AUTISM SOCIETY
Improving the Lives of All Affected by Autism
Maine

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Testimony of Betsy Mahoney, Esq in favor of LD 716, An Act To Enhance and Improve the Maine Developmental Services Oversight and Advisory Board and To Establish the Aging and Disability Mortality Review Panel

Senator Claxton, Representative Meyer, and members of the Health and Human Services Committee, my name is Betsy Mahoney and I am the Community Outreach Liaison for the Autism Society of Maine. I am also the mother of a 29-year-old son with autism and intellectual disabilities who has a Medicaid Sec. 21 waiver and lives in a group home. I am testifying on behalf of the Board of Directors in favor of this bill.

Four years ago, a federal audit from the U.S. Office of the Inspector General found that the State of Maine failed to protect adults with developmental disabilities, including some who died under unknown circumstances.

Three and a half years ago, in August of 2017, the OIG issued a report finding that, during a 2 1/2-year period ending in June 2015, Maine DHHS failed to investigate 133 deaths and did not report 34% of the critical incidents involving developmentally disabled Medicaid patients. The report also found that DHHS did not comply with requirements for reporting and monitoring critical incidents for Medicaid beneficiaries, Including 1,800 adults with intellectual disabilities who live in group homes.

As the parent and guardian of a young adult who lives in Medicaid funded home, I was devastated by this news.

Three years ago, in early 2018, news reports stated that the HHS legislative committee was considering new oversight options. Two years ago, a bill was introduced (LD 1377) that would have made changes in the MDSOAB and created an Aging and Disability Mortality Review Panel.

Here we are, almost four years after the OIG issued its report, and we are no closer to a transparent look at the deaths that were not investigated by the State.

The mortality review panel proposed in this bill was recommended by the Office of the Inspector General. DHHS needs to create the panel to come into full compliance after the OIG report and ensuing Centers for Medicare and Medicaid Services scrutiny. The Department needs to re-build trust in the DHHS system of care for guardians like myself.

This bill proposes critical steps to address the scandalous lack of oversight and accountability on the part of DHHS, including disclosure requirements and direct access to DHHS client records; medical examiner reports; and records of department investigations into suspicious deaths.

We strongly urge this committee to pass LD 716.
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