Summary of Comments and Department Responses and List of Changes to Final Rule

Chapter I, Section 1, General Administrative Policies and Procedures

The Department of Health and Human Services held a public hearing on Monday, May 7, 2018 to obtain public comments on proposed rule changes. Written comments were accepted through Thursday, May 17, 2018. This document combines, summarizes, and responds to all the comments received during the public comment period ending Thursday, May 17, 2018. Changes made to the final rule from the proposed rulemaking are listed at the end of this document.

1. Andrew MacLean, J.D., Maine Medical Association
2. Al Durgin, LCSW, Spurwink
3. Lydia Dawson, Esq., Maine Association for Community Service Providers
4. Claudine Chaput, MPA, CHC, CHTS-TR, Kennebec Behavioral Health

Comments

The Department thanks all commenters for their input.

1. Comment: Commenter expressed support in the Department’s decision to remove the personal liability language located in Section 1.12-2 of the rule. (1)

Response: The Department made no changes to the final rule as a result of this comment.

2. Comment: Commenter expressed support in the Department’s decision to clarify that Section 13 and Section 92 services can overlap with Section 97, Appendix D services. (2)

Response: The Department has determined to not adopt the proposed change of adding an Appendix #3 (Duplication Table) to this rule. Concerns and questions about this Duplication Table were raised in several written comments, as well as from the Office of the Attorney General.

3. Comment: Commenter explained that Behavioral Health Homes (BHH) and Targeted Case Management (TCM) can reasonably be provided concurrently with Section 97 services. The commenter further explained that although “case management” is a part of the Private Non-Medical Institutions (PNMI) bundle, the nature of the service focuses that case management on events and needs that are specific to that intensive services and PNMI providers are challenged to offer the breadth of case management that community-based providers can facilitate. Commenter noted that an important issue, particularly in a rural state, is that Section 13 and 92 providers are knowledgeable about resources available in the community where families are located, and Residential providers, who may be far removed from that community, do not have that important knowledge base. Commenter further noted that since Section 13 services are billed as they are provided, and Section 92 services have a minimal threshold for attestation, the services are only provided as the needs of the case dictate and result in a minimal cost to MaineCare for an important service on the continuum. (2)

Response: Please see the Department’s response to Comment #2.
4. **Comment:** Commenter understands that the Department may not share the same perspective on concurrent services, and proposes that the concurrency extend from 30/60 to 60/90 with the following rationale:

- The recommendation for 60 days at the beginning of Section 97 services better meets the demands of the transition. Particularly for families who go through the decision-making process to apply for Section 97 services and the crises that often precede that decision, the relationship with a Section 13/92 provider is seen as valuable and is often invested with a great deal of trust. It takes more time to effectively transition that relationship to the 97 provider because of the quality of the relationship. And, the degree to which that relationship can be successfully transitioned is a significant factor in the success of the 97 treatment. In addition, Section 13 and 92 providers often provide a critical historical perspective that contributes to success in residential treatment.

- The recommendation for a 60-day concurrency at the beginning of Section 97 is also made for the sake of continuity when placement fails. The stress experienced by a child and a family in the transition to an out-of-home setting results in some placement failures. Such failures are more likely in the first 60 days of placement than later based on our experience. Having case management services of Section 13 or 92 continue allows for an important continuity should failure occur. This facilitates the completion of new ITRTs or arrangements for other treatment arrangements. In addition, the knowledge held by case managers can sometimes help treatment to continue through difficult transitions.

- Arranging for post-discharge services is time-consuming and often takes more than 45-60 days to set in place. Commenter’s experience is that it takes at least 60 days to get HCT services in place and often that long to get medication management in place. Based on that experience, commenter recommends at least 90 days of concurrency as discharge is planned.

**Response:** Please see the Department’s response to Comment #2.

5. **Comment:** Commenter requested that concurrency be allowed without limits for youth/young adults age 18-21 who are in PNMI settings. Commenter explained that the transition to appropriate adult programming often takes several years of concerted effort and involves processes that are not familiar to many Appendix D providers. Commenter also requested, for the same reason, that concurrency between Section 97, Appendix D and Section 13, Adult DD should be allowed without limits.

**Response:** Please see the Department’s response to Comment #2.

6. **Comment:** Commenter requested that where limits on concurrency seem necessary to the Department, there should still be some mechanism for extending concurrency based on extenuating circumstances. Some such circumstances might be a homeless parent, complex medical needs, or multiple psychiatric hospitalizations.

**Response:** Please see the Department’s response to Comment #2.
7. **Comment:** Commenter commends the Department for its decision to remove personal liability for provider debts against individual employees, officers, directors, and members from Section 1.12-2. Commenter explained that as a community provider, they rely heavily on non-profit boards and advisory councils to guide them and ensure proper oversight of program administration and operation, and that extending person liability broadly as to include anyone serving as an unpaid, volunteer board member, the inclusion of this provision dramatically changed the risk analysis for competent and qualified people considering volunteering their time. (3)

**Response:** The Department made no changes to the final rule as a result of this comment.

8. **Comment:** Commenter requested that the Department clarify and provide guidance regarding the inclusion of Targeted Case Management for adults with intellectual and developmental disabilities (i.e. Section 13 Adult DD) as a non-duplicative service within the Duplication Table. Commenter explained that the Department has historically taken the position that TCM was a duplicative service for Intermediate Care Facilities for Individuals with Intellectual Disabilities (i.e. Section 50 ICF-IID), and for this reason, approximately 200 individuals receiving ICF-IID services statewide are not utilizing TCM. Commenter added that further clarity, guidance, and training will be necessary for individuals seeking this service for the first time and integrating TCM into their current services. (3)

**Response:** Please see the Department’s response to Comment #2.

9. **Comment:** Commenter explained that with regards to personal planning, it is important for the Department to provide clarification for TCM and ICF-IID providers regarding interaction and responsibilities specific to the Individual Program Plan (IPP) and Person Centered Plan (PCP). Commenter noted that at this time, the coordination and documentation required for the IPP is conducted through the Interdisciplinary Team with the support of a Qualified [Intellectual Disabilities] Professional, and that Coordination and documentation required for a PCP is conducted through the PCP Team with the support of a Targeted Case Manager for individuals receiving other community based services. Commenter believes that these roles will need to be clarified in integration to ensure appropriate coordination of service delivery, documentation, and personal planning. Commenter additional requests that the Department clarify and respond to the following:

- Will TCM be an optional service for individuals with intellectual and developmental disabilities receiving ICF-IID services?
- What functions will Targeted Case Managers serve for individuals with intellectual and developmental disabilities receiving ICF-IID services?
- Will there be training provided to Targeted Case Managers regarding ICF-IIDs and supporting individuals with intellectual and development disabilities receiving ICF-IID services?
- What, if any, role with Targeted Case Managers have in the development of the Individual Program Plan and/or Person Centered Plan for individuals with intellectual and developmental disabilities receiving ICF-IID services? (3)

**Response:** Please see the Department’s response to Comment #2.
10. **Comment:** Commenter asked the Department if Community Integration (CI) is not permitted in the PNMI, except for 30/60, how will providers meet the obligation of the consent decree which permits all class members to have CIS (class members are entitled to receive an ISP and be assigned a community support worker regardless of need, pursuant to paragraph 49 of the Settlement Agreement). (4)

**Response:** Please see the Department’s response to Comment #2.

11. **Comment:** Commenter asked the Department if CI is not permitted in the PNMI, will this now become an allowable service in the PNMI? Commenter explained that CI is a specific service, which differs from Rehabilitation and Personal Care work in the PNMI, and when the PNMI rate is built as per a submitted budget, the work of CI is not included in that expense calculation. Commenter believes if CI is to be included, then PNMI rates must then be recalculated upward to accommodate for the additional service requirement and the associated service delivery costs.

**Response:** Please see the Department’s response to Comment #2.

**CHANGES MADE TO THE FINAL RULE**

As a result of these public comments and further review by the Department and the Office of the Attorney General, the Department made the following changes to the final rule:

1. Removed the proposed change of adding an Appendix #3 (Duplication Table) to this adopted rule.