Lawmaker calls DHHS response to federal audit ‘vague and unsatisfactory’

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By Noel K. Gallagher

The state’s effort to explain why a recent federal audit found it failed to review the abuse and deaths of people with developmental disabilities – and how it would prevent those shortcomings in the future – is “brief, vague and unsatisfactory,” a lawmaker said Wednesday.

Health and Human Services Commissioner Ricker Hamilton sent a 21-page response to the Health and Human Services Committee late Tuesday in an attempt to answer questions committee members had about the audit’s findings.

One of the questions is why the agency failed to investigate the deaths of 133 disabled adults who were receiving services. The federal Office of Inspector General report also concluded that Maine health officials failed to properly report critical incidents including sexual assault, suicidal acts and serious injuries over the 2½-year period under review.

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The committee’s questions included requesting more information about those deaths, whether the department has followed up on those deaths or issued any report, whether they conducted any internal reviews in response to the audit and whether any staff members were reassigned or disciplined because of the audit.

“I am not yet satisfied with the response of DHHS and will be working with Senator (Eric) Brakey and members of the HHS committee to continue our critical function of oversight,” said Rep. Patty Hymanson, D-York, the panel’s House chairwoman.

Read Ricker Hamilton’s letter to the committee.

“The answers lack critical information explicitly requested by members of the committee and most of the answers are brief, vague, and unsatisfactory,” she said Wednesday. “Other than vague mentions of rule evaluations and updates, DHHS declines to outline substantive corrective action, as requested. In many instances, the answers shift blame to other agencies and cite statutory obligations without mention of whether those obligations are adequately caring for this vulnerable population or are sufficiently responsive to the critical incidents that occurred.”

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Hymanson said the committee would determine its next steps in the coming weeks. Brakey, a Republican from Auburn who co-chairs the committee, did not respond to a request for comment Wednesday.

DHHS spokeswoman Emily Spencer said the department hoped the committee members would “take time to carefully review these replies.”

Read the HHS Committee's letter to Ricker Hamilton.

"This matter is of extreme importance to Acting Commissioner Hamilton, who has devoted his career to ensuring the health and well-being of our state's most vulnerable populations," Spencer said in an email. Hamilton met with Hymanson after the audit was released "to establish an open dialogue between DHHS and the HHS committee moving forward. … The commissioner had hoped for direct communication between the department and the committee, however, it seems that the media has served as the sole communicator of the committee's thoughts and comments on this topic. DHHS rejects any insinuation of a lack of dedication to the safety of those we serve."

Cullen Ryan, the parent of an adult son with autism, had seen a copy of the report and was hoping the department would have provided more detailed answers.

"I was looking for DHHS to reassure me as a parent that they will keep my son, and thousands of others like him, safe," said Ryan, who is chair of the Maine Developmental Services Oversight and Advisory Board, a governor-appointed board that provides independent oversight of DHHS-funded programs and services for adults with intellectual disabilities or autism. He is also a leader with Maine Coalition for Housing and Quality Services, a special needs advocacy group with about 4,000 parents and advocates.

"I expected DHHS to seize the (Office of Inspector General) report as a learning opportunity – and to take it very seriously with ownership and humility," Cullen said. "The responses left me wondering if the department has been humbled by this report."

Read the federal audit report.

The audit, released Aug. 10, found several critical problems with how Maine DHHS and, in some cases, service providers, carried out their responsibilities under federal law to protect and meet the needs of adults who receive Medicaid benefits for community-based services. The audit found that DHHS failed to:

• Properly monitor and hold accountable the community-based providers who care for adults with developmental disabilities.

• Investigate the deaths of 133 Mainers in the program. Law enforcement did not open investigations into any of those deaths. The auditors found that nine of the deaths were unexplained, suspicious or untimely, and that there was not enough information about another 32 deaths to determine whether they were unexplained, suspicious or untimely.

• Report potential abuse, neglect and exploitation cases to law enforcement.

• Provide reports of rights violations to the state contractor paid to investigate such allegations.

The department gave an initial response to the findings that was included in the audit itself and issued a statement when the audit was released, and the committee sought further clarification on those responses.

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In its earlier statement, the department said the audit report is accurate for the period it covers, but doesn't reflect current practices. The audit was based on a review of medical records and incident reports from January 2013 to June 2015 for 2,640 adult Medicaid beneficiaries with developmental disabilities.

The department also said it had changed some of its practices in light of the findings, and was in the process of amending and updating some rules for better reporting.

In the letter to the committee, the commissioner listed some of the changes that have taken place since the audit, including improving how critical incidents such as injury and abuse are reported and reviewed; meeting quarterly with provider agencies to review critical incident data; having Adult Protective Services review all deaths; creating a system to spot trends in injuries and critical incidents; and rewriting rules for reporting to “clarify areas of confusion for providers and the public.”

Hamilton also said the department added staff to Adult Protective Services and created a four-person financial abuse team – although the audit did not address any financial issues.

But the letter from the commissioner does not give the committee all the additional information it asked for, Hymanson said.

“In several of the responses, the department touted creating ‘efficiencies’ without taking responsibility, or providing explanation, for the individuals and programs that appear to fall through the cracks,” she said. “Most substantially, we need significantly more information about the corrective action plan, specifics about steps that have or will be taken, and how we will be able to measure improvements. It is my hope and expectation that the department will be a willing partner in this conversation.”

Maine Democrats also criticized the department’s response, and said both DHHS and former Commissioner Mary Mayhew, who is now running for governor, should provide more information. After the audit was released, Mayhew put out a statement blaming problems in the Office of Inspector General’s report on previous administrations, then refused to clarify her remarks.

“One hundred and thirty-three families in Maine have lost their loved ones because of DHHS and former Commissioner Mary Mayhew’s negligence. They deserve answers. DHHS has not responded adequately and appropriately to the committee’s very legitimate questions,” said Katie Mae Simpson, the executive director of the Maine Democratic Party. “Their response is so insultingly lacking of critical information that it makes clear DHHS is, at best, indifferent to these tragedies. At worst, they are entirely dismissive of the lives lost under their watch.”

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