Blueprint for Change: Guiding Principles for a System of Services for CYSHCN and their Families and from Eileen Forlenza, former president of the Association of Maternal and Child Health Programs. Stacey LaFlamme, Maternal and Child Program Manager in the Maine CDC, presented on Maine's Blueprint for Change: Standards for Systems of Care for Children and Youth with Special Health Care Needs.

Title V of the Social Security Act enacted in 1935 authorizes the State Maternal and Child Health Block (MCH) Grant program. The MCH block grant aims to improve the health of pregnant women, mothers, and children, particularly those with low income or limited access to health services. One of the purposes of Title V funds is to provide specialized care to CYSHCN. The program was renamed in 1986 by Surgeon General C. Everett Koop (it was previously known as the Crippled Children's Services). State MCH block grant funds can be used for a broad array of health services and activities. However, federal law requires states to use 30% of federal funds for preventive and primary care services for children and an additional 30% for services specific to CYSHCN.

In addition to CYSHCN under Title V of the Social Security Act, the Medicaid statute created the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children. Dr Houtrow and Eileen Forlenza both noted that EPSDT also came from the crippled children legislation of 1935. The EPSDT program is intended to identify and diagnose health problems of low-income children, up to the age of 21 years old, through periodic physical and developmental examinations and medically necessary treatment. In 1975, Congress enacted the Education for All Handicapped Children Act, which was renamed the Individuals with Disabilities Education Act in 1990. These three major pieces of legislation, along with other legislation developing Developmental Disability Councils and the Supplemental Security Income Disabled Children's Program, are intended to provide services to children with disabilities and health issues.

Dr Houtrow outlined the conceptual framework for services to CYSHCN. Title V block grant funding is envisioned to provide: direct health care services; enabling services such as transportation, outreach, family support services, and case management; population-based services such as newborn screening, immunization, oral health, nutrition and outreach; and infrastructure-building services such as needs assessment, policy development, coordination and

services to thrive, even though each child's needs may vary. See: https://mchb.hrsa.gov/programs-impact/focus-areas/children-youth-special-health-care-needs-cyshcn

[17] On November 25, 2024, prior to the completion of this report, this case was settled.

quality assurance. System of Care Goals for services to CYSHCN for individuals and families include community-based services, early continuous screening, access to a medical home, transition services to adulthood, adequate insurance and ensuring families are partners in decision-making. For health services, each child needs primary care, specialty care, community services, school services and hospital care. Dr Houtrow pointed out that these services do not talk to each other very well.

Dr Houtrow's presentation stated that according to the National Survey of Children's Health, Maine has approximately 60,000 children and youth with serious health care needs. She shared core indicator data from 2021-22 that compared Maine to the US. At times, Maine's performance indicators were better than national data. However, even those indicators showed poor performance overall. For example, 42.9% of Maine children and youth were receiving developmental screening early and continuously, compared to 33.7% nationwide, but that still means that far less than half of all children are being screened early and continuously. Core indicators show that Maine and U.S. children do not all have a medical home that is patient-centered, coordinated, comprehensive and ongoing and may also lack insurance with adequate coverage. Dr Houtrow noted that the core indicators show an adequate system of care for CYSHCN is only 14.6% in Maine and 13.2% in the United States.

Dr Houtrow also pointed specifically to care coordination for CYSHCN which was 55.6% for the U.S. and 51.5% in Maine. Care coordination stands at the center of a functioning system for CYSHCN. Commission member, Nancy Cronin asked about the difference between care coordination and targeted case management. Dr Houtrow stated that families have reported that they have sufficient targeted case managers – "targeted" being the key word – and what families often need is an overall care coordinator that can cross silos in order to serve the child or youth with special health care needs. Similarly, the importance of a medical home cannot be overstated. An individual with complex health needs may have a team of specialists but needs an overarching doctor or nurse that can provide family centered coordinated care while also preventing unnecessary emergency room visits. Ideally, the care coordinator should be located in the medical home.

Dr. Houtrow, and then Eileen Forlenza, former president of the Association of Maternal and Child Health Programs shared information on the Health Resources and Services Administration's Maternal and Child Health Bureau "Blueprint for Change" which was developed to serve as a national framework to improve the lives of children and youth with special health care needs because families consistently stated that the current system was not working. The goal of the framework is for CYSCHN to enjoy a full life and thrive in their community from childhood to adulthood. This requires a service system with access to integrated quality services, sufficient financing of services, health equity and a quality of life and well-being that allows children and their families to flourish.

The National Center for a System of Services for Children and Youth with Special Health Care Needs is a group of organizations working collaboratively to support state Title V programs and their allies in their efforts to advance the Blueprint for Change. Eileen Forlenza, is working with Maine on its Blueprint for Change framework. During Ms. Forlenza's presentation to the Commission, she told the Commission that the State should financially support the program and

the framework because when a system works for a child with serious and complex health conditions, it works for all children.

In Maine, services for CYSHCN are located within the CDC, and Stacey LaFlamme is the Program Manager for children with special needs. Ms. LaFlamme presented on the work that the Department is doing to implement the Blueprint for Change framework. She outlined the vision with the framework goals around screening, referrals, insurance, access to care, medical home, home and community-based services, and receiving necessary services. The Department has hired a contractor to do a systems asset and gap analysis. In June, when the presentation was given, the expectation was that it would take approximately eight months to complete.

Stacey LaFlamme outlined the Department's focus on care coordination and medical homes. She stated that there is one fulltime employee in the Department who is a health care coordinator but one position cannot meet the needs of all. The Department is looking at models to figure out how to train and support workers before they can take the next step of hiring additional coordinators. Another Department focus is improving partnerships with families. To that end, the Department has contracted with Eileen Forlenza to elevate family voices in running the program providing services to CYSHCN. In addition, the Department is undertaking an initiative to improve the system of identifying children. As noted above, the National Survey of Children's Health estimate that there are 60,000 CYSHCN in Maine but there is not a way to identify children. Therefore, the Department is working to develop a system that would accurately identify children to be served.

2. Children's Behavioral Health Services

The Commission is aware and concerned about the lawsuit filed by the Department of Justice against the State of Maine in the United States District Court, District of Maine, *United States of America v. State of Maine.* In this case, which was settled after the Commission's last meeting[18], the Department of Justice sought a judicial order compelling Maine to provide behavioral health services to children with disabilities in their homes and communities, rather than unnecessarily segregating them or placing them at serious risk of unnecessary institutionalization.

At the 2024 meetings of the Commission, the Department shared presentations on how individuals with specific needs would be served by the Department. At the June 12, 2024 meeting, the Department prepared two case studies as an illustration:

1. A child with complex medical needs who is receiving Individuals with Disabilities Education Act, Part C, needs speech and language services, physical therapy, occupational therapy, neurology, and intensive early education treatments. The family also needs child care services.
2. A low-income family facing homelessness with two children with special needs. One child has ADHD and needs medication management and the other child has autism spectrum disorder and receives Section 28 MaineCare services from providers that are understaffed.

[18] The settlement agreement may be found at: https://www.justice.gov/crt/case-document/settlement-agreement-us-v-state-maine

The case study presented by the Department of the child with complex health needs included input from members representing children's behavioral health services, MaineCare, the CDC, Early Childhood Education within OCFS, and OFI. The Department also noted that the Department of Health and Human Services is only one piece of the puzzle in providing services for a child with complex medical needs. For example, school services provided by the Department of Education would also be required. The programs administered by other state agencies was also a complicating factor in the second case study of the low-income family facing homelessness. The Maine State Housing Authority or local housing authorities are the entities responsible to administer housing assistance programs so would need to be involved with the family starting at the application stage.

Commission member, Nancy Cronin, noted that the number of departments and offices involved in providing services to a child with complex health needs such as the child in the case study, shows how important care coordination is as a service, as well as the need for a complex case manager within the Department who is authorized to solve problems across departments and offices. For the second case study, Nancy Cronin noted that children with autism and behavioral issues have to pick either targeted case management and a community care team or a behavioral health home. She also noted the recent issues with ADHD medications at pharmacies. Dean Bugaj, Associate Director of Children's Developmental and Behavioral Health Services in the Office of Behavioral Health, noted that the issues around targeted case management and behavioral health homes are rooted in federal law. Associate Director Bugaj agreed that the two pieces of the puzzle don't always work well together and there is future work to be done in this area.

Nancy Cronin, stated that in her capacity as Executive Director of the Maine Developmental Disabilities Council, she has been working on two cases of children unable to get any appropriate services. One child spent 206 days in an emergency room without any apparent prospect for placement. The child was 13 years of age with cerebral palsy, incontinence, developmental disability and behavioral challenges and there seemed to be no appropriate placement in the nation, and there was talk of placing her in a nursing facility. She was confined to the emergency room and was not allowed to go outdoors during this period. Commission member Cronin stated that even though the services do not exist, in such extreme cases the attitude should be "what can we do to help?" She also noted that it is the responsibility of government to provide services to this child with complex needs. Nancy Cronin's second example was a three-year-old with complex medical needs in the child protective system. The child was not receiving any early intervention services and they were looking for a nursing facility for her. Commission member Cronin stressed that people were working hard and the gaps in services are not anyone's fault, but that there is no one in charge and working across systems to coordinate such difficult cases. She emphasized the implementing the Blueprint for Change in Maine is the key to solving these types of problems.

Members of the Commission discussed the lack of care coordination or case management and determined that this is an issue broader than children and youth with complex health care needs. It also applies to adults in emergency rooms with behavioral health issues or developmental disabilities or autism, and to segments of the elderly population with dementia and Alzheimer's

disease. They also agreed that unmet housing needs (financially, physically, and supply) is a cross-cutting issue that underlies complex cases.

Commission members agreed, unanimously of those present and voting, to make the following findings and recommendations regarding CYSHCN and children's behavioral health services:

Finding: Leadership at the Commissioner's office level is necessary for a transition to whole-child system that holistically integrates initiatives among department offices and this requires some reorganization within the Department.

Finding: The development and coordination of policies within the Department of Education and the Department of Corrections is necessary to ensure the health and wellbeing of children is maximized.

Finding: The lack of services available to children with multiple health needs (i.e. physical, developmental, behavioral) and the availability of service providers results in too many children who either go without needed services or receive services at a higher level than necessary, i.e. within residential programs or institutions, including out-of-state placements, rather than in the community. This lack of services has contributed to the lawsuit filed by the Department of Justice against the State of Maine in the United States District Court, District of Maine, *United States of America v. State of Maine.*

Finding: Service programs for children should be expanded to include monitoring and supportive services for children and youth who require supports such as nursing services, Section 28 (Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations under MaineCare) and developmentally-focused services.

Finding: The Department could consider waiver programs for children with complex health needs similar to those used in other states.

Recommendation: The Department should develop a continuum of care service model that serves children with any combination of physical, developmental, neurological, or other care needs that connect to behavioral needs as necessary to provide adequate and appropriate care in the least restrictive setting possible.

Recommendation: The Department should update the Health and Human Services Committee on the lawsuit filed by the Department of Justice against the State of Maine in the United States District Court, District of Maine, *United States of America v. State of Maine*. The Health and Human Services Committee should also consider inviting the Government Oversight Committee to any presentations related to the lawsuit.

Recommendation: The Department should identify and expand, as appropriate, funds that should be targeted to CYSHCN from the Maternal and Child Health Services Block Grant to support the CDC's Blueprint for Change.

Recommendation: If the percentage of the Title V Block Grant funds allocated for preventative and primary care services for CYSHCN in the State's five-year State Plan for children's health needs is not at least 30% of the grant funds, the Department should reallocate funds to meet the 30% obligation.

Recommendation: The Department should study, and report to the Health and Human Services Committee how the Department is meeting its obligations under the Medicaid Early and Periodic Screening, Diagnostic and Treatment benefit, including identifying gaps in the services offered or the accessibility of services. As part of this study, the Department should engage stakeholders in the process of identifying gaps.

Recommendation: The Department should conduct a compliance evaluation of the current statutes, State Plan and operations of the CDC to ensure the Department meets its obligations with respect to CYSHCN.

C. Behavioral Health

The Commission made findings and recommendations regarding adult behavioral health and substance use disorder. The findings and recommendations generally mirror other themes discussed by the Commission, especially for children's behavioral health. Concerns about unmet needs, lack of service availability (especially in rural areas of the state or for Medicaid patients or those who lack health insurance), silos within the Department, and concerns about over-institutionalization are not unique to behavioral health. The National Alliance for Mental Health (NAMI) and the Maine Alliance for Addiction and Mental Health Services briefed the Commission at its July 10, 2024 meeting and stated that the need for increased behavioral health services is clear; in the U.S. one in five adults have a mental illness, yet fewer than half received treatment in the past year. According to NAMI, the most common reason for not receiving mental health services is an inability to access care. Waitlists, costs, and quality of treatment services also present barriers to accessing services.

1. Certified Community Behavioral Health Clinics

NAMI and the Department briefed the Commission on Certified Community Behavioral Health Clinics (CCBHCs). The Health and Human Services Committee received regular updates and considered several bills on CCBHCs during the 131st Legislature.

CCBHCs began at the federal level in 2014, expanding slowly, and then more rapidly during the pandemic with American Rescue Plan funding. CCBHCs are a different behavioral health organizational model that is aimed at breaking down silos and looking at the whole person. Services provided include behavioral health but also primary care and physical health screenings. Maine received a planning grant in 2021 which was used to apply to be a demonstration state for the clinics. Subsequently, Maine was accepted into the CCBHC Medicaid Demonstration in June 2024. With an implementation date of January 2025, the program will run for four years. During that four-year period, the State will receive an enhanced Medicaid match from the federal government.

The Department explained that there has been a huge team effort to implement the new model in Maine. Clinics within the program are subject to certification by the State to ensure that they meet federal and state criteria. Certification provides that CCBHCs will receive a monthly reimbursement rate that is tied to the quality and expansion of behavioral health and substance use disorder services available in the community. Those criteria involve: staffing, availability and accessibility of services, care coordination, scope of services, quality and other reporting, and organizational authority, accreditation and governance. The reimbursement rates are value-based. Thus, payments are tied to quality and bonuses are available when there are outcomes for those receiving services. Reimbursement rates are intended to cover costs for providers and therefore remain sustainable.

The Department explained that the CCBHC model assesses a person when they come through the door. If the person is in crisis, the person receives immediate access to crisis care. If the need is urgent, services are accessed within a day. If the visit is routine, then services are received within 10 days. Care coordination is built into the system and is part of the reimbursement structure, rather than a separate service under a traditional fee-for-service model. The model requires comprehensive behavioral health services so that the person receiving services does not have to piece together services across multiple providers on their own. The federal government requires certain behavioral health and substance use services along with others that are allowable depending on the needs of the community and the capacity of the organization. If services are not available at the client's location, referrals must be made to where services are available. Services required by the model include: mobile crisis and stabilization; screening, assessing and diagnosis; patient-centered treatment planning; outpatient behavioral health and substance use services; primary care screening and monitoring; targeted case management; psychiatric rehabilitation services; peer supports; and behavioral health services tailored for veterans.

Representatives from NAMI shared data that showed that CCBHCs in other states have improved service provision, decreased emergency room visits and hospitalizations, and resulted in job creation within the behavioral health sector. They described the model as more than a service but as a "transformational and innovative way of meeting the behavioral health needs of our communities". However, they did caution that implementing the CCBHCs will require continued partnership with the State to support infrastructure development, capacity building, technical assistance, staffing and training.

The Commission felt that the CCBHCs hold a great deal of promise because of the wraparound service model that includes care coordination at every level. The intent is to also improve access to services that are high quality and evidence based, at the appropriate community or residential level, and can be provided at an earlier stage for the individual reducing the need for higher levels of care and institutionalization. The Commission's findings, in their discussion of adult behavioral health services, mirror those in several areas of Departmental services.

The Commission agreed, unanimously of those present and voting, to make the following findings and recommendations.

Finding: Access to community based behavioral health services reduces the need for higher levels of care and institutionalization.

Finding: There is a significant lack of services, especially in certain areas of the State.

Finding: Evidence-based services are necessary to address the needs of individuals with behavioral health needs.

Recommendation: The Department should identify the amount of funds necessary to sustain Maine's Certified Community Behavioral Health Clinics, with fidelity to the national model, and develop a plan to fully fund and expand them in the future.

Recommendation: The Department should develop a plan to increase accessibility to behavioral health crisis services, including mobile crisis services and crisis receiving centers.

Recommendation: The Legislature should increase funding to the behavioral health crisis centers in the counties of Penobscot and Aroostook and the City of Lewiston.

Recommendation: The Department should develop a plan to provide preventative, community-based behavioral health services in rural areas of the State.

D. Developmental Disabilities

1. Lifespan Waiver

Director Bogart provided information to the Commission about the major initiative the Department is currently undertaking to move to a new waiver program called the Lifespan waiver. Currently, the Office of Aging and Disability Services (OADS) manages five existing home and community-based waivers under MaineCare for Sections 18 (brain injury), 20 (other related conditions), 21 and 29 (intellectual disabilities and autism), and 19 (elderly and adults with disabilities). These programs allow adults to receive services under a waiver approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. The Department is currently developing the Lifespan waiver to eventually replace the four waivers and provide services to individuals beginning at 14 years of age. The Health and Human Services Committee has frequently heard about teenagers who receive services at school through the Department of Education but then experience "falling off a cliff" as they age out of the education system and find themselves on waiting lists for adult services while losing skills learned as children.

The Department is currently completing several projects related to the development and implementation of the Lifespan waiver. These projects have been funded with federal American Rescue Plan Act funds as pilots that will be completed at the end of 2024. In 2025, under the Lifespan waiver, services will be offered for the first time to eligible youth starting at age 14. OADS has developed new staffing roles to assist the population entering the new waiver. One is the Community Resource Coordinator who will assist families with navigation along with four

Transition Liaisons who will provide training and education in the regions and help students and families who are still in school learn about the Lifespan waiver and services available in OADS. Once the individual is found eligible and a Lifespan waiver offer is made, the individual will be asked to complete a Supports Intensity Scale (SIS-A) assessment. Currently, all assessments are voluntary, and the information provides data regarding services needed in the system. OADS and OMS have an existing organizational structure for waiver management onto which the Lifespan waiver will be added. The Department has hired an outside consultant to complete a rate study for all the waivers, including Lifespan and that work is close to completion.

Bonnie Jean Brooks, Interim Executive Director of the Maine Developmental Oversight and Advisory Board (OAB) briefed the Commission on the work of the OAB and the issues that people with developmental disabilities face. The OAB was created when the Pineland Consent Decree was terminated. She stated that the OAB is supportive of the Lifespan waiver and that it was one of the most comprehensive policy efforts from the Department that she had seen. She stated that the OAB continues to work to get questions answered from the Department on behalf of stakeholders and members. However, the OAB has remaining concerns around service clarification, confusion about case managers and community resource coordinators, waitlists, coordination between departments, and remaining regulatory and technical changes within the Department that should be resolved prior to the Lifespan waiver going live.

The Commission did not make many recommendations around the Lifespan waiver. Members of the Health and Human Services Committee have received several briefings on the development of the waiver and expect to continue receiving detailed updates. They have also heard concerns from individuals receiving services (or on waiting lists) and their families about capacity, assessment, group homes, shared living and other issues. However, the Commission did make one related recommendation concerning clarifying an existing predicament for children with developmental disabilities who also need behavioral health services.

Commission member, Nancy Cronin, pointed out that under current Centers for Medicare and Medicaid Services policy and rules, children with developmental disabilities who also need behavioral health home services are having to choose between one of the two types of services they receive. Nancy Cronin stated that although the upcoming Lifespan waiver could be described as a triumph, it is unclear if there will be any improvement in coordination between developmental disability and behavioral health services, and whether questions about coordination are even being asked. Commission members noted that they had not examined this issue earlier and therefore lacked clear information. However, they stressed the importance of interdepartmental work and coordination of services as the Department implements the Lifespan waiver. Commission members who are also members of the Health and Human Services Committee noted that as they have been receiving updates on the progress of the Lifespan waiver, the answer to this question could be included as part of a future presentation by the Department.

> **Recommendation**: The Department should investigate how children's behavioral health services will be coordinated with the Lifespan waiver.

2. Case Management and Coordination

Commission member, Rob Moran, also raised issues about consolidation of services and staff in the Department's central offices in Augusta. He commented that it used to be easier for providers to have a conversation with Department staff within the district offices but they are now in Augusta. The Commission did not make a recommendation but did make a finding:

> **Finding**: The location of Department staff within district offices was a successful model that advanced navigation of the system and access to services by the public and service providers. With the consolidation of services and staff, access to staff has decreased.

Commission members, Rob Moran and Nancy Cronin, raised the issue of the shortage of case managers and lack of clarity about credentials for case managers who serve different populations. Section 13 of the MaineCare Benefits Manual governs case management, a service for which different client populations, including individuals with a developmental disability, behavioral health issues or substance use disorder may be entitled. Individuals on waiting lists for Section 21 and 29 services, or those who have been approved but unable to access work force to provide services, may receive case management services only. Commission member Moran noted that turnover rates among case managers are often extremely high, especially among new case managers within their first 90 days of employment. Although he noted that his area of Aroostook County had been remarkably fortunate to escape the high turnover problem. Both Commission members noted that there could be efficiencies and consolidation of roles to meet the needs given small populations, and that there could be ways to cross-train or use staff differently. Commission member, Rob Moran noted that he knew of individuals who would be excellent case managers, who had been direct support professionals for a long time and could step up but they do not meet the formal qualifications, including having a four-year degree. He suggested that amending the reimbursement rules to remove obstacles to providing efficient services would be helpful, for example, travel time is not billable even if a case manager in Aroostook County needs to travel two hours between clients.

> **Recommendation**: The Department should review the requirements of case management to improve versatility across different client populations, reduce duplication, and examine required credentials in order to improve employee retention and services for clients.

3. Newly Emerging Information

Just prior to the final meeting of the Commission, members received testimony from Bonnie Jean Brooks, Interim Executive Director of the Maine Developmental Oversight and Advisory Board (MDSOAB) and Kim Humphrey, founder of Community Connect related to the MDSOAB and allegations of criminal abuse at a residential care facility for adults with intellectual disability and autism in Hampden, Maine. Although the Commission did not have time to examine this issue, we have included their testimony as Appendix H. The Commission suggests that the Health and Human Services Committee should follow up and request updates on the situation within whatever boundaries may exist because of criminal prosecutions.

E. Elder Services

1. Workforce Shortage

The Commission was briefed on Department administered programs and services available to Maine residents 60 years of age or older (hereinafter referred to as "older Mainers") at meetings held on November 14, 2023 and July 10, 2024. Information shared at these meetings included the Department's follow up on the recommendations of the Commission to Study Long-term Care Workforce Issues[19] ("LTC Commission"), a presentation by Megan Walton, CEO, Southern Maine Area Agency on Aging and a case-study briefing by the Department's Office of Aging and Disability Services.

Workforce shortages has been a common topic of discussion in the Legislature regardless of committee or economic sector in the State. In both Health and Human Services Committee and Commission discussions, there is a recognition that workforce shortages cross into all Department of Health and Human Services programmatic areas. In 2021, the Legislature enacted several initiatives as part of the budget in response to the LTC Commission report, particularly in Section AAAA of Public Law 2021, chapter 398. This section required MaineCare and state-funded home and community-based services and long-term care services to reimburse providers at rates that support at least 125% of the minimum wage for the labor portion of the rate, with the intent that the direct care workers receive no less than 125% of the minimum wage.

Section AAAA also required five years of annual reports that would outline the Department's efforts to implement the recommendations of the LTC Commission including: aligning entry-level qualification requirements for direct-care workers across setting whenever possible; working with the Department of Labor and Maine's institutions of higher education to attract more people into the direct care field; and working on addressing barriers to workforce recruitment and retention. The law also requires the report to include data on unstaffed hours, vacancies for direct care workers, and unfilled beds in nursing facilities and residential care facilities due to staffing shortages. The Health and Human Services Committee has received three Section AAAA annual reports along with reports from the Essential Support Workforce Advisory Committee in the Department of Labor. The Commission reviewed these reports as well. Due to the continued focus on workforce issues within the Department and the continued oversight of this work by the Health and Human Services Committee, the Commission decided that recommendations on the workforce issues, whether focused on older Mainers or other populations, would add little that is new to an issue that is already a topic of significant attention and multiple initiatives.

2. Nursing Home Closures

Another topic of continued concern to the Health and Human Services Committee and the Commission is the closure of nursing facilities in Maine, especially in rural areas. These closures are particularly concerning because Maine is the oldest state in the nation, with 23% of

[19] The LTC Commission was established Public Law 2019, chapter 343, part BBBBB. The LTC Commission's report may be found at: https://legislature.maine.gov/doc/3852

residents over the age of 65, and that percentage is expected to grow significantly in the future.[20] Commission discussions on nursing home closures included conversations about whether the MaineCare reimbursement rates for nursing home care is adequate and updated frequently enough to counteract the closure trend. Commission members discussed the Department's ongoing work on rate reform pursuant to Public Law 2021, chapter 639.[21] Commission members also noted that there have been a number of budget initiatives during the 131st Legislature to provide funding to nursing facilities and residential care facilities while the rate reform is in progress.

Over the last several years, rate setting has been a frequent topic of conversation in the Health and Human Services Committee that has generated multiple bills in all areas of MaineCare and state-funded programs. Legislators have expressed frustration at the scattershot nature of bills addressing rate-setting and the lack of a systematic rate review process. There was also a sense of inequity as some groups of providers were able to mobilize and receive rate increases through the legislative process while other groups of providers were unheard even though they are equally in need of rate increases. After conducting a Comprehensive Rate System Evaluation, the Department undertook an overhaul of the MaineCare rate-setting process that resulted in the enactment of Public Law 2021, chapter 639. The evaluation found that many MaineCare rates were outdated and inconsistent, some with no known basis or methodology. Some sections of MaineCare received annual cost of living adjustments while other sections did not. The newly enacted rate setting procedure sets a schedule for regular rate review and adjustment; establishes the MaineCare Rate Reform Expert Technical Advisory Panel (TAP) for consultative purposes; establishes a rate system subcommittee in the MaineCare Advisory Committee; establishes a more transparent process for rate determination with public notice, presentation, and comments; and ensures review of relevant state and national data to inform rate amounts and payment models, with emphasis on models that promote high value services by connecting reimbursement to performance.

Important for this particular policy area, the Department has been working on a rate review process for nursing facilities (under Section 67 of MaineCare) and residential care or assisting living facilities (known as Private Nonmedical Institutions – PNMIs – Appendix C, under Section 97 of MaineCare) for the last couple of years. Although there is an expectation that these rates will be significantly overhauled, that work has not yet been completed.[22] Therefore, the Commission members decided not to make a recommendation on this matter but did vote, unanimously of those present and voting, to make the following finding:

> **Finding**: Nursing homes continue to close in part due to inadequate reimbursement under the MaineCare program and workforce challenges.

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[20] https://www.maine.gov/dafs/economist/news/oct-09-24/ageism-awareness-day-2024-shifting-demographics-contributions-older-adults#:~:text=Maine%2C%20like%20many%20other%20states,in%20the%20nation%20%5B1%5D.

[21] Public Law 2021, chapter 639. https://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP1377&item=3&snum=130

[22] Please see the DHHS website on MaineCare rate setting: https://www.maine.gov/dhhs/oms/providers/mainecare-rate-system-reform

3. Meals on Wheels

When the Commission was briefed by Megan Walton, CEO, Southern Maine Area Agency on Aging, one of the services provided by Maine's Area Agencies on Aging, the Meals on Wheels program, was of particular interest to some Commission members. This program provides meals to older Mainers who are homebound, have difficulty getting around or are unable to regularly prepare meals for themselves. There are no income or assets eligibility criteria and meals are provided for free but donations or co-pays are voluntary. In addition to providing nutritional meals to older Mainers, the volunteers who deliver the meals are trained to make sure the clients are safe and serve as an important social contact for isolated individuals.

The Meals on Wheels program saw an increased demand during the COVID-19 pandemic which has not returned to pre-pandemic levels. Many recipients of Meals on Wheels new to the program due to the pandemic were found to have been eligible for the program all along. With a reduced stigma attached to receiving the home-delivered meal, demand has remained high. During the pandemic additional funds were available to the Area Agencies on Aging but those additional funds are no longer available resulting in wait lists for the program. The value of these meals provide was discussed by Commission members and the members agreed, unanimously of those present and voting, to make the following finding and recommendation:

> **Finding**: During the COVID-19 pandemic, the number of older Mainers who received Meals on Wheels increased and that continued demand for the program has led to an ongoing waitlist.
>
> **Recommendation**: The Legislature should increase funding for the Meals on Wheels program administered by Maine's Area Agencies on Aging to eliminate waiting lists.

4. Non-Emergency Transportation

Another perennial issue in Maine is the lack of transportation options for older Mainers, and other individuals with disabilities, particularly those who live in rural areas. The MaineCare Non-Emergency Transportation (NET) system covers transportation to medical appointments, but there is no similar service for other appointment types such as trips to a pharmacy or grocery store or to attend church or engage in other social activities. This lack of transportation creates isolation which in turn has a negative impact on health. According to the Maine State Plan on Aging Needs Assessment, produced by the University of Southern Maine, Catherine Cutler Institute for the Office of Aging and Disability Services[23], a 2023 Advisory of the U.S. Surgeon General states that "[the] mortality impact of being socially disconnected is similar to that caused by smoking up to 15 cigarettes a day, and even greater than that associated with obesity and physical inactivity."[24]

Commission member Representative Shagoury described how some states, in particular, New York, have implemented pilot programs to provide this type of transportation service. In the

[23] https://mainecouncilonaging.org/wp-content/uploads/2024/01/SPOA-Final-Report-FINAL-1_4_24.pdf
[24] Maine State Plan on Aging Needs Assessment, pgs. 29 – 30.

130th Legislature, an 18-month pilot program similar to the New York program was proposed in LD 17 (See Appendix I). The pilot proposed in the bill would have provided nonmedical transportation services to individuals receiving services under Section 19 of MaineCare Benefits, Home and Community Benefits for the Elderly and Adults with Disabilities. The pilot required transportation services to be provided when the individual has no other means of transportation up to $2,000 each over a period of 18 months. LD 17 passed in the House as an emergency measure and was placed on the Special Appropriations Table where it died upon adjournment of the 130th Legislature. The fiscal note for the pilot, at that time, was a one-time General Fund appropriation of $583,920. Commission members agreed that the physical and mental health of older Mainer's would be greatly improved if the transportation barrier was addressed. The Commission agreed, unanimously of those present and voting, to make the following recommendation:

> **Recommendation**: The Legislature should develop and implement a nonmedical transportation pilot program similar to the Majority Report of the Health and Human Services Committee to LD 17, Resolve, to Provide Nonmedical Transportation Services to the Elderly and Adults with Disabilities Receiving Home and Community Benefits under the MaineCare Program from the 130th Legislature.

F. Complex Cases

A recurring theme in Commission discussions relates to the difficulties presented when individuals who have a complicated set of issues, and as a result of the complexity of their needs, face barriers to receiving appropriate services. The Health and Human Services Committee repeatedly received presentations, and dealt with bills related to children and adults receiving services out of state, or who remained in a holding pattern in an emergency room, because appropriate services were unavailable. Individuals awaiting appropriate services run the gamut from children with developmental disabilities and complicated behavioral issues, to adults in a psychiatric crisis, to an elderly person with complicating factors (e.g. behavioral issues relating to dementia or medical issues such as morbid obesity) awaiting a nursing facility placement. For example, the Health and Human Services Committee, and the Commission, heard from the Department regarding progress on developing a Psychiatric Residential Treatment Facility (PRTF) for children (including LD 181 enacted as Resolve 2023, chapter 78 related to ongoing work within the Department to develop such a facility) as well as plans for providing behavioral services to children in-state (including LD 435 enacted as Resolve 2023, chapter 158). Dean Bugaj, Associate Director of Children's Developmental and Behavioral Health Services in the Office of Behavioral Health, addressed the Commission on July 10, 2024 and shared the Department's projected work plan for developing a PRTF and the Department's progress to-date (See Appendix J).

The Health and Human Services Committee and the Commission acknowledge that persons awaiting placement and services is a long-standing issue. The Commission to Study Difficult-to-Place Patients report[25] from the 127th Legislature examined the problem. Many of the recommendations from that study follow similar themes as discussed by this Commission: expanding geropsychiatric facilities, expanding the Long-Term Care Ombudsman Program,

[25] https://legislature.maine.gov/doc/3657

enhancing rates for complex services, facilities that refuse placement, and the need to pay hospitals that are providing services in emergency rooms after the medical necessity has passed.

As with other findings and recommendations in this report, the lawsuit filed by the Department of Justice against the State of Maine in the United States District Court, District of Maine, *United States of America v. State of Maine*, is central to the recommendations around complex cases. In this case, the Department of Justice sought a judicial order compelling Maine to provide behavioral health services to children with disabilities in their homes or communities, rather than segregating them unnecessarily or placing them at serious risk of unnecessary institutionalization.

To that end, the Commission agreed to make the following recommendation:

> **Recommendation**: The Department should designate a person within the Commissioner's office with sufficient decision-making authority to coordinate services among the Department's offices to solve complex cases, such as individuals stuck in hospitals awaiting placement, or individuals institutionalized out-of-state due to lack of services and resources within the State. The designee should have decision-making authority including the authority to develop individualized plans of care for these complex cases.

Note: The vote for this recommendation was 6 in favor, 1 opposed with the three members from the Department of Health and Human Services abstaining.

The Commission decided not to make this a recommendation that would create a new position in the Department, recognizing that a realignment within the Department could be an appropriate way to develop this position.

G. Service Delivery Improvements

A key principle held by Commission members is that Mainers should be receiving services for which they are eligible. Throughout the work of the Commission, a theme of improving service delivery that cross-cut the offices within the Department was highlighted. The Department is constantly engaged in efforts to improve and streamline service delivery and reduce the stigma associated with receiving services. The Department has worked to incorporate a "no wrong door" approach, especially with respect to long term services and supports, as an effort to streamline client entry into the system. As noted earlier, Director Bogart stated that the federal unwinding of continuous Medicaid coverage has placed pressure on the eligibility specialists at call centers. This led the Department to create a new call center in Wilton, contracting for an additional 150 staff and redesigning the Department's online services platform, mymaineconnection.gov.

1. Technology

Commission members commented that when an individual or family qualifies for multiple public benefit programs they must repeatedly provide the same information with Department offices for

each application as well as with local entities that administer public benefit programs. This is frustratingly inefficient and can also create additional stress on the individual or family who is in need of services. Ian Yaffe, Commission member and Director of the Office of Family Independence stated that certain state and federal laws require personal information to be confidential and thus cannot be shared across programs, but that the Department continues to make efforts to improve the sharing of information when permitted. He also mentioned the recently enacted section 3110 in Title 22.[26] This statute requires the Department to provide electronic access, upon request, to income records and program enrollment information to other state agencies and entities administering certain public benefit programs such as fuel assistance and housing assistance programs and permits the Department to provide the information to other entities that the Department determines substantially promote the health and well-being of program recipients. Because this electronic sharing requires new technology, the law required the Department to convene a stakeholder group, no later than November 1, 2023, to determine the means of delivering the information. The Department is required to adopt rules to implement this electronic records access program by October 1, 2025.

Commission members expression appreciation for the Department's ongoing efforts and recognized the limitations imposed by the federal confidentiality laws, but agreed that continued efforts at standardization of the application process and sharing of information across programs is an important goal. The Commission agreed, unanimously of those present and voting to make the following finding and recommendation:

Finding: The Department continues to invest in technology to improve the administration of public benefit programs both across Department programs and with outside entities and local government units administering other public benefit programs.

Recommendation: Whenever possible, the Department should enroll members of the public in all programs for which they are eligible at one time and provide applicants with information on all Department programs for which they may be eligible and all local or community programs offered.

2. Trauma-informed Services

The need to repeatedly share the same or similar information is inefficient but it can also create unnecessary stress to the individual or family applying for public benefits. As pointed out by Commission member, Allina Diaz, this stress can raise the level of trauma for the applicant and Department staff should be trained in and required to implement trauma-informed practices when interacting with members of the public. Similarly, Department staff should have knowledge of, and have easy access to, culturally and linguistically appropriate services, including translation services to make applying for, and receiving public benefits, as accessible as possible. The negative impact when Department staff are not able to support all individuals and families applying for benefits was recognized by the 130th Legislature when it enacted Public Law 2021, chapter 648, section 7. This law, in Title 22, section 1053-B, subsection 21, requires the Department to work with TANF and ASPIRE-TANF participants to provide "culturally and linguistically appropriate services and trauma-informed services" and, when necessary, to use

[26] Enacted in Public Law 2023, chapter 412, Part VV

"appropriate methods and techniques" to work with the participant. The law also required the Department to adopt rules implementing the law by October 1, 2023. At an October 2024 meeting, Director Ian Yaffe said that the rulemaking is currently in progress. He also noted that all employees, including contracted organizations, are required to have training in the culture of respect and empathy. Because the Department has not yet completed its work under chapter 648, the Commission agreed, unanimously of those present and voting, to make the following findings and recommendations:

Finding: Interdepartmental and intradepartmental communications are not streamlined and information is not always shared to allow for efficiency, and sometimes results in members of the public experiencing additional emotional burden and trauma from interactions with the Department.

Finding: Trauma-informed services for TANF and ASPIRE are required by law. Rulemaking has not yet occurred but the Commission was informed that it is in process. The Department also provides training in the culture of respect and empathy and this is required of Department staff and contractors, including Fedcap.

Recommendation: The Health and Human Services Committee should schedule an update from the Department, including OFI, during the Committee orientation, on the efforts of the Department to increase and improve language access of Department documents.

Recommendation: The Health and Human Services Committee should request an update from the Department, during the Committee orientation, on the Department's progress in adopting rules related to trauma-informed services required by the TANF statute, including the state entity contracted to provide ASPIRE services, Fedcap.

Recommendation: The Health and Human Services Committee should request an update from the Department, during the Committee orientation, on the Department's progress in providing training to all Department employees and contractors (including Fedcap staff) in the culture of respect and empathy.

3. Plain Language and Communication

Commission member, Rob Moran raised questions about previous departmental pamphlets that provided easy-to-understand summaries of different MaineCare and public assistance programs available through the Department in the district offices. This conversation led to further discussion by Commission members that participants in TANF and TANF-ASPIRE reported they were unaware of their appeal rights when a request is denied by the Department or its vendor. Director Ian Yaffe explained the appeal process, or fair hearing process, to the Commission and stated that the Department is working on increasing and standardizing communication specific about the TANF and TANF-ASPIRE programs, particularly the types of support services available under those programs. He agreed to share the Commission's concerns related to providing program participants with clear information on their rights and the fair hearing process. He also committed to sharing the Commission's desire for the availability of easy-to-understand materials for all the public benefit programs.

The Commission agreed, unanimously of those present and voting, to make the following findings and recommendation:

Finding: Plain language pamphlets should be available to members of the public on each MaineCare and public assistance program available through the Department.

Finding: Available support services for individuals in the TANF/ASPIRE program are not always clear and answers are not always available to participants.

Recommendation: The Health and Human Services Committee should request an update from the Department on its progress to increase and standardize communication to TANF/ASPIRE recipients on services available, requests for fair hearings, and access to plain language descriptions of Department programs.

H. Legislative Oversight

Joint Standing Committees of the Legislature have an important role in legislative oversight of Executive branch functions. They play a role in examining, evaluating and making recommendations on the Governor's proposed supplemental and biennial budget bills, as well as oversight and review of regulatory agendas, departmental reports, including under the Government Evaluation Act, and other reports required by statute such as the quarterly child welfare updates (pursuant to Public Law 2023, chapter 261). The committees can also invite Executive branch agencies to give briefings on different departmental activities and programs. The Health and Human Services Committee takes the oversight role seriously and does this on a regular basis.

1. Government Evaluation Act

The Commission had several conversations about the requirements of the State Government Evaluation Act ("GEA")[27] found in Title 3, chapter 35 of the Maine Revised Statutes and how the GEA review process can facilitate further investigation and oversight of the Department after the Commission's work ends. The law provides legislative committees with the authority and responsibility to periodically review state agencies and independent agencies created by statute to evaluate their efficacy and performance. The review includes an examination of the agency's management and organization, program delivery and goals and objectives. The Act requires state agencies to submit a report to the legislative committee of jurisdiction with specific information for each program administered by the agency: the state and federal requirements of the program; the priorities, goals, objectives of the program; the performance measurers used to determine compliance with the state and federal requirements; and an assessment, based on the data from the performance measurers, of whether the agency meets the state and federal obligations and the priorities, goals and objectives it set for the program. The legislative committee of jurisdiction may change or expand the scope of its review, require a follow-up review, including additional written reports and public hearings, and the Committee may also introduce legislation in response to a GEA review.

[27] https://legislature.maine.gov/statutes/3/title3ch35sec0.html

The usual statutory cycle for a GEA review is every eight years although the schedule can be changed by a majority vote of the committee of jurisdiction. Currently, the Department of Health and Human Services is scheduled for review by the Health and Human Services Committee during the 132nd Legislature. Under the statutory timeline, the Committee must notify the Department of its intent to conduct a GEA review by May 1, 2025 and the Department must submit its report to the committee by November 1, 2025. The review of the Department must begin no later than February 1, 2026 and the Committee must submit its findings, recommendations and any necessary legislation to the 132nd Legislature no later than March 15, 2026.

During Commission discussions, members agreed that the upcoming GEA review provides an opportunity for the Health and Human Services Committee to follow up on many of the findings and recommendations in this report in a timely manner. The Commission agreed unanimously of those present and voting to make the following recommendation:

> **Recommendation**: The Health and Human Services Committee should follow the current statutory schedule and conduct a GEA review of the Department during the 132nd Legislature. The Committee could consider requiring the Department to submit additional information in the report to allow the Committee to better determine whether the Department is meeting its obligations.

2. Block Grants

Health and Human Services Committees in previous sessions have considered legislation that would have required reporting on the expenditures from federal Health and Human Services block grant funding.[28] The Department has also, on occasion, presented briefings to the committee on expenditures within a certain federal block grant. This typically occurs during budget deliberations and is related to bills for which the funding source is a federal block grant. For example, LD 1877, enacted as Public Law 2023, chapter 622, increased the amount of a TANF benefit by 20% which is funded by the federal TANF block grant. The Department presented its five-year spending plan for the TANF block grant during the deliberations on the bill.

The eight block grants administered by the Department under the oversight of the Health and Human Services Committee are:

Community Care Development Fund Block Grant
Substance Use Prevention, Treatment and Recovery Block Grant
Social Services Block Grant
Community Services Block Grant
Community Mental Health Services Block Grant
Maternal and Child Health Services Block Grant
Preventative Health and Health Services Block Grant
Temporary Assistance for Needy Families Block Grant

[28] For example, the amended version of LD 1435 in the 128th Legislature. This bill was vetoed by the Governor and sustained by the Legislature.

Commission members noted that having the ability to see the entire picture of federal block grants received by the Department, the amount of funds received, the programs funded, and the requirements for each program would be extremely helpful in determining where flexibility exists in the use of federal funds for the maximum benefit to program participants.

The Commission agreed, unanimously of those present and voting to make the following recommendation:

> **Recommendation**: The Health and Human Services Committee should require the Department to submit a report to the Committee on the use of all federal block grant funds and review the specifics of how the funds are allocated among the programs and consider ways to increase flexibility in the use of these funds. (Please note, this is in addition to earlier recommendations about the use of Maternal and Child Health Services block grant funds for Children and Youth with Special Health Care Needs.)

APPENDIX A
Authorizing Legislation: Resolve 2023 chapter 98

LAW WITHOUT GOVERNOR'S SIGNATURE

JULY 19, 2023

CHAPTER 98

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

H.P. 571 - L.D. 915

Resolve, to Establish the Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

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 legislation establishes the Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services; and

Whereas, this legislation must take effect before the expiration of the 90-day period so that the commission may timely meet and make its report to the Legislature; 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 the Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services, referred to in this resolve as "the commission," is established.

Sec. 2. Commission membership. Resolved: That, notwithstanding Joint Rule 353, the commission consists of 13 members as follows:

1. Three members of the Senate appointed by the President of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;

2. Three members of the House of Representatives appointed by the Speaker of the House of Representatives, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;

3. Two members appointed by the President of the Senate, one of whom must have lived experience in caring for one of the following types of individuals and one who

represents the interests of at least 2 of the following types of individuals or providers of care to at least 2 of the following types of individuals:

A. Individuals with intellectual disabilities or autism;

B. Individuals with mental health disorders or substance use disorder;

C. Individuals experiencing poverty;

D. Elderly individuals;

E. Children receiving child welfare services; or

F. Children receiving early childhood services;

4. Two members appointed by the Speaker of the House of Representatives, one of whom must have lived experience in caring for one of the following types of individuals and one who represents the interests of at least 2 of the following types of individuals or providers of care to at least 2 of the following types of individuals:

A. Individuals with intellectual disabilities or autism;

B. Individuals with mental health disorders or substance use disorder;

C. Individuals experiencing poverty;

D. Elderly individuals;

E. Children receiving child welfare services; or

F. Children receiving early childhood services;

5. The Commissioner of Health and Human Services or the commissioner's designee; and

6. Two directors of offices within the Department of Health and Human Services chosen by the commissioner.

Sec. 3. Chairs. 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.

Sec. 4. Appointments; convening of commission. Resolved: That, notwithstanding Joint Rule 353, 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, 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.

Sec. 5. Duties. Resolved: That the commission shall examine the organizational structure of the Department of Health and Human Services and the services provided by the department. The commission shall examine:

1. The organizational structure of and service delivery by similar agencies in other states and in nongovernmental organizations;

2. The strengths and weaknesses in the services provided with state and federal funding;

3. Current proposals for improving the safety and well-being of children and strengthening families across all populations and geographical areas of the State;

4. Barriers to accessing services, as well as system failures and additional needed resources; and

5. Areas in which processes can be streamlined and efficiencies made within the department.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Report. Resolved: That, no later than November 6, 2024, 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. The committee may submit legislation to the 132nd Legislature in 2025.

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

APPENDIX B
Membership list: Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

Resolve 2023, chapter 98

Membership List

Name	Representation
Senator Jill Duson – Chair	Member of the Senate, appointed by the President of the Senate
Representative Margaret Craven – Chair	Member of the House, appointed by the Speaker of the House of Representatives
Senator Joseph Baldacci	Member of the Senate, appointed by the President of the Senate
Senator Marianne Moore	Member of the Senate, appointed by the President of the Senate
Representative Daniel Shagoury	Member of the House, appointed by the Speaker of the House of Representatives
Representative Kathy Javner	Member of the House, appointed by the Speaker of the House of Representatives
Rob Moran	Member representing interests of those with intellectual disabilities, behavioral health disorders, poverty, elderly or children receiving child welfare services or early childhood services
Allina Diaz	Member representing interests of those with intellectual disabilities, behavioral health disorders, poverty, elderly or children receiving child welfare services or early childhood services
Nancy Cronin	Member representing interests of those with intellectual disabilities, behavioral health disorders, poverty, elderly or children receiving child welfare services or early childhood services
Sharon Moore	Member who has lived experience in caring for one with intellectual disabilities, behavioral health disorders, poverty, elderly or children receiving child welfare services or early childhood services
Beth Hamm	Deputy Commissioner, Department of Health & Human Services
Ian Yaffe	Director of an office within the Department of Health & Human Services
Bill Montejo	Director of an office within the Department of Health & Human Services

Carl Toney 9/2023 to 5/2024, replaced by Dawud Ummah 5/2024, replaced by Sharon Moore 6/2024
Commissioner Jeanne Lambrew 2023, replaced by Beth Hamm for 2024
Paul Saucier 2023, replaced by Ian Yaffe for 2024

APPENDIX C
Office of Policy and Legal Analysis Memo on History of Department of Health and Human Services

OPLA RESEARCH REQUEST MEMO

To: Anna Broome, Principal Analyst, HHS Committee
From: Kristin Brawn, Legislative Researcher
Date: May 24, 2023
RE: Legislative History of Department of Health and Human Services Reorganization

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Hi Anna,

You asked me to compile a history of legislation to reorganize the Department of Health and Human Services (DHHS). Please see the history compiled from my research below.

Resolve 1993, c. 36 required that on July 1, 1994, the Department of Human Services (DHS) and the Department of Mental Health and Mental Retardation (DMHMR) would be abolished and the functions of the agencies would be reorganized functionally into a newly created Department of Children and Families and a newly created Department of Health, as well as delegated to other existing State agencies. The law also created the Health and Social Services Transition Team to develop legislation needed to implement the reorganization of services, including amendments to the statutes, reallocation of funds and transitional language. The Transition Team was required to present legislation to the Legislature by January 1, 1994 for consideration during the Second Regular Session of the 116th Legislature. The Transition Team issued its **final report** with recommendations on January 19, 1994. With a few exceptions, the Transition Team reached consensus on recommendations for the functions that should go into each of the new departments. The Transition Team also agreed on an organizational scheme for the Department of Children and Families. However, the Transition Team was divided regarding the organizational scheme for the Department of Health. The Transition Team recommended an implementation date of July 1, 1995, giving the existing departments a 15-month transition period from the expected date of enactment of the proposed legislation. Although the Resolve called for an implementation date of July 1, 1994, the Transition Team stated in its report that it felt that such an early date could seriously disrupt service delivery and would very likely result in the loss of federal funds.

Resolve 1993, c. 43 transferred all responsibilities of the Bureau of Rehabilitation within DHS, except for the Division of Disability Determination Services, to the Department of Education, and directed the Commissioner of Education to submit to the Legislature by January 30, 1994, proposed legislation detailing the statutory and budgetary changes necessary to implement the transfer.

LD 1793, An Act to Implement the Recommendations of the Health and Social Services Transition Team, was introduced by the Transition Team to the Second Regular Session of the 116th Legislature on January 27, 1994. The bill contained all of the recommendations of the Transition Team as presented in the **final report**, including abolishing DHS and DMHMR and creating the Department of Children and Families and the Department of Health and Developmental Services; repealing Titles 22 and 34-B and creating two new titles: Title 22-A and Title 22-B; and developing a single point of access for customers of health and social services and unified case coordination systems for customers of health and social services who have multiple needs. However, committee and floor amendments repealed most of the proposed recommendations from the bill. **P.L. 1993, c. 738**, as enacted, did not abolish or create any department. Instead, the law established policy principles for health and social services and created the Public Participation Team to solicit broad public comment on the policy principles and suggestions for changing the service delivery system in a manner that would achieve the principles. However, the law created 3 studies recommended in the original bill: consolidation of homeless services, transfer of administrative hearings from DHS to the Department of the Attorney General, and integration of food safety functions. In addition, the law directed the Commissioner of Administrative and Financial Services to convene a task force to recommend consolidation of health and social service financial audits into one agency. The law also moved services for children with developmental disabilities from the Division of Mental Retardation to the Bureau of Children with Special Needs and required DMHMR and DHS to jointly locate their service delivery sites as leases expire, when doing so passed a cost-benefit test, as recommended in the original bill.

P.L. 1995, c. 99, Part D established the Productivity Realization Task Force in the 1996-97 biennial budget bill to advise and assist the Governor and Legislature in the design and implementation of changes in State government operations intended to improve the productivity of the work force and the efficiency of State services. According to the Task Force's **1996 Summary Report**, when faced with a predicted State budget gap of $300 million at the beginning of his term in January 1995, Governor King proposed the Task Force in his first biennial budget as a means to recommend savings through enhanced productivity of $32 million, which was amended by the Legislature to approximately $42 million. The enacted law also required the Task Force's productivity recommendations to achieve the following: improve the effectiveness with which General Fund dollars were spent; reduce the ratio of management, administrative, clerical and supervisory personnel to front-line personnel; consolidate or restructure redundant State government services, programs and operations; integrate the effective use of technology; and achieve the most effective delivery of services to Maine citizens. According to the Task Force's Summary Report, the following reorganizations were recommended by the Task Force and implemented in regard to DHS and DMHMR:

- Reduced DHS field structure from five regions to three, and DMHMR field structure from five regions to three to parallel the DHS field regions.
- Eliminated or reclassified DHS Deputy Bureau Directors, Assistant Bureau Directors and Assistant Division Directors.
- Centralized and combined DHS eligibility determination for disabilities, Aid to Families with Dependent Children (AFDC) and Medicaid.
- Consolidated DHS administration for long-term care in one location; clustered specific licensing functions performed by two bureaus; centralized and combined state determination of disability in the AFDC and Medicaid programs; and merged the Office of Child Care and the State Head Start Program.
- Reduced the number of Divisions within the Bureau of Health from nine to six; centralized the intake system for referrals of child abuse and neglect and reassigned some of the intake workers to specialty assessment units to facilitate evaluation of substantiated cases; and consolidated AIDS programming within the Bureau of Health.
- Created four administrative service centers to reduce administrative overhead, including an audit, contracting and licensing service center for DHS, DMHMR and the Office of Substance Abuse (**P.L. 1995, c. 665, Part CC**).

P.L. 1995, c. 560, Parts K and L, implemented changes related to DMHMR's Productivity Realization Task Force proposal, including:

- Placing the Office of Substance Abuse into DMHMR and changing the Department's name to the Department of Mental Health, Mental Retardation and Substance Abuse Services.
- Consolidating five to three regional service delivery areas
- Eliminating the Bureau of Children with Special Needs and the Division of Mental Retardation and also eliminating two appointed division and bureau director positions
- Eliminating two additional appointed positions: Director, Bath Children's Home and Assistant to the Associate Commissioner for Administration.
- Reorganizing the department's administrative structure into three divisions (program, administration and systems operations) and establishing an Associate Commissioner for Systems Operations and three regional director positions to oversee regional operations.
- Administratively combining the Office of Consumer Affairs and the Office of Advocacy.
- Contracting out services offered at the Bath Children's Home.

P.L. 2003, c. 20, Part K-18 required the merger of the DHS and the Department of Behavioral and Developmental Services (formerly Department of Mental Health, Mental Retardation and Substance Abuse) and the submission of a plan to implement the merger and the submission of implementing legislation to the Second Regular Session of the 121st Legislature.

P.L. 2003, c. 673, Parts III-1 and III-2 eliminates 31 positions as a result of the merger of DHS and the Department of Behavioral and Developmental Services.

P.L. 2003, c. 689, legislation submitted by Governor Baldacci, reorganized the delivery of services to adults, children and families by DHS and the Department of Behavioral and Developmental Services, establishing the new Department of Health and Human Services (DHHS). The goals of the reorganization were to improve services, increase programs and fiscal efficiency and improve relations with consumers and community organizations. The law provided that the new department would assume the duties of the current DHS and the Department of Behavioral and Developmental Services and contained provisions for the orderly transition to the new Department. The law also required the Commissioner of Health and Human Services to consolidate certain administrative components of DHHS, including auditing, financial management, human resources and information technology, and consolidate adult protective functions, but delayed the consolidation of guardianship and conservatorship functions. In addition, the law required the Commissioner to submit a report with recommendations and legislation by January 31, 2005 to the HHS Committee and required the report to include recommendations on the following issues related to the establishment and implementation of the new department: bureau structure, administrative structure and functions, program and service delivery functions, advisory boards and the child welfare ombudsman program. The law authorized the committee to report out legislation to the 122nd Legislature following review of the report and recommendations.

P.L. 2005, c. 412 furthered the transition to the new DHHS. The law established the salaries of the Deputy Commissioner of Integrated Services and the Deputy Commissioner of Health, Integrated Access and Strategy and listed in statute positions that serve at the pleasure of the Commissioner; established a number of positions as major policy-influencing positions within DHHS; and established within the department the Health, Integrated Access and Strategy Unit; the Operations and Support Unit; the Finance Unit; and the Integrated Services Unit. The law specified that the units established within the department assumed the functions and duties of the bureaus, divisions and offices established under the Maine Revised Statutes, Title 22 and Title 34-B and the Office of Substance Abuse established under Title 5, chapter 521. The law also required the child welfare ombudsman program, the long-term care ombudsman program and the Office of Advocacy within DHHS to report to the committee by February 15, 2006 on ways to maximize their independence, effectiveness and ability to provide consumer advocacy and ombudsman services and long-term budget stability.

P.L. 2005, c. 519, Part Z removed the Chief Information Officer position from the positions within the DHHS that are major policy-influencing positions.

P.L. 2007, c. 240, Parts DD, GG and QQQ provided the method of distributing departmentwide savings and elimination of 100 positions in the Office of MaineCare Services resulting from a departmentwide reorganization and required the Commissioner of Health and Human Services to review the structure, systems and operations of the Office of MaineCare Services program to transition to a model operated by a fiscal agent. The law also required the Appropriations Committee to conduct the initiative to streamline State government, a comprehensive analysis of State government with the goals of consolidating functions and eliminating duplication and inefficiencies in programs, in contracted personal services and administrative and management positions within State government. The committee was tasked to investigate and identify major sources of administrative excess, redundancy, inefficiency and program overlap with other state, local or federal programs and to identify $10.1 million in savings to be achieved during the 2008-2009 biennium. The committee issued a **report of its findings and recommendations** regarding the initiative to streamline State government in January 2008.

P.L. 2007, c. 539, Parts N and FFF repealed certain powers and duties of the Commissioner of Health and Human Services, provided a transition and planning process for the privatization of the Elizabeth Levinson Center, reduced funding as part of a departmentwide reorganization of DHHS, including the elimination of 21 positions, and required a report to the Legislature detailing the new organizational structure and the specific positions eliminated.

P.L. 2009, c. 213, Part EE repealed the requirement in **P.L. 2007,c. 240, Part GG** that the Office of MaineCare Services eliminate 100 positions by June 19, 2010.

P.L. 2011, c. 380, Part KKK required the Commissioner of Administrative and Financial Services to establish the Streamline and Prioritize Core Government Services Task Force to carry out the following work:

- Undertake a comprehensive analysis of departments and agencies within the executive branch, offices of the constitutional officers, the Department of Audit and independent agencies statewide with the goals of prioritizing services provided by government agencies, consolidating functions and eliminating duplication and inefficiencies in programs, contracted personal services, state travel policies and advertising and public notice policies;
- Investigate and identify major sources of administrative excess, redundancy and inefficiency and program overlap with other state, local or federal programs;
- Identify any positions that should be reduced, eliminated or consolidated to deliver optimum services in the most cost-effective manner, including positions in the unclassified service and major policy-influencing positions as set out in the Maine Revised Statutes, Title 5, chapter 71, and in contracted personal services; and
- Develop recommendations designed to achieve a targeted spending reduction of a minimum of $25 million in fiscal year 2012-13.

The law required the Task Force to submit monthly progress reports to the Appropriations Committee and a report of its findings and recommendations and any necessary implementing legislation to the committee by December 15, 2011. The Task Force submitted its **final report,** with proposed implementing legislation, to the Committee on December 15, 2011.

P.L. 2011, c. 422 reorganized the provision of long-term care services for Maine citizens by consolidating long-term care services provided directly or indirectly through MaineCare or other state-funded programs and providing a framework for consolidated in-home and community support services and nursing facility services with combined funding and integrated service delivery beginning July 1, 2012. The law required DHHS to administer long-term care accounts as one account with one budget. The law also required DHHS to report to the Health and Human Services Committee regarding the progress in implementing consolidation of long-term care services, with a progress report by January 5, 2012 and a final report by November 1, 2012. DHHS submitted a **final report** to the committee in November 2012.

P.L. 2011, c. 657, Parts AA-FF eliminated as separate and distinct offices within DHHS the Office of Substance Abuse, the Office of Elder and Adult Services, the Office of Adults with Cognitive and Physical Disability Services and the Office of Adult Mental Health Services. The law also eliminated the Office of Advocacy within DHHS and directed the department to contract with an agency to provide services to individuals with intellectual disabilities and autism. The law directed the Commissioner of Health and Human Services to review the current organizational structure, systems and operations of DHHS and restructure the department in order to improve and streamline services. The law also required the Commissioner of Health and Human Services and the State Budget Office to submit reports to the Appropriations and Health and Human Services Committees by December 1, 2012, and June 30, 2013, outlining the progress towards the new organizational structure and any transferred amounts.

P.L. 2017, c. 471 provided funding to create a new Child Welfare Investigator position; for the creation of 16 Human Services Casework Supervisor positions and two Regional Associate Director for Child Welfare positions; and for the creation of 16 Human Services Caseworker positions and eight Customer Representative Associate II positions within the Office of Child and Family Services.

P.L. 2021, c. 398, Part VV establishes the Office of Behavioral Health as a distinct unit within DHHS and as the successor to the Office of Substance Abuse and the Office of Substance Abuse and Mental Health Services and changes references to those offices accordingly.

APPENDIX D
Child Welfare Budget Initiatives 131st Legislature

Summary of Child Welfare Initiatives in 131st Legislative Session
In Biennial or Supplemental Budgets

Through 1st Special Session
PL 2023 c.412

	Short Description	Sum of SFY 2024	Sum of SFY 2025
(1)	1 new position to serve as an out-of-home investigator	$ 95,050	$ 99,880
(2)	1 position recalassified	$ 3,833	$ 4,195
(3)	2 new Hearing Specialists	$ 210,939	$ 222,043
(4)	53 positions reorganized within the child welfare programs	$ 221,175	$ 217,516
	Grand Total	**$ 530,997**	**$ 543,634**

Through 2nd Regular Session
PL 2023 c.643

	Short Description	Sum of SFY 2024	Sum of SFY 2025
(1)	1 new Child Protective Services Assistant Program Administrator	$ -	$ 120,832
(2)	3 new positions to handle Legal paperwork	$ -	$ 275,357
(3)	5 positions reorganized within the child welfare programs	$ -	$ 20,241
(4)	8 new positions to handle onboarding and training and to mentor new caseworkers - 1 per District	$ -	$ 1,026,834
(5)	Increases pay range for 545 positions as caseworkers and supervisors	$ -	$ 3,955,675
(6)	One-time funding for incentives to Behavioral Health Providers to provide serves to families in the child welfare system in rural areas	$ -	$ 500,000
	Grand Total	**$ -**	**$ 5,898,939**

APPENDIX E
Letters from Health and Human Services Committee

STATE OF MAINE
ONE HUNDRED AND THIRTY-FIRST LEGISLATURE
COMMITTEE ON HEALTH AND HUMAN SERVICES

TO: Senator Jill C. Duson, Senate Chair
Representative Margaret Craven, House Chair
Members, Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

FROM: Senator Joseph M. Baldacci, Senate Chair
Representative Michele Meyer, House Chair
Joint Standing Committee on Health and Human Services

DATE: April 9, 2024

The Health and Human Services Committee recently considered LD 1788, An Act to Establish the Office of the Inspector General of Child Protection. The original draft of LD 1788 was modeled on the Nebraska law. After the bill was printed, new language based on the New Hampshire Office of the Child Advocate was proposed by the sponsor, Senator Baldacci. The Committee voted Ought Not to Pass on LD 1788 as there were too many unresolved issues to make a policy decision, including particular concerns about confidentiality of records and interfering with criminal investigations. Every member of the committee is committed to improving the lives of children and families who are involved in the child protective system.

We are requesting that the Blue Ribbon Commission includes the issue of oversight of the child protective system as a specific topic as part of your discussions in the 2024 interim. There are current oversight requirements in federal and state statute and the question is whether additional oversight is necessary and, if so, what form that additional oversight should take. Additional oversight might take the form of a separate office or organization along the lines of that in Nebraska and New Hampshire, or it might take the form of additional functions and authority granted to the existing Child Welfare Ombudsman.

In addition, there are issues around the confidentiality of information and records as well as the timing of criminal investigations that were brought to our attention by the Office of the Attorney General that would need to be resolved as part of any statutory action. We have also asked Attorney General Frey to assemble a stakeholder group to discuss this topic. Please note that Senator Baldacci, a member of the Blue Ribbon Commission is the sponsor of the bill and the Senate Chair of our committee. He is also expected to be involved in the stakeholder group convened by the Attorney General.

We look forward to your report on the organization and services of the Department of Health and Human Services at the end of this year. We urge you to include this topic in your discussions. Thank you for your willingness to service on the Blue Ribbon Commission.

cc: Christine Alberi, Child Welfare Ombudsman
Aaron Frey, Attorney General

STATE OF MAINE
ONE HUNDRED AND THIRTY-FIRST LEGISLATURE
COMMITTEE ON HEALTH AND HUMAN SERVICES

TO: Senator Jill C. Duson, Senate Chair
Representative Margaret Craven, House Chair
Members, Blue Ribbon Commission to Study the Organization of and Service Delivery by the Department of Health and Human Services

FROM: Senator Joseph M. Baldacci, Senate Chair
Representative Michele Meyer, House Chair
Joint Standing Committee on Health and Human Services

DATE: May 13, 2024

The Health and Human Services Committee recently considered LD 779, An Act to Create a Separate Department of Child and Family Services. The majority of the Committee voted Ought Not to Pass on LD 779 and the minority voted Ought To Pass as Amended (updating dates to reflect the bill was carried over from the First Special Session and adding a fiscal note). The vote in Committee was 11-2. The OTP-A motion was supported in the Senate but the bill was not taken up in the House prior to adjournment.

The majority of the Committee were concerned that establishing a new department centered on child and family services would create duplicative managerial positions rather than programmatic improvements to services. However, each member of the committee is committed to improving the lives of children and families who are involved in the child protective system regardless of their vote on the bill. In that light, we are requesting that the Blue Ribbon Commission might choose to include in your discussions this interim, the possibility of whether splitting up the department into two might be beneficial to clients of the department, including children and families involved in the child protective system.

Please note that Senator Baldacci, a member of the Blue Ribbon Commission supported the passage of LD 779 and is the Senate Chair of our Committee.

We look forward to your report on the organization and services of the Department of Health and Human Services at the end of this year. Thank you for your willingness to serve on the Blue Ribbon Commission.

APPENDIX F
Office of Policy and Legal Analysis Memo on Offices of Inspector General

OPLA RESEARCH REQUEST MEMO

To: Anna Broome, Senior Analyst, HHS Committee
From: Kristin Brawn, Legislative Researcher
Date: March 13, 2024
RE: Other State Child Welfare Offices of Inspector General (LD 1788)

Hi Anna,

You asked me to look into other states that have established independent offices of investigation to oversee the states' child welfare programs, similar to the Office of Inspector General of Child Protection proposed in LD 1788. I looked at similar offices in Illinois, Nebraska and New Hampshire. Please see the findings of my research below.

Illinois – Office of the Inspector General for the Department of Children and Family Services (20 ILCS §505/35.5, 35.6 and 35.7)

The Office of Inspector General (OIG) for the Illinois Department of Children and Family Services (DCFS) was established by the General Assembly in 1993 to reform and strengthen the state's child welfare system. According to the OIG's first annual report in 1995, prior to the establishment of the OIG, complaints from biological, foster and adoptive families "received a bureaucratic response to their concerns that ignored the root of the issue, the child involved." The OIG operates independently within DCFS, and the Inspector General is appointed by the Governor and confirmed by the Senate for a term of four years. The law charges the OIG with conducting investigations into allegations of or incidents of possible misconduct, misfeasance, malfeasance, or violations of rules, procedures or laws by any DCFS employee, or any foster parent or private agency with which DCFS contracts. The law also grants OIG the power to subpoena witnesses and compel the production of books and papers pertinent to an investigation.

The office responds to and investigates complaints filed by the state and local judiciary Department and Child Welfare Contributing Agency (CWCA) employees, foster parents, biological parents, the public, referrals from the Office of Executive Inspector General (OEIG), and referrals pertaining to Child Welfare Employee Licensure (CWEL), and investigates deaths of all Illinois children with whom DCFS has had prior involvement. At the request of the DCFS Director or when the OIG has noticed a particularly high level of complaints in a specific division of DCFS, the OIG will conduct a systemic review of that division. Investigations may yield case-specific recommendations, including disciplinary recommendations, and/or recommendations for systemic changes within the child welfare system. The OIG monitors compliance with all recommendations. The OIG is required to submit an annual report to the Governor and the General Assembly regarding reports and investigations made for the prior fiscal year, including recommendations for administrative actions and matters for consideration by the General Assembly.

According to the OIG's 2024 Annual Report, in FY 2023, the OIG received 612 requests for investigation, 103 OEIG referrals, and 53 CWEL referrals totaling 768 complaints, a 16% increase from FY 2022. From these complaints, the OIG opened 768 general investigations and 160 investigations of child deaths, and conducted 7,276 searches for criminal background information.

Nebraska – Office of Inspector General of Nebraska Child Welfare
(Nebr. Rev. Stat. §§43-4301, 43-4302, 43-4317, 43-4318, 43-4319, 43-4321, 43-4323, 43-4324, and 43-4331)

The Office of Inspector General of Nebraska Child Welfare (OIG) was created by the Legislature in 2012, following a significant crisis in the state's child welfare system after a failed attempt at privatization that resulted in multiple problems, including upheaval in the workforce, increasing the risk to children and the families being served and the loss of many critical private providers needed to serve children in the system, according to the OIG's 2022-2023 Annual Report. The OIG was established at the recommendation of a report published by the Legislature's Health and Human Services Committee regarding the committee's review, investigation and assessment of the effects of child welfare reform which the Nebraska Department of Health and Human Services began implementing in July of 2009.

The OIG is established within the Legislature's Office of Public Counsel for the purpose of conducting investigations, audits, inspections and other reviews of the Nebraska child welfare system. The Inspector General is appointed by the Public Counsel for a term of five years, with approval from the chairperson of the Executive Board of the Legislative Council and the chairperson of the Health and Human Services Committee of the Legislature. The law requires the OIG to investigate allegations or incidents of:

1. Misconduct, misfeasance, malfeasance or violations of the statutes or rules and regulations of the Department of Health and Human Services (DHHS), Juvenile Probation, the Crime Commission, or juvenile detention facilities by employees or persons under contract with those agencies and facilities; and
2. Deaths and serious injuries of youth (a) in homes, facilities, and programs licensed or under contract with DHHS or Juvenile Probation; (b) in cases in which services were being provided to a child or family by DHHS or Juvenile Probation; or (c) in cases that have had an open investigation for child abuse and neglect in the last 12 months, if, after review, the OIG determines the death or serious injury did not occur by chance.

The law also requires the OIG to receive and assess complaints from members of the public and authorizes the OIG to open an investigation based on those complaints if certain requirements in the law are met. The law authorizes the OIG to conduct full investigations and retrieve relevant records or compel persons to testify through subpoena, request or voluntary production, review all relevant records, and interview all relevant persons. The office may request or subpoena any record necessary for an investigation from DHHS, the juvenile services division as permitted by law, the Nebraska Commission on Law Enforcement and Criminal Justice, a foster parent, a licensed child care facility, a juvenile detention facility, a staff secure juvenile facility or a private agency that is pertinent to an investigation.

The law also requires the Inspector General to provide to the Health and Human Services Committee, the Judiciary Committee, the Supreme Court, and the Governor an annual summary of reports and investigations made for the preceding year, including recommendations and the status of implementation of the recommendations and recommendations to the committees regarding issues discovered through investigation, audits, inspections and reviews by the OIG that will increase accountability and legislative oversight of the Nebraska child welfare system, improve operations of DHHS, the juvenile services division, the Nebraska Commission on Law Enforcement and Criminal Justice and the Nebraska child welfare system, or deter and identify fraud, abuse and illegal acts.

In regard to effectiveness of the OIG since its creation, the 2022-23 Annual Report states that the creation of the OIG has resulted in over 11 years of accountability and increased transparency in the child welfare system. In 11 years, the OIG has received and reviewed over 5,000 intakes including

incident reports, complaints and grievances. It has issued 44 reports of investigation which incorporated case reviews of over one hundred individual children. The OIG has made 115 recommendations for system improvement to DHHS, two private providers contracted with DHHS's Division of Children and Family Services and the Administrative Office of Probation, Juvenile Services Division. Eighty-four of those recommendations have been accepted by those agencies and providers. The OIG's work has informed senators on key issues as they drafted legislation related to child welfare, including but not limited to, Sudden Unexpected Infant Death education, sexual abuse of state wards, oversight of Nebraska's Youth Rehabilitation and Treatment Centers and the privatization of case management in the state's child welfare system.

New Hampshire – Office of the Child Advocate
(RSA, Chapter 21-V)

The Office of the Child Advocate (OCA) was established by the Legislature in 2017. According to the OCA's 2018 Annual Report, the deaths of two young girls in 2014 and 2015 whose families were known to the New Hampshire Division of Children, Youth and Families (DCYF) and a call from a grieving grandmother constituent prompted Senator David Boutin to sponsor legislation in 2015 to form the Commission to Review Child Abuse Fatalities (SB 244). Early commission hearings unearthed two prevailing themes: a lack of transparency in child welfare and a lack of public trust in DCYF. These findings prompted Senator Boutin to create a subcommittee to explore the idea of an independent children's ombudsman. The subcommittee met throughout 2015-2016, examining the response to the child deaths, which led to the subcommittee's recommendation of independent oversight of DYCF through an Office of the Child Advocate and enactment of legislation to establish the OCA.

The OCA is established as an independent agency that operates with full independence from any state official, department or agency in the performance of its duties. The law charges the OCA with the following duties:

- Provide independent oversight of executive agencies to:
    - Ensure that children involved with an agency, and in particular, children served by the child welfare or juvenile justice systems, receive timely, safe, and effective services and that their best interests are being protected;
    - Strengthen the state by working in collaboration with agencies and other necessary parties on cases under review;
    - Ensure that children placed in the care of the state or receiving services under the supervision of an agency in any public or private facility, receive humane and dignified treatment at all times, with full respect for the child's personal dignity, right to privacy, and right to adequate and appropriate healthcare in accordance with state and federal law;
    - Examine, on a system-wide basis, the care and services that agencies provide children, and provide recommendations to improve the quality of those services in order to provide each child the opportunity to live a full and productive life;
    - Advise the public, governor, commissioners, speaker of the house of representatives, senate president, and oversight commission about how the state may improve its services to and for children and their families; and
    - Periodically review and investigate any aspect of an agency's policies, procedures, and practices and work collaboratively with the agency to improve policies, procedures, practices, and programs affecting children.

- Upon its own initiative or upon receipt of a complaint, review and if deemed necessary:
    - Investigate the actions of any agency and make appropriate referrals; provided that department of health and human services specific complaints shall be handled by the ombudsman;
    - Investigate those complaints in which the child advocate determines that a child or family may need assistance from the office or a systemic issue in the state's provision of services is raised by the complaint; and
    - Provide assistance to a child or family whom the child advocate determines is in need of assistance, including seeking resolution of complaints, which may include, but not be limited to, referring a complaint to the appropriate agency or entity, making a recommendation to such agency or entity for action related to the complaint, and sharing information in any proceeding before any court or agency in the state in which matters related to the division's child protection and juvenile justice services are at issue.

- Regularly consult with executive agencies and the oversight commission;
- Provide information and referral services to the public regarding all child-serving state services, particularly child protection and juvenile justice services;
- Perform educational outreach and advocacy initiatives in furtherance of the mission and responsibilities of the office; and
- Periodically review the facilities and procedures of any and all institutions or residences, public or private, where a child has been placed by an agency.

In 2020, the Legislature also established the Oversight Commission on Children's Services to provide oversight to the OCA, and tasked the Commission with the following duties:

- Recommend candidates to the Governor for appointment to the position of child advocate;
- Provide oversight to the OCA in its effort to support an effective, comprehensive, and coordinated system of services and programs for children, youth, and families;
- Review with the OCA the efficacy of selected programs and services of executive agencies;
- Collaborate with the office to identify and implement best practices on behalf of children and families; and
- Monitor and review implementation of the memorandum of understanding entered into by the department of health and human services and the department of justice regarding the collaboration between the agencies in the investigation and prosecution of abuse and neglect cases.

The Child Advocate is appointed by the governor and executive council, upon the recommendation of the Oversight Commission on Children’s Services. The Child Advocate serves a term of four years. The law grants the OCA the authority to subpoena witnesses, records, documents, reports, reviews, recommendations, correspondence, data and other evidence that the OCA reasonably believes is relevant. The law requires the Child Advocate to submit an annual report of the activities and findings of the OCA, and present his or her recommendations to the Oversight Commission. The report must also be provided to the commissioner of any executive agency that is the subject of a report prepared by the OCA, the Governor, the Speaker of the House of Representatives, the Senate President, and the state library.

APPENDIX G
Department of Health and Human Services Activities in Response to Government Oversight Committee Report

Implementation of the Government Oversight Committee's February 2024 Recommendations – 9/17/2024 OCFS update

Recommendation	Status	Notes
Front Line Staff		
Recruit and retain more case aides	Ongoing	The Legislature approved the budget initiative to increase pay for these positions in recognition of the complexity and critical nature of this work. The vacancy rate in these positions recently dropped from 25% to ~10% and OCFS continues to work diligently to recruit and retain these staff.
Address burnout, turnover, vacancies, and workload	Ongoing	OCFS has undertaken a number of initiatives to both directly and indirectly address workload, burnout, and turnover. These including increasing the pay for caseworker and supervisor positions, establishing Supervisor Trainer positions to support new and established staff's training needs, working to strengthen internal management structure and support for frontline staff both through a reorganization of the child welfare division and a comprehensive review of decision-making processes at all levels of OCFS, and establishing ongoing discussion between child welfare leadership and frontline staff. These efforts have already decreased the vacancy rate by about 50%.
Provide specific coaching/mentoring opportunities	In Progress	OCFS sought and was granted in the budget 8 new Supervisor Trainer positions, one per District. These staff will provide in-district support for training and onboarding of new staff as well as supporting opportunities for ongoing training for more established staff.
Increase and enhance ongoing training opportunities, including job shadowing	In Progress	*See above*: the work of the Supervisor Trainer positions will include enhancing and increasing job shadowing opportunities (among other things). OCFS is also partnering with the Cutler Institute on training development, working with subject-matter experts on specific curriculum topics, and continuing to survey new workers at the completion of Foundations Training and implement changes based on their input and recommendations.
Create special teams to deal with complex cases	In Progress	OCFS is in the process of establishing a cross-office complex case protocol. Much of this work is already being done in an informal manner but the protocol will formalize the process and the various members of the team OCFS staff can access when working on complex cases.
Services for Families		
Improve family team meetings	In Progress	OCFS is currently considering the best path forward to both improve Family Team Meetings and create a process for ongoing evaluation and improvement. OCFS is reviewing the current model and the many changes that have occurred within it since it was implemented in 2002 and seeking the input of national partners with expertise in child welfare to ensure that any framework that OCFS implements has had success in other jurisdictions.
Resource Families and Other Placement Support		
Ensure placement options exist other than in hotels or hospital emergency departments	Ongoing	OCFS hired a dedicated hotel and emergency department coordinator and is engaged in the national dialogue regarding this topic as it is being experienced in jurisdictions throughout the country. Some of the solutions will continue to be pursued in partnership with other DHHS offices as we seek to ensure there are appropriate behavioral health treatment opportunities, including residential where appropriate, for all youth (including youth in State custody).
Improve home-based therapeutic and other resource family resources and supports	Ongoing	This is and will continue to be an ongoing effort between OCFS, other DHHS offices, and community partners who provide these services and supports. This includes therapeutic foster care investments in the 2024 supplemental budget.

Expand financial support to resource families and ensure timely reimbursements for appropriate expenditures	Ongoing	OCFS has established a workgroup to review and ensure the process for addressing any delay in reimbursement to resource parents is quickly and efficiently addressed.
Department Management, Plans, and Reporting		
Task the new director with an improvement plan containing short, medium, and long-term strategies and metrics with regular public updates on progress and challenges	In Progress	OCFS is currently working to develop this plan, working from a comprehensive list of over 200 recommendations OCFS has received from the Legislature, Citizen Review Panels, and other partners. A comprehensive child welfare improvement plan is in development and OCFS intends to begin providing regular updates on the status of action items in the plan in January of 2025.
Require outcomes data	In Progress	*See above* re: improvement plan.
Require specific public reporting on any hospital, hotel, or Department office stays	Under Discussion	OCFS is considering inclusion of these metrics in its work and is currently reviewing whether such metrics could accelerate appropriate placements for children.
Improve culture and job satisfaction	Ongoing	OCFS has undertaken several initiatives to both directly and indirectly address workload, burnout, and turnover. These including increasing the pay for caseworker and supervisor positions, establishing the Supervisor Trainer positions to support new and established staff's training needs, working to strengthen internal management structure and support for frontline staff both through a reorganization of the child welfare division and a comprehensive review of decision-making processes at all levels of OCFS, and establishing ongoing discussion between child welfare leadership and frontline staff. These efforts have already decreased the vacancy rate by about 50%.
Courts		
Improve access to courts for children and families	Outside of OCFS	OCFS works in partnership with the courts but cannot control the specific level of access for cases involving children and families.
Improve child and family access to legal services	Outside of OCFS	This is the role of the Maine Commission on Public Defense Services.
Statute		
Initiate a review of statutes relevant to child protection	Ongoing	OCFS plans to propose changes to the Child and Family Services and Child Protection Act in the upcoming session. OCFS has consistently brought forward bills to improve the statutes where appropriate and ensure we adapt to changes in federal law and policy, as well as best practice.
Technology		
Fix issues with critical Department technology (Katahdin)	Ongoing	The Information Services (IS) team has established a process to regularly survey supervisors and caseworkers about their experience with Katahdin, as well as meeting with District offices to discuss experiences and concerns. The IS team has engaged in focus groups with both staff and external partners, collaborated with the Training Unit to address training-related concerns, and worked with OCFS' Quality Assurance staff to identify system-related feedback they have gathered in their work. In conjunction with this information gathering the IS team is constantly working on updates, enhancements, and improvements to the system to address established child welfare priority items (many of which are the result of the feedback work outlined above).

Child Safety		
Address Department struggles to determine the safety of children at the beginning of involvement during child protective investigations and when deciding whether or not to reunify children with their parents	Ongoing	This is being address via multiple pathways to ensure the greatest success possible. Many initiatives touch on this including efforts to update and improve Foundations Training, provide training support via the new Supervisor Trainer positions, update policy and practice expectations, support strong supervisory oversight through the Supervisory Framework, efforts to comprehensively review decision making processes and establish a framework to support and empower staff to make well-supported decisions, the implementation of Safety Science reviews of critical incidents, among others.
Share Safety Science recommendations with stakeholders and implement systemic recommendations	Ongoing	OCFS has an established annual Safety Science report, and the latest version will be published in the coming months.
Make consultation with child abuse pediatricians more routine in the child protective intake process and investigations	In Progress	As part of OCFS' efforts to review and update policy we are ensuring that consultation with child abuse pediatricians is a practice expectation at all appropriate junctures.
Join the National Center for Fatality Review and Prevention's Case Reporting System	Completed	OCFS announced they had joined the National Partnership for Child Safety and National Center for Fatality Review and Prevention's Case Reporting System in early 2024. Work is currently underway to establish the formal MOU required to share OCFS data with the NCFRPC
Support the current child abuse pediatricians and hire more child abuse pediatricians through appropriate financial support from the state in addition to the pre-existing contract with the Department	Completed	In the last contract renewal, the organization that provides Maine's child abuse pediatrician services received a substantial increase. The program now has two certified child abuse pedestrians on staff as well as other clinical staff to provide support.
Management, Plans, and Reporting		
Review and assess informal policies and practices	In Progress	OCFS is working methodically to review and update all existing policies which includes reviewing related informal practices that may have been established over the years and determining whether they need to be included in the policy. Recognizing that no policy can address the myriad situations staff encounter and that policy is intended to support good decisions and casework, OCFS is comprehensively reviewing decision making processes at all levels of OCFS to establish a framework to support and empower staff to make well-supported decisions.

Services for Families		
Conduct an outside evaluation of the family team meeting model and create a structure for ongoing quality assurance monitoring	In Progress	A bill to fund an outside evaluation of the Family Team Meeting (FTM) process did not become law last session. As such, OCFS is currently considering the best path forward to both initially improve Family Team Meetings (FTMs) and create a process for ongoing evaluation and improvement. OCFS is seeking the input of national partners with expertise in child welfare to ensure that the framework OCFS implements has had success in other child welfare jurisdictions while also reviewing the current model and the many changes that have occurred within it since it was implemented in 2002 to help establish a path forward to meaningful improvement.
Increase access to mental health, behavioral health, substance use disorder, domestic violence, and other services for families as well as housing and transportation	Ongoing	This is and will continue to be an ongoing effort between OCFS, other DHHS offices, and community partners who provide these services and supports. OCFS has been a partner with CDC in launching https://bethereforme.org/ which provides support to parents and caregivers in connecting to existing resources and support.
Greater supports for new mothers with substance use disorder	Completed	Maine MOM program and OCFS' efforts around the Plan of Safe Care for infants and their caregivers when infants are born affected by substances.
Implement the Nurse Family Partnership model of public health nursing to prevent child maltreatment	Outside OCFS	This recommendation is directed to the Maine CDC which oversees public health nursing.

APPENDIX H
Maine Developmental Services Oversight & Advisory Board Testimony

Maine Developmental Services Oversight and Advisory Board (MDSOAB)

365 Cape Jellison Road

Stockton Springs, ME 04981

COMMENTS TO

BLUE RIBBON COMMISSION THE ORGANIZATION OF AND SERVICE DELIVERY BY DHHS

Introduction: I am Bonnie-Jean Brooks. I live in Stockton Springs, Maine. I have been the Interim Executive Director of the MDSOAB since March 2023. Previously I served for 42 years, starting in 1979, as the founding CEO of OHI, a Bangor-based nonprofit organization supporting Mainers with intellectual disabilities, mental illness, autism, and brain injuries – many with physical disabilities in 7 counties. I was also on the Board of Directors of the Maine Consumer Advisory Board (CAB), serving several years as its Chair, until 2010 when the Community Consent Decree was settled and the MDSOAB was created. I was its original chair. I resigned from the MDSOAB Board in 2023 to fill my current position.

What is MDSOAB? – I will provide you with a handout of the statute that authorizes our role and will briefly describe the current activities of the MDSOAB in my oral comments to the Commission. Following are some highlights:

- The MDSOAB is established by Title 5, section 12004-J, subsection 15 and is authorized by Title 34-B: Behavioral and Developmental Services – Chapter 1: GENERAL PROVISIONS – Section 1223.
- The MDSOAB is a quasi-governmental entity known as a 'J' Corporation.
- The Statute requires 15 members of the Board, appointed by the Governor. Currently, there are 11 members of the Board.

Four (4) members have been appointed by Governor LePage and the other 7 members are serving in unofficial non-voting capacities since their applications have not been dealt with by either Governor LePage or Governor Mills.

- The MDSOAB meets monthly and representatives of OADS join each meeting. There is a positive relationship between OADS and the MDSOAB.
- The funding for the MDSOAB has been static for over 2 decades. Its contract changed from DHHS to DAFS in 2022.
- The MDSOAB has one employee.
- The Board's primary responsibilities are:
  - Independent Oversight of services for adults with IDD and ASD.
  - To focus on systemic concerns
  - Provide advice and systemic recommendations to the DHHS Commissioner, Governor and the Legislature regarding policies, priorities, budgets and legislation affecting the rights and interests of persons with IDD and ASD.
- Another primary responsibility is to oversee the Correspondent Program.

General Comments:

1. Systems Issues: The MDSOAB identifies systems issues by holding Public Forums and Listening sessions; encouraging public comments at its monthly meetings; providing written testimony at relevant hearings and proposed rulemaking; participating on all 6 of the Regional Review Committees that review and approve Behavior Management Plans and Safety Plans; and engaging in updates from the Office of Aging and Disability Services at each of our monthly meetings.

2. Model Initiatives: We are not aware of any nationwide model initiatives for adults with IDD/ASD similar to Maine's development of a blueprint for children based on the CYSHCN model and as described on the Boston Children's Hospital website.
3. Access to Information – The statute entitles the MDSOAB to access to information about numerous things including case management, reportable events, APS and Rights investigations, unmet needs, crisis services, quality assurance and improvement, budgets and reports that contain other relevant data.
4. Lifespan Waiver – The MDSOAB is supportive of the concepts of the Lifespan Waiver. The department has done an admirable job in holding listening sessions, meeting with various stakeholder groups, publishing FAQ'S that illustrate responsiveness to what they are hearing and maintaining comprehensive website information about this evolving new waiver. The MDSOAB continues to hear from many stakeholder groups and individuals about continuing concerns about this Waiver including but not limited to: A. not enough clarification about the 17 services within Lifespan; confusion and concern about case managers and community resource coordinators – their differing roles, disparities with rates, role and responsibilities B. lack of capacity to meet the staffing and housing requirements while adding a whole new group of 14 – 17-year olds to the Waiver and in the face of the mounting waitlists for all services. C. a major concern that there has not been close enough coordination between OADS, Licensing, DOL, OMS, Education, and the Provider Integrity Unit resulting in important unanswered questions. D. premature start of the Lifespan Waiver, particularly in light of other extensive system reform in which OADS is engaged including new licensing

rules, new rate-setting, ongoing authorization for services challenges, and continuing problems with Evergreen.

Challenges and Concerns

1. Data – OADS provides the MDSOAB with a Quarterly Data Report which provides data on selected aspects of services for people receiving Sections 21 and 29 services. The data is not broken down into age ranges. The MDSOAB has asked for further delineation of many of the areas outlined and for the report to be expanded to include other areas required by 34-B. We are told that transition from EIS to Evergreen, limitations within the software and shortage of staff have, in part, prevented us from receiving the data that we have requested. This prevents us from having an ability to identify certain systems issues.

   Nursing Homes – MDSOAB is unable to get data about the number of people with IDD/ASD who are in nursing homes. Who are they? Where are they? What are their ages? Why are they there? The answers to these questions have systems consideration.

   Aging and Disability Mortality Review Panel 2023 Annual Report – The MDSOAB recently reviewed this annual report and had a brief discussion with one of the panelists. Its findings, investigations and recommendations can help to inform the conversation about the organization and delivery of services by DHHS. Notably, this report identifies age ranges, which is helpful. There were several recommendations that may be useful to the Blue-Ribbon Commission. Some include: need for more frequent assessment of members with complex medical needs; more training and oversight of personal care providers, especially paid family members; more robust healthcare training

to help service providers to spot the signs and symptoms of potentially preventable causes of death; need to increase medical and nurse case management; a need for OADS and Maine CDC to refine the process of gathering and filtering data.

2. Unmet Needs – Data about Unmet Needs, as required by the statute, is not available. This may be the largest systems issue at this time. The MDSOAB needs this data to identify systems issues and OADS needs it to calculate its budgetary needs. This detailed information was available until 2010 when the Community Consent decree ended.
3. Dental Crisis – The MDSOAB has identified the lack of IV sedation and general dental services as a crisis in the IDD/ASD community. OADS and MaineCare do not have data about the extent of these unmet needs. We have learned that people are having teeth unnecessarily removed while others are in so much pain that they exhibit dangerous behaviors that require otherwise unnecessary Behavior Management Plans and copious amounts of psychotropic medication. The statute guarantees people with IDD/ASD the right to timely dentistry. This issue is broad reaching and affects Mainers of all ages and is ripe for a systems approach to this challenge.
4. Shared Living – This model of support has increased exponentially in the last few years. There are many families who are now providing Shared Living support. We are unable to find out what the demographics of Shared Living are including: the number of families versus the number of agency vendors that are providing shared living; where are the Shared Living homes located; what is the turnover of shared living providers and the number of people who come and go from Shared Living; the ages of Shared Living recipients; and more.

   Families, providers and others have expressed concerns about the overreliance of Shared Living with the reality that both

Shared Living providers and recipients of Shared Living are aging. As people age, they will need more and more support services. It is inevitable that people will have to move, disrupting lives by loss of friends, community, family and by the deleterious behavioral and medical impact of the disruptions. In the information provided by OADS regarding Shared Living, we have not seen any anticipation of how the system of care will be impacted by aging-related turnover.

5. Aging Differences – As our state works toward a more integrated system of care for all Mainers, it must be acknowledged that there are some significant differences in the support needs of people who are aging who have IDD/ASD and those who do not. This must be taken into consideration as we make systems reform. The recent 2023 Mortality Review report is helpful in pointing out some of these differences.
6. Alzheimer's Disease, Dementia and other memory issues – We have identified a lack of a comprehensive system approach to addressing the needs of individuals with these conditions. We see a lack of staff training, specialized services and data. OADS recently awarded several Innovation Grants. We have heard that a couple, including a collaborative project including Spurwink, may focus on this area and hope there is potential for replication.
7. Deaf and Hard of Hearing and People Who are Medically Fragile – Any systems reform must address these individuals. There are not enough nurses, interpreters and professionals to support this ageing population.

Other Recommendations

1. User Groups – We recommend that the department create more multi-stakeholder User Groups to inform various elements of planned systems changes. Several that have been convened have been extremely helpful.

2. We think it would be useful for this Commission to hear from other stakeholder groups as you go forward. We recommend speaking with the Maine Association for Community Service Providers, SUFU, DRM, MDDC, family groups and others to provide further insights and information.

I have offered these comments representing the MDSOAB and speaking within its limited scope of responsibility. I would be happy answer questions you may have and to follow up on anything you request – including reaching out to provider agencies around the country through the ANCOR network to explore other what other states are doing similar to the work of this Commission. We wish you the best as you go forward with this important study.

Respectfully,

Bonnie-Jean Brooks, Interim Executive Director MDSOAB

TO: Blue Ribbon Commission to Study the Organization of and Service Delivery by DHHS
FROM: the Maine Developmental Services Oversight Advisory Board
RE: Timeline Update and Addendum to MDSOAB Report
DATE: October 15, 2024

Timeline Update

- *July 10, 2024* The Executive Director of Maine Developmental Services Oversight Advisory Board (MDSOAB) reported to the Blue Ribbon Commission.
- *September 9, 2024* News media revealed that the DOJ is suing the state for children's behavioral services, after being warned by the DOJ in June of 2022 of statewide issues. (The MDSOAB notes that issues highlighted in children's services are also well-known issues within adult services)
- *September 10, 2024* Media reports revealed horrific cases of abuse by multiple staff of adults with intellectual and developmental disabilities (I/DD) that occurred over three years in Lee Residential Care in Hampden. (Links to related articles are below)
- *September 17, 2024* The Maine Developmental Services Oversight Advisory Board discussed the abuse at Lee Residential Care with DHHS. The MDSOAB came to a consensus that any systemic issues related to this case be defined to learn how the system of care failed the individuals served in that home.

Addendum

The MDSOAB is writing to the Commission to request an addendum to our July 10 testimony to include the need, through analysis and reporting, to understand and define the points of systemic failure whereby multiple individuals living in a home operated by Lee Residential Care were abused by multiple staff over a three-year period. We would like the Commission to include a placeholder in its reporting to the HHS Committee to add this analysis with any potential recommendations for positive change in the system of care as it relates to the Lee Residential Care analysis.

The Blue Ribbon Commission is tasked with examining the following:

1. The organizational structure of and service delivery by similar agencies in other states and in nongovernmental organizations; Page 3 - 131LR0259(03)
2. The strengths and weaknesses in the services provided with state and federal funding;
3. Current proposals for improving the safety and well-being of children and strengthening families across all populations and geographical areas of the State;
4. Barriers to accessing services, as well as system failures and additional needed resources; and
5. Areas in which processes can be streamlined and efficiencies made within the department.

The inclusion of such an analysis as requested in our addendum fits within the scope of the Commission's existing duties. Understanding the points in the system of care that could have prevented the Hampden incident may provide a snapshot that quickly and comprehensively capsulizes critical systemic issues—for both children and adults—including issues that led to the DOJ lawsuit. We urge the Commission to grant our request for this addendum in order to improve our system of care as a positive outcome of that horrific incident.

Examples of questions that can guide systemic improvement:

Oversight and Accountability, Resources

1. The statute 20-A 7258 requires the state Department of Education to file a report to the HHS and Appropriations committees each year, "working in conjunction" with DHHS, to plan for adults transitioning out of children's services. This is required as a way for the state to plan for and allocate adequate funding to serve the population it will support in the coming years. But this legal requirement has been ignored consistently for the past 20 years. If the law had been followed, would staffing levels have been robust enough to prevent this horrific abuse from occurring? If state departments have the leeway to ignore important oversight laws this freely, how will the system be improved? How can this population be prioritized differently so that their needs are not systematically ignored for decades?
2. If the specific crimes committed against the residents at Lee Residential Care could not be prosecuted because the people abused were nonverbal and/or non-communicative, how can the rights of that population be upheld by the criminal justice system so as to not exclude them? Could changes be made legislatively to give this population equitable justice?
3. How can the system be held accountable to the people who rely on it?
4. If abuse occurs in a region of the state where there are no other resources to serve people, or if an agency does not have the capacity to help someone with behavioral needs, how is the state system of care held accountable?
5. What opportunities for observation and reporting were available but missed by the case managers and house manager? Were any incident reports filed as a result of the behavioral changes observed in the adults living in the home? Did the review committee see these reports? Were they discussed within the home; if not, why? Were the families notified?
6. What red flags were ignored or not noticed while the abuse was occurring?
7. Did any staff members report that they suspected abuse, and when? Were their concerns taken seriously and acted upon in a timely manner?
8. Why was the MDSOAB not made aware of the situation?
9. Did Disability Rights Maine know about the abuse? If people were concerned, were they aware of their resources, such as contacting DRM?
10. Did the abused adults have access to annual physical exams? Why didn't healthcare providers who interacted with them detect the abuse?
11. How were family members' concerns handled, and where could they turn for help? If a family member or guardian has a concern about an agency, where should they go for help?
12. What was the exchange between the DHHS and law enforcement and others investigating the allegations?
13. Were families notified when Lee Residential Care lost its license to operate the group home where the abuse occurred? Did the licensing offer more protection? Why was it dropped?
14. What support is the state providing for individuals that have been abused under their care?
15. What communication channels existed between the agency and the family members to discuss a residents' ongoing wellbeing?

16. Could anything be detected through the Person Centered Planning process regarding the individuals' discontent? Were unmet needs documented?
17. Did failures in the state's data system interfere in any way with oversight that may have indicated potential problems at this home? How could data systems be used in ways that would better help with oversight that could prevent future abuse?
18. Were appropriate background checks done on the DSPs? Had background checks or screenings of the DSPs indicate any reasons not to hire them? In other words, did any of these employees have a history of abusing people in their care?
19. Was Lee Residential Care recommended so highly because there are so few choices in that region for residential services for higher-needs adults with I/DD?
20. Increasing behaviors, a form of communication, were not addressed at the agency level, and outside help was not brought in. Everything appears to have been handled "in-house," right down to the BCBA being "on-call." Was the resident also taken to the doctor?

Training

21. Did anyone who had access to the abused individuals have training in trauma-informed care?
22. How can we improve training for physicians, allied healthcare providers, and others supporting vulnerable Mainers, to pick up on signs of distress?
23. Was the role of Direct Support Providers being mandated reporters underscored in their training? If an agency has a closed "don't talk" culture, what should a DSP do to report concerns outside of their agency? What is the process?
24. How can this nightmare case inform the good work of ThriveTogether Maine, a collaboration between Disability Rights Maine, The Maine Coalition Against Sexual Assault, Speaking Up For Us, & The Maine Association For Community Service Providers? It is a grant initiative aimed at enhancing services for survivors of sexual violence who have developmental disabilities.

Communication/Transparency

25. How can we improve communication, respect, and trust among everyone involved in the system of care that supports vulnerable Mainers?
26. How could this residential home agency be recommended as top notch to those seeking residential care in the Hampden area while this terror was occurring within? How would parents know when selecting an agency for a loved one that this agency was not the place to go.
27. Dismissal of parental/guardian concerns contributed to the length of the abuse. The mom registered concerns, "but nobody listened," according to news reports. Did agency leadership ask, "Why am I dismissing this parent's perspective? Is there something there?"
28. Do individuals with communication and/or behavior issues have access to speech and language pathologists who can "interview" them using alternative communication, especially if behaviors are increasing? So many individuals lose forms of supportive communication when transitioning from school to adult services. And for those people

who are verbal, are they able to communicate the need for help? To what degree does the system have adequate access to communication training and technology that are essential to minimize or prevent on-going abuse?

Quality of Life, Resources, Data

29. How do you measure the quality of the lives of the individuals regarding person centered interest and goals, their health and wellbeing, and community access? What is the relationship between a failure to accurately measure individual indicators of quality life and the abuse that occurred?
30. As the funding source for the system of care, DHHS bears the ultimate responsibility for its oversight. How could 'No Eject, No Reject' ever be approved by the legislature if the legislation does not hold DHHS accountable to address failures within the system?

Thank you for considering our request.

BDN Article
https://www.bangordailynews.com/2024/09/10/bangor/bangor-health/atrocities-lee-residential-care-hampden-maine-joam40zk0w/?fbclid=IwZXh0bgNhZW0CMTEAAR1PZVgAC_dFYFknq6KCQtiNDI1Sa_82l8jBDsZ8zbCvsiCLiIaZ1M66RzE_aem_rs54LlG-XqwO_IvBtbbH8w

WABI video
Court records detail disturbing abuse of residents at Hampden residential group home at https://www.wabi.tv/video/2024/09/10/court-records-detail-disturbing-abuse-residents-hampden-residential-group-home/

BDN Op Ed Parent Piece
https://www.bangordailynews.com/2024/10/03/opinion/opinion-contributor/mainers-disabilities-health-safety-lee-residential-care/?fbclid=IwZXh0bgNhZW0CMTEAAR3io0jwonLs5DO2uuH1PCYwv87KEdh2QJwX-fPjRZ-OfwzdFVhUW0E1ySU_aem_QutVcSKdNioFtdRcXM_4TQ

APPENDIX I
LD 17 Resolve, To Provide Rural Nonmedical Transportation Services to the Elderly and Adults with Disabilities Receiving Home and Community Benefits under the MaineCare Program
130th Legislature

130th MAINE LEGISLATURE

FIRST REGULAR SESSION-2021

Legislative Document **No. 17**

S.P. 24 In Senate, January 13, 2021

Resolve, To Provide Rural Nonmedical Transportation Services to the Elderly and Adults with Disabilities Receiving Home and Community Benefits under the MaineCare Program

Received by the Secretary of the Senate on January 11, 2021. Referred to the Committee on Health and Human Services pursuant to Joint Rule 308.2 and ordered printed.

DAREK M. GRANT
Secretary of the Senate

Presented by Senator MAXMIN of Lincoln.
Cosponsored by Representative MEYER of Eliot and
Representatives: COREY of Windham, CRAVEN of Lewiston, FAY of Raymond, MADIGAN of Waterville, PLUECKER of Warren, STOVER of Boothbay.

Sec. 1. Pilot project. Resolved: That the Department of Health and Human Services shall establish a pilot project lasting 18 months that allows individuals currently receiving services under rule Chapter 101: MaineCare Benefits Manual, Chapter II, Section 19, Home and Community Benefits for the Elderly and Adults with Disabilities, to receive up to $2,000 each in nonmedical transportation services that are specified in the individual's service plan when the individual has no other means of transportation, in addition to currently permissible medical transportation. The department shall provide written notice to these recipients regarding the availability of the pilot project. The department shall submit a report to the joint standing committee of the Legislature having jurisdiction over health and human services matters with an evaluation of the costs and effectiveness of the pilot project and an assessment regarding its long-term viability no later than January 30, 2023. The committee may report out legislation based on the report to the First Regular Session of the 131st Legislature.

SUMMARY

This resolve requires the Department of Health and Human Services to develop a pilot project lasting 18 months that provides nonmedical transportation services to individuals receiving services pursuant to rule Chapter 101: MaineCare Benefits Manual, Chapter II, Section 19, Home and Community Benefits for the Elderly and Adults with Disabilities, in an amount up to $2,000, in addition to currently permissible medical transportation services. The department is required to submit a report regarding the costs, effectiveness and future viability of the pilot project to the joint standing committee of the Legislature having jurisdiction over health and human services matters no later than January 30, 2023.

APPENDIX J
Department of Health and Human Services Update
Psychiatric Residential Treatment Facility Development

Projected DHHS Workplan on PRTF

Timeframe	Activity Benchmark	
June 2023	DHHS held a Rate Determination stakeholder meeting on June 15, 2023. The Comment period active from June 15, 2023, to July 7, 2023. August /September comments were reviewed, and written responses worked on.	✓
July – September 2023	Public comment process closed. DHHS reviewed comments, worked on written responses, consulted with a national PRTF provider on model and rate recommendations.	✓
Fall 2023	DHHS finalizes service model following feedback from local stakeholders and national experts. Draft rate model being reviewed for process consistencies and to see where/if any changes can be made on the draft rate model based on comments from stakeholders.	✓
November 2023 – February 2024	DHHS rule drafting, including senior management internal review	**Ongoing**
Winter 2023-24	DHHS finalizes rates based on feedback from rate determination. Publishes result of Rate Determination.	**Ongoing**
February – March 2024	OAG pre-review of proposed rule drafts; DHHS final revisions to proposed rule drafts; Commissioner review of proposed rule drafts	
May 2024	DHHS proposes the Chapters II and III, Section 107, policies. APA public engagement process begins.	
July 2024	DHHS provides a written progress report to the Joint Standing Committee on Health and Human Services	
Fall/Winter 2024	Section 107 policies are adopted	