Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
109 Capitol Street
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-3005
TTY: Dial 711 (Maine Relay)

January 24, 2024

Senator Joseph Baldacci, Chair
Representative Michele Meyer, Chair
Joint Standing Committee on Health and Human Services
100 State House Station
Augusta, Maine 04333-0100

Senator Baldacci, Representative Meyer, and Honorable Members of the Joint Standing Committee on Health and Human Services,

Please find attached a summary of the work of the stakeholder group established by Resolve 2023, Ch. 60 (introduced as LD 1003), *Resolve, to Develop a So-called No Eject, No Reject Policy to Support Children Receiving Behavioral Health Services and Individuals with Intellectual Disabilities or Autism.* This Resolve tasked the Department with convening a stakeholder group to develop a No Eject/No Reject proposal, which would require providers of residential services for children or individuals with autism spectrum disorders to receive written approval from the Department for termination of services to an individual, executing a discharge plan, or declining a referral of an individual when a bed is available.

As you will read in the report, full consensus was not achieved on the development of a process for either population noted in the Resolves. The Department has not taken a position on each of the stakeholder recommendations included in this report. However, we continue to work to address the concerns raised by the legislation and stakeholders, and we appreciate the Committee's collaboration and consideration of potential solutions.

Sincerely,

Jeanne M. Lambrew, Ph.D.
Commissioner

LD 1003 Stakeholder Group Report

Introduction

Resolves 2023, Ch. 60 (introduced as LD 1003) instructed the Department of Health and Human Services (DHHS) to convene a stakeholder group to develop a No Eject/No Reject proposal, which requires providers of residential services for children or individuals with autism spectrum disorders to receive written approval from the Department for the following:

- Termination of services to an individual,
- Executing a discharge plan, or
- Declining a referral of an individual when a bed is available.

The Resolves further requested the stakeholder group examine any existing data to determine the reasons that providers terminate services, decline referrals, or transfer individuals to emergency departments when there is no medical reason for the transfer and to determine the barriers to individuals being accepted for residential services.

The Resolves requested that the stakeholders include individuals from the following categories:

- Residential providers of behavioral health services to children.
- Residential providers of services to individuals with intellectual disabilities or autism.
- Hospitals.
- Disability Rights Maine, advocates for services for children and adults, and
- Any other relevant parties.

DHHS facilitated the stakeholder group in several sessions running from September through mid-November 2023. Due to the differences in the two major populations (children and adults with an intellectual disability or autism), the stakeholders agreed to work separately in order to work on population-specific topics and to convene jointly when the topics posed shared interest. Stakeholders were encouraged to attend any session of interest, and several stakeholders continued to attend both sessions. The Department greatly appreciates the time and thoughtful input and conversation from the participants who participated in these stakeholder meetings and contributed to this effort.

The Department contracted with Sheena Bunnell, a Professor of Business Economics at the University of Maine Farmington to facilitate the conversations. Participants included:

Residential Providers:

- Stephanie Coreau - Chief Clinical Officer, DayOne
- Justin Gifford - Child and Family Provider Network and Vice President, Beckett Family of Services
- Jennifer Putnam - Executive Director, Waypoint
- Beth Sullivan – Executive Director, Granite Bay Care
- Misty Marston - Vice President of Children's Residential and Education Services, Spurwink
- Paul Dann – Child and Family Network Executive Director, NFI North
- Malory Shaughnessy - Executive Director, Alliance for Addiction and Mental Health Services, Maine (The Alliance)
- Shannon Gove – Alliance for Addiction and Mental Health Services, Maine, Program Director, Aroostook Mental Health Services

Hospital Representatives:

- Katie Fullam Harris - Chief Government Affairs Officer, MaineHealth
- David Winslow - Vice President of Financial Policy, Maine Hospital Association
- Jeff Austin – Vice President Government Affairs and Communications, Maine Hospital Association
- Lisa Harvey-McPherson - Vice President of Government Relations, Northern Light Health

Advocates for Children and Families and Disability Rights Maine:

- Staci Converse - Developmental Disabilities Managing Attorney, Disability Rights Maine (DRM)
- Katrina Ringrose - Deputy Director, DRM
- Rachel Dyer – Associate Director, Maine Developmental Disabilities Council
- Cathy Dionne - Executive Director, Autism Society of Maine
- Carrie Woodcock - Executive Director, Maine Parent Federation

DHHS Staff:

- Dean Bugaj - Associate Director of Children's Behavioral Health Services (CBHS), OCFS
- Brielle Balmer - Office Specialist with CBHS and Early Care and Education (ECE), OCFS
- Kat Kasheta - Children's Behavioral Health Manager, OCFS
- Bob Gauthier - Children's Residential Licensing Supervisor, OCFS
- Betsy Hopkins - Associate Director of Developmental Disabilities and Brain Injury, OADS
- Emily Kalafarski - Resource Development Manager, OADS
- Deb Johnson – Developmental Disability and Brain Injury Services Program Coordinator, OADS
- Erin McDermott – Initiatives and Implementation Manager, OADS
- Thomas Leet - Long Term Services and Supports (LTSS) Manager, OMS

Meeting dates and times (note: September 28 - November 9 sessions were split into two sessions. The first half for Intellectual Disabilities and Autism second half for Children's, with shared time in between):

- September 7, 3:00-4:30pm
- September 28, 2:00-4:30pm
- October 12, 2:00-4:30pm
- November 9, 2:00-5:00pm
- November 15, 3:00-5:00pm (Final Session – Children's Stakeholder group)
- November 29, 1:00-2:30pm (Final Session – Intellectual Disabilities and Autism Stakeholder group)

Children's Stakeholder Discussion

Starting in September and continuing through November, DHHS convened and facilitated stakeholder discussions in line with the intent of the legislation. The initial discussion, a joint meeting with child and adult stakeholders, set the group norms, meeting cadence, and goals of the stakeholder engagement which were as follows:

Stakeholder engagement will inform the development of a No Eject/No Reject process for residential services which will include:

- Identifying any considerations necessary to implement a No Eject/No Reject Process
- Identifying the steps necessary to implement the No Eject/No Reject Process
- Identifying service provider/system needs

- Identifying any challenges and potential solutions to implementation

Throughout the stakeholder engagement sessions, the group addressed the required topics in the Legislative Resolve within the context of achieving the goals noted above. The group explored the concept of a No Eject/No Reject (NENR) process and explored impressions of the previous No Eject/No Reject pilot project explored by the Department around 2010. A residential stakeholder presented their perspective from participation in this pilot and reported several challenges in implementation before the pilot was ultimately ended. The stakeholder reported that for their agency, safety concerns for staff and other residents arose while attempting to serve high acuity youth, noting that while behavioral health needs were not an everyday occurrence, when they did present, it often required emergency services, with one occurrence where a staff was "catastrophically injured" during the behavioral health event. It is through this experience and others that the residential providers expressed concern of implementing a NENR process generally, noting their impression that youth are at a higher acuity than the previous pilot, there are more youth at this high acuity than previously, and Children's Residential Care Facility (CRCF) providers are not equipped to be able to treat such a high level of behavioral health needs. The Department was not able to accurately compare the acuity of youth from 2010 to today, but we note that we currently have 215 youth served in a CRCF, with 64 youth currently served in out of state placements, and an additional 40 youth seeking care out of state, having been denied by in-state providers.

The group additionally explored a range of data including data supplied by CRCF providers on discharges to emergency departments (ED), data from Homeless Youth shelters on discharges to or admissions from EDs, and hospital ED data and sample member profiles of individuals seeking behavioral health services in EDs. Additionally, the group reviewed reasons current CRCF providers may deny a referral to better understand the reasons for denial and the factors considered in the process. Providers shared that decisions to deny a referral include several considerations, with the safety of their current youth served and staffing at the forefront of these decisions. Reasons for CRCF denial include no beds currently available, insufficient staff availability, insufficient educational resources available (i.e., youth is not connected to school), youth's clinical needs are not a good fit with other youth in the milieu (i.e., level of physical aggression, level of self-injurious behaviors, property destruction, elopement, problem sexualized behaviors), youth's clinical needs exceed the current available level of supervision the agency can provide (i.e., youth need 1:1 or higher upstaffing to keep them safe), youth appear to need a higher level of care (i.e., inpatient treatment), youth's clinical needs exceed the type of treatment an agency can provide (i.e., physical medical needs, specialized treatment models for eating disorders or problem sexualized behaviors), physical plant limitations or modifications that could impact safety, or youth needing PRN medications for medical or behavioral health needs. It is important to note that providers may choose multiple reasons depending on the youth's presented clinical needs.

The stakeholders also had robust discussion related to considerations of implementing a NENR process, including referral management, supporting program specialties, considering flexible funding or differential rates to support placement needs, and potential resources needed to implement a NENR process successfully. Of note is that staff from the Office of Behavioral Health (OBH) presented their process of implementing a NENR system for adults with Serious and Persistent Mental Illness supported through the Consent Decree to both the child and adult stakeholders, including staffing resources for referral management and funding resources available to support placement. The children's stakeholders by and large embraced this concept for youth programs, and recommended the Department consider a similar structure to the OBH system for implementing this NENR process. The group additionally reviewed attributes of the out of state providers, who have been able to take youth unable to be accepted for in-state services. This review showed that the out of state facilities have similar attributes to their in-

state counterparts, though some facilities specialize in certain populations, like serving males only, or service only youth with problem sexualized behaviors. These providers have similar workforce issues and generally follow similar rules as in-state providers.

While details are outlined below, the stakeholder discussion surrounded not only the process and resources needed to implement NENR, but also the concerns indirectly related to implementation. Stakeholders agreed that implementing NENR for youth in a vacuum, devoid of other broader system changes, would not in fact fix the identified problem of children in EDs while seeking access to behavioral health services. CRCF providers additionally were concerned that high acuity youth with behaviors unable to be managed in the design of their facility would have a forced placement, presenting safety issues for existing youth served and the staff in the facilities. A provider in the stakeholder group, speaking for their agency and as a representative for other providers as a part of the Child and Family Network, noted in the final discussion that if a NENR process were implemented, their agency, and other agencies would need to consider whether they could continue to provide residential services to youth in Maine, and it would be likely they shut their doors.

Meeting Outcomes

The stakeholder group did not reach a consensus on the implementation of a No Eject/No Reject Proposal for children. This said, certain aspects of the design were agreed upon, including the scope of a potential policy. This scope includes:

- Youth seeking or residing in Mental Health CRCFs
- Youth seeking or residing in Intellectual and Developmental Disability CRCFs
- Youth seeking or residing in substance use facilities for youth (Adolescent Residential Rehabilitation Services)

Additionally, stakeholders agreed on several elements important to the referral process, including:

- Youth are assessed for level of care using a standardized evidence-based assessment through Acentra HealthCare (current process).
- Residential Navigators (new positions) would manage the referral list and engage with PNMI providers on referrals and facility needs, including reviewing decisions and working with providers on any resource needs.
- Considerations for placement include but are not limited to the youth's individualized need and the specialty of the provider, licensed capacity, current staffing levels, etc.
- Stakeholders recommended having flexible funding available to support placement of challenging youth.
- Residential Navigators would provide technical assistance (TA) to providers on challenging cases, and consider contracting with a clinical subject matter expert to provide additional support as well.

Stakeholders also identified important elements for the discharge planning stage:

- Providers should be in regular contact with Residential Navigators and other CBHS staff as needed to consult on challenging cases and cases approaching discharge.
- The Department should provide clinical technical assistance, as requested.
- Advanced written notice of termination, prior to termination of the member's services, should be required.
- The Department may approve expedited termination of services in cases where the member poses a threat of imminent harm to persons employed or served by the provider.
- Prior to discharge/termination, the provider should assist the member in obtaining clinically necessary services from another provider to the extent possible.

The stakeholder group discussed several considerations it felt would be critical to successfully implementing a No Eject/No Reject Process. These considerations include the following:

- Implement the single assessment across the CBHS delivery system.
- Create diversion services from Emergency Department.
- Increase availability of crisis beds.
- Develop respite services to support planned breaks in services for youth in residential care.
- Build out access to services at all acuity levels (including Psychiatric Residential Treatment Facility Services (PRTF), Therapeutic Foster Care services, and community-based services to facilitate step-down from higher acuity levels).
- Support parent training programs, including TA for youth and families; and
- Increase facility reimbursement rates (Providers assert that despite the 2021 rate update and Maine's minimum wage and Part AAAA increases, recruiting and retaining staff costs have increased, resulting in a net loss).

Complementary Initiatives of Note

The Department of Health and Human Services and the Mills Administration have identified several strategic priorities related to children's behavioral health services (CBHS) aimed at improving the availability, accessibility, and quality and consistency of children's behavioral health services and the system within which they operate. As such, the considerations noted by the stakeholders have relevance to ongoing work that the Department and Legislature have collaborated on in the last several years. Some examples include:

- PL 2023, Ch. 412 appropriated one-time funding to implement the CBHS single assessment. This will allow the Department to implement a standardized level of care utilization instrument, to be used for youth seeking services from community-based care to CRCF services. This will provide an understanding of the most appropriate level of care for youth, which should improve individual access to care as well as data for system-level development.
- The Department, through its SAMHSA planning grant, has been working on updating the mobile crisis system to meet the definition of CMS Qualifying Mobile Crisis Services under the American Rescue Plan Act, which in part focuses on providing crisis response services outside of the hospital setting, with a goal of preventing ED use for behavioral health services altogether. Additionally, through the rate system reform process, MaineCare has been undergoing rate determination for this service model.
- Along with the mobile crisis work, the Department reformed the rate structure for Crisis Residential Services effective Jan. 1, 2023. The Department is beginning to see the benefits of this work with a provider coming back online who had previously closed their doors to service under the prior rate structure. The Department continues to work on establishing Psychiatric Residential Treatment Facility (PRTF) services. Updates on that work will be submitted in a separate report to the Health and Human Services Committee in 2024.
- The Department also continues its work to update the model and rates for Therapeutic Foster Care services, including development of the evidence-based therapeutic foster care model, Treatment Foster Care Oregon. A public presentation on this work was held in December.
- Considering Parent Support Programs, the Department leveraged federal funding available under the America Rescue Plan Act to purchase 5,000 codes for the self-directed, online version of the Positive Parenting Program (Triple P, Online), an evidence-based parenting service designed to increase parental understanding and skill in addressing problem behaviors. We are currently in the process of contracting for clinical support for families as they progress through the web-based program and anticipate roll-out in early 2024.

These initiatives and more, noted in the Department's blog, *Boosting Implementation of Maine's Children's Behavioral Health Plan* will have a positive impact on the delivery system as whole, but need time to be implemented so they may be successful. The Department has heard and understands the concerns raised by stakeholders and the community at large, and through these efforts believes we will begin to see the positive changes desired to the Children's Behavioral Health System.

Recommended Next Steps

The Department aims to assess youth at the right level of care at the right time and facilitate timely access to services for youth seeking mental and behavioral healthcare – a goal shared by the stakeholders that convened for this work. A No Eject/No Reject policy is one piece of a larger puzzle toward meeting that goal.

However, stakeholders along with the Department recognize that NENR is only successfully implemented as part of broader system work. This includes the development of Psychiatric Residential Treatment Facilities, the revision of the Therapeutic Foster Care models, the full implementation of CMS Qualifying Mobile Crisis work, and the development of Certified Community Behavioral Health Clinics – all multi-office efforts within the Department. These initiatives will have a lasting impact on children's ability to access the right service with the right level of clinical care, when and where they need it.

Considering this ongoing work, the Department recommends revisiting the proposal to formalize a No Eject/No Reject policy, including the necessary financial and staff resources, in the next biennium. In the meantime, the Department remains committed to collaborating with stakeholders through already established processes to address system concerns.

Intellectual and Developmental Disabilities and Autism Stakeholder Discussion

Maine's two Home and Community-Based Settings (HCBS) waivers serving adults with an intellectual disability or autism are the primary pathway for accessing services supporting the pursuit of one's goals, employment, and engagement in the community. HCBS waivers are Medicaid-funded service packages designed to help individuals who would otherwise require institutional services live as independently as possible in the community.

Maine's HCBS waivers are often referred to by their section numbers in the MaineCare Benefits Manual[1], §21, sometimes referred to as the "Comprehensive Waiver," provides a broader array of services than available under §29, sometimes referred to as the "Support Waiver." Both §21 and §29 offer Home Support, Work Support, and Community Support, which are direct support services[2] and assistive technology designed to support people in their homes, at work, and in the broader community. Both waivers provide services and support in a privately owned or rented home or apartment or in a shared living arrangement.

Enrollees under §21 can access services in a provider-owned or controlled group home. In addition, under §21, enrollees also have access to therapies (e.g., physical, occupational, and speech therapy), as well as communication aids and other devices and services designed to overcome physical, sensory, or other barriers to mobility, communication, participation in the community, and other activities.

[1] The MaineCare Benefits Manual is found at 10-144 C.M.R. ch.1.

[2] "Direct support" includes assistance with personal care and other tasks, exercising safe and responsible judgment, and promoting personal development and health and well-being.

The following are the types of residential support options available for individuals with Intellectual and Development Disabilities (IDD):

- Shared Living (Sections 21 and 29)
- Family-Centered Support (Section 21)
- Home Support - Agency Per Diem (Section 21)
- Private Non-Medical Institution (PNMI, Section 97, Appendix F)
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID, Section 50)
- Emergency Transitional Housing (state-funded)
- Office of Aging and Disability Services (OADS) Disability Services Crisis Homes (state-funded)

Meeting Outcomes

Stakeholders made a number of recommendations related to the system of care and the development of a NENR policy for adults with intellectual and developmental disabilities and Autism. These include:

- Providers and OADS should work together to determine the best qualifications and the amount of staffing needed for someone who requires more clinical and behavioral health support to be incorporated into the rates to support hiring more qualified staff.
- Physical layout, materials, and furnishings of a home should be considered to ensure the safety of staff and residents.
- OADS has a new Rate Study/Design underway for Lifespan and all its current IDD waiver services. As that is being developed, OADS should consider how best to reimburse providers for accepting individuals who require more significant behavioral support.
- Not all providers have access to clinical support on their teams; there will need to be a plan to consider this if contemplating a broader NENR policy across the system.
- Further research needs to be done regarding how or if other states have implemented this policy with IDD agencies. There was considerable disagreement among IDD stakeholders in the work group over whether implementing a policy like this is best practice. Some argued that it could cause harm in that it would make it more challenging to find placements to serve individuals who require exceptional behavioral support needs.
- Concerns were raised that a NENR policy conflicts with the HCBS rule in that HCBS requires individuals living in homes to choose who they live with.
- For success of NENR, it would be necessary for the State to invest in appropriate and adequate resources to support families and providers to create a robust, multi-layered state system of crisis services, behavioral supports, and intake management.
- OADS would need to develop a process and capacity to:
    - Oversee all referrals, discharges, and admissions.
    - Develop additional clinical support to support providers and review discharge requests for appropriate clinical reasons.
    - Work with additional stakeholders, including families and members receiving services, as well as additional IDD providers, to draft a clear NENR policy, including the ramifications for providers who eject or reject individuals without following the policy.

Complementary Initiatives of Note

The Department of Health and Human Services has undertaken several strategic initiatives related to adults with IDD as part of its HCBS Improvement Plan. These include several behavioral health initiatives, innovation grants to providers of adult services, and development of the Lifespan program, which includes payment approaches for individuals with significant behavioral health needs.

Recommended Next Steps:

While stakeholders did not reach consensus on implementation of NENR for adults with IDD, they did

make several useful suggestions for additional consideration and analysis, noted above in the Meeting Outcomes. These include the need to determine qualifications and levels of staffing required for individuals with behavioral needs, as well as rate methodology to pay adequately for those services. In light of the work already underway to improve behavioral supports, develop innovative services and supports, implement the Lifespan program, and conduct a rate study for Lifespan and existing waiver programs, the Department recommends revisiting NENR in the next biennium. The Department will continue to engage stakeholders in these initiatives as they evolve, including working on the following

- Develop new specifications for Emergency Transition Housing (ETH) that enhance the model, including pricing out corresponding rates and developing policies and procedures through the contracting process with these agencies
- Explore the costs and benefits of a bed management system to track housing openings. This would allow OADS to track capacity and staffing and to tailor or eliminate the current vendor call process. For example, could this be done through: Acentra, Evergreen, or another off-the-shelf provider management system
- Ensure, in the meantime, that providers follow the current MaineCare rules, which state, "Once a provider has been authorized to provide services, the provider cannot terminate the Member's services without written authorization from OADS." (*See* MBM Ch. II, Section 21.05 and Ch. II, Section 29.05).
- Develop (with stakeholder input) a standardized intake process/form, which includes information providers need before accepting a referral.
- Reinforce with all providers that they can access the OADS crisis team for consultation regarding challenging cases at any time

Conclusion

The group discussions on this topic have helped clarify the challenges that need to be addressed and the potential pathways the system can consider. The Department appreciates the opportunity to provide this update on the work. It looks forward to continued collaboration with stakeholders to improve access to services in the right place at the right time and minimize the languishing of patients in inappropriate settings.