The Maine
Long-Term Care
Ombudsman
Program

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August 20, 2014

Derrick Grant, Comprehensive Health Planner
MaineCare Services
11 State House Station
242 State Street
Augusta, Maine 04333-0011

Re: Comments on Proposed Section 19 Rules

Dear Mr. Grant:

The Long-Term Care Ombudsman Program is pleased to enter comments on the proposed rules for Section 19 of the MaineCare Benefits Manual. As advocates for long-term care consumers we are concerned with some of the rules.

Definitions

The Ombudsman Program suggests that "service need" be defined in this section. Service need is referenced throughout the rules, but what this encompasses should be defined clearly. This is especially important when looking at whether or not a member requires a new assessment. The need for a new assessment may be related to a change for example a loss of informal support or a change in a function such as the ability to feed oneself. These changes may result in an increased need for services, but these changes may not meet the definition of a significant change. The Ombudsman Program believes that including a clear definition of service need in the rules will be helpful in identifying when a member may require a new assessment.

Service Coordination Agency

Members should be offered their choice in Service Coordination Agency. It does not appear that the ability to choose a Service Coordination Agency and at what point this choice is made is included in these rules. The rules should define how this choice will be explained and at what point the member will make this selection of the Service Coordination Agency. The Ombudsman Program would like to see the Assessing Services Agency, at the time of the assessment, explain the options for Service Coordination Agency and allow the member to

choose. If the member would like additional information about their options, a referral can be made to the Ombudsman Program.

19.02 Eligibility for Care

19.02-3 Other Specific Requirements G

The Ombudsman Program is concerned that the requirement that a physician verify a permanent or chronic disability or functional impairment as an eligibility requirement is a barrier to some members accessing services. Members who use clinics or the Emergency Room for care may not have regular access to a physician who will be able to provide this verification which could leave them without needed services. The face to face assessment is done by nurses who use nursing judgment to assess for needed services. Requiring an additional verification by a physician could be an unnecessary barrier to some members in accessing services.

19.03 Duration of Care

19.03-4 Out of State Services

The Ombudsman Program supports allowing members to travel out of state while continuing to receive their personal care or attendant services. The Ombudsman Program questions why the rule is written in such a way that the member can only use fourteen (14) consecutive days at a time rather than the thirty (30) day allotted to them.

19.04 Covered Services

19.04-5 Care Coordination A. Responsibilities 13.a

The Ombudsman Program supports allowing the care coordinator to adjust frequency of services in order to address the needs of a member. We believe that allowing this adjustment will allow for the development of a comprehensive plan of care. The Ombudsman Program suggests that the "timeframe" during which the adjustments can be made be clearly defined.

19.04 Covered Services

19.04-2 Assistive Technology Device and Services

The Ombudsman Program welcomes the addition of assistive technology to these rules. The Ombudsman Program does not believe these services should be part of the member's personal care cap. In many cases, the technology will be an additional safety measure, but will not take the place of a need for personal care services. As the rule is proposed if a member accesses remote monitoring the cost will result in a reduction of personal care hours due to the cap.

Members should be able to access the assistive technology without affecting the amount of personal care they receive.

19.05 Non-Covered Services D

The Ombudsman Program does not support the denial of spouses as paid caregivers. Given the continued shortage of qualified direct care workers, members whose spouses are capable and willing to provide personal care services should be allowed to be the paid caregiver for the member. Federal rules do allow this under certain circumstances and the Ombudsman Program feels spouses should be allowed to be paid caregivers.

19.05 Non-Covered Services G

The Ombudsman Program questions the definition of an "unlicensed assisted housing setting" as there cannot be an unlicensed setting providing assisted housing services per Chapter 113 Regulations Governing the Licensing and Functioning of Assisted Housing Programs. Failing to define this term could result in services being denied to a member residing in an appropriate group setting.

19.06 Limits A

The Ombudsman Program questions why the proposed program cap appears to be lower than the current program cap. The current program cap is $4341 with $4151 for personal care services. The new cap of $4200 which will continue to include nursing and therapy services will now also include assistive technology and does not appear to be adequate to meet the needs of members with extensive needs. The Ombudsman Program questions why the cap appears to have been reduced. The Ombudsman Program strongly supports an increase in the program cap. While reimbursement rates have been increased in some other long-term care settings the cap for waiver services has not increased.

19.06 Limits I

The Ombudsman Program supports the provision that allows members to exceed the program cap up to eighty-six hours when needed. We are concerned however about the disparity between the attendant care services rate and the personal care services rate and if this will affect the ability of those members receiving services at the higher personal care services rate to access the eighty-six hours as needed.

19.07 General Eligibility Services

D. Redetermination of Eligibility 4

The Ombudsman Program strongly feels that a member who meets the requirements to have a significant change assessment should be allowed to have the assessment even when under appeal. A member can be at risk if they are required to withdraw an appeal that is maintaining services in order to have a new assessment. While waiting for a new assessment, the member may not have all their needs met, especially if there is a delay in scheduling a new assessment, which could put the member at risk of hospitalization or institutionalization. There is also added stress to the member and their family or other natural supports as they may have to provide more care than expected. The Ombudsman Program also suggests that "health and welfare" be defined.

19.08-46 Member Appeal

The Ombudsman Program would like to see the phone number to file appeals added to the rules. As stated the member or applicant has the right to appeal in writing or verbally, but the phone number is not provided in these rules.

Thank for you for your consideration.

Sincerely,

Pamela Marshall

Pamela Marshall
Ombudsman Program Manager