Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

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August 19, 2014

To: Senator Dawn Hill, Chair
Representative Margaret R. Rotundo, Chair
Members of the Joint Standing Committee on Appropriations and Financial Affairs

From: Mary C. Mayhew, Commissioner, Department of Health and Human Services

Re: DHHS responses to questions in preparation for the August 19th AFA interim meeting in which HHS Committee will be invited to.

MAINECARE NON-EMERGENCY TRANSPORTATION

Members were sent notifications in early July alerting them to the transition and the new brokers they needed to be in touch with for rides after 8/1. Call centers were operational on 7/18 for members to call the new brokers to schedule rides post 8/1. As part of the transition, CTS worked with each of the brokers selected to supply them with necessary data to transition trip information to the new brokers. They worked with each vendor to ensure they had what they were asked to supply.

CTS will be keeping their phone systems operational for 60 days for members who call their number instead of the new brokers. Members will be auto routed to the new brokers if they happen to call CTS.

We have continued to use the same performance metrics that were implemented on 8/1 with the beginning of the contract. Call center; speed to answer, abandoned rate, etc. Trip delivery; number of scheduled trips, number of missed trips, etc.

For further information on NET, please refer to **Attachment A**, which was also included in the packet provided to the Committee on August 7, 2014.

COST OF CARE

PL 2013 c. 594 requires the Department of Health and Human Services to collect a total of $13 million in SFY '15 in PNMI Cost of Care overpayment recoupment. The legislation authorizes an acceleration and modification of current payment terms as necessary to successfully collect the full recoupment. We are continuing to identify strategies to recoup the required funding without exerting undue fiscal strain on facilities.

NURSING FACILITY FUNDING

Through a multi-faceted effort to improve financial forecasting and utilizing management efforts including the emergency department collaborative, the implementation of health homes and behavioral health homes, MaineCare concluded State Fiscal Year `14 with a small balance. Based on the legislative directive within LD 1776 to rebase nursing facilities, to hold nursing facilities harmless based on their current rates, and to provide increased funding based on higher MaineCare utilization, the Legislature's appropriation fell significantly short of the total costs for funding these increases to nursing facilities.

Through the small carry forward balance from SFY `14, an additional $4.6 million in State funding was made available to increase the funding resources in SFY `15 for nursing facilities to meet this critical need for Maine's elderly.

MAINECARE EXPENDITURE FORECASTING

During 2012, for the first time, DHHS began forecasting MaineCare expenditures using the Holt Winters algorithm. The latter is a time-series algorithm that can recognize and capture three primary facets of datasets - the Y intercept, trend and seasonality. This means the algorithm can detect subtle changes in trend and seasonality while producing the most likely future costs. The MaineCare Financial Analysis Team runs the forecast twice per year and is able to forecast expenditures within one percent of overall MaineCare spending by forecasting 75 cost-drivers at an object code level to predict program outcomes.

Our forecast is supported by talented, experienced personnel from across the Department and represents a strong collaborative effort between the Financial Analysis Team, Office of MaineCare Services Data Analytics Group, licensing, eligibility, rates setting, audit and DAFS Service Center professionals. Socializing the forecast among a large group of individuals provides for a system of checks and balances with high visibility, transparency and accuracy.

Internal discussions supporting the forecast take place over several months. During those meetings, the MaineCare forecast team discusses year-over-year policy changes affecting MaineCare utilization, including planned changes to rates, audits, state laws, federal laws, MaineCare policy, eligibility changes and other changes that have an impact on the program. In addition, the team conducts formal analysis of national data and trends to identify drivers of differences between Maine data benchmarks and national averages. Variables affecting such discrepancies include national unemployment figures, demographic factors, census data information, changes in policy or payment method, CMS benchmarks, Kaiser Family Institute analysis of national data, effects of assumed Affordable Care Act expansion and other known events. This subjective step creates handshakes that either affirm our forecasted results or create questions that trigger further research.

The final steps in the forecast attribute costs on a month-by-month basis to state, federal and special funds. The forecast team uses a sample of AdvantageME actual costs as an allocation base to spread the forecast to the rest of the account string, absent consideration of fund (*i.e.*, state, federal or special funds). The forecast then attributes the resulting data set to the various funds using an FMAP crosswalk that codes the costs to the funds in a manner similar to that of the MIHMS claims matrix. By this point, the forecast has been populated to the entire accounting string, to each of the 52 cycles of the year and has been based on actual CMS-published FMAP rates.

MAINECARE PAYMENT CYCLE INITIATIVE

The Department has been working internally to assess the MaineCare Payment Cycle Initiative under the guidelines provided in PL 2013 Chapter 595. Due to the high number of exemption requests by providers, implementation that both reduces cycle payments by $20,000,000 and equitably exempts providers from lengthened payments will be extremely challenging to achieve. The Department will continue to assess and prepare for next steps related to this initiative and will provide a full report on further work by the deadline of September 30, 2014 as required PL 2013, Chapter 595, Sec. Q-1.

RIVERVIEW PSYCHIATRIC CENTER

The Department has submitted its application for certification and CMS has confirmed receipt of the application. As outlined in an email to the Committee sent on June 29, 2014, Riverview has successfully addressed all CMS conditions of participation related to patient and staff safety, patient rights and quality

of care. CMS identified only one condition that Riverview was unable to meet pertaining to treatment plans. Riverview has been focused on reforms to the documentation and structure of the treatment plans. It is important to note that the national accrediting body, the Joint Commission, recently conducted a comprehensive survey of Riverview and concluded that Riverview was in complete compliance with all accreditation requirements. The Joint Commission's standards mirror CMS requirements.

While there are always improvements to be made, the Department continues to disagree with the CMS decision to decertify the hospital last fall. We continue to pursue legal action to retroactively re-establish certification. No formal action has been taken by CMS to disallow DSH funding and we must continue to draw DSH to preserve our claim on the Federal funding. If DHHS ultimately loses all appeals, the State will be responsible to repay the amount of DSH drawn during the period of decertification. The timing of a formal decision and disallowance from CMS is unknown, but previous precedence would indicate that it could be multiple years before the issue would be resolved and the financial impact established. Maine's current exposure from the time of decertification to August 1, 2014 is $11 million.

For further information, please see **Attachment B**, Commissioner Mayhew's testimony from February 12, 2014.

LD 386: AN ACT TO REDUCE TOBACCO-RELATED ILLNESS AND LOWER THE HEALTH CARE COSTS IN MAINECARE (PL 2013 C. 444)

Implementation of LD 386 is currently underway. One of three rules related to this change has already been proposed and the other two rules are in process. All rules will be retroactive to 8/1/14. The system changes to facilitate billing and reimbursement are already in place. Like other Medicaid benefits, the Department is using federal match for all allowed changes related to these services. Providers will be made aware of all changes through the proposed rulemaking process, where they have ample opportunity for public comment. Most providers that could bill for these services are already enrolled and can bill through their normal billing practices utilizing the appropriate procedure codes. Providers must be qualified to render these services under their scope of practice. Pharmacists are not permitted to bill for these services, but the department is open to exploring what is allowed in their scope of practice.

TRANSFER OF VETERANS FROM MAINECARE TO VETERANS' HEALTH CARE SERVICES

Response: VA Pilot Project Summary

Under the General Assistance Pilot Program, two dedicated Department of Health and Human Services Veteran Advocates (DVA) are working exclusively with veterans and their dependents to identify and facilitate the coordination of military related benefits, with the objective of maximizing the benefits they can receive from the VA and, if possible, reduce the benefits they receive from Maine's public assistance programs (primarily MaineCare).

Beginning on September 4, 2012, the Department of Health and Human Services (DHHS), Office for Family Independence (OFI), started working with the Public Assistance Reporting Information System (PARIS) to identify and assist those veterans and their dependents who are receiving public assistance. PARIS is a computer data matching and information exchange system administered by the U.S. Administration for Children and Families to provide states with data matching resources to improve

program integrity in public assistance programs. Using the client's Social Security number (SSN) as the unique identifier, files are submitted quarterly to the Defense Manpower Data Center to match data against the Department of Veterans Affairs (VA), Department of Defense (DOD), Social Security

Administration and State Public Assistance Agencies. PARIS offers three matches:

- **Interstate Match:** matches SSN of public assistance clients that are submitted by participating states and matched with data from all other participating states to determine if participants are enrolled in two or more states.

- **Federal Match:** matches state data with information from DOD and the Office of Personnel Management to determine if clients are receiving income from any of these sources or are eligible for federal health coverage.

- **Veterans Match:** provides states with information on clients' eligibility for veterans' benefits and also allows states to confirm if their clients are receiving income and medical assistance payments from the VA.

Background

Washington State was the first state to launch a Benefit Enhancement Project. They are the pioneers of connecting veterans and their families to benefits they earned through their military service. Ten years in the making, Washington is credited with avoiding millions in state costs. The key ingredient is a cohesive partnership with the applicable state's Department of Veterans Affairs.

Modeled on Washington State's success, OFI has joined forces with the Department of Maine Veteran Services (MVS) to help veterans obtain benefits they may have earned and/or help them receive additional federal benefits. DHHS has signed a Memorandum of Understanding (MOU) with MVS along with the establishment of a solid referral system. Under the terms of the MOU, DHHS is responsible for administering PARIS with the federal government, matching results, and sending outreach referrals to MVS. MVS is responsible for making contact with eligible veterans to assist them through the process of attaining deeper military benefits. DHHS Veteran Advocates have familiarized themselves with specific characteristics in PARIS to help identify quality referrals that will result in new benefits or enhancement of benefits for veterans and their families. PARIS has proven to be an effective tool in many other states. It provides multiple purposes which can impact many different public assistance programs.

Time Frames

It is important to note that the project's success is largely at the mercy of the VA; specifically, the amount of time it takes for them to process claims. Exhibit 1 represents normal processing time for VA claims. However, there is currently a backlog of claims; veterans are experiencing longer delays than normal. Over the last three years, the Veterans Benefit Administration (VBA) claims backlog has grown from 180K to 594K claims as of December 31, 2012. Fortunately, a strategic plan has been implemented by the VA to eliminate the compensation claims backlog by FY 2015. The VBA goal is to eliminate the claims backlog and achieve a processing time of all claims within 125 days with 98% accuracy by December 31, 2015.

Exhibit 1: VA Processing Time

Type of Claims	VA Processing Time for Claims	
	low	*high*
New Application for Benefits	9 months	1 year
Reinstating Suspended Benefit	3 months	6 months
Reinstating Terminated Benefit	3 months	6 months
Adding Dependents to Benefit	6 months	1 year
Homeless Application	3 months	6 months
New Application for Health Assessment	1 month	3 months
CHAMPVA Application	6 weeks	6 months
Disability Rating Review	2 years	5 years
Appeals Process - Togas (Levels 1 & 2)	1 year	3 years
Appeals Process - Washington DC (Level 3)	3 years	5 years
Fiduciary Initial Appointment	6 months	1 year
Contracted Nursing Facility	Based on Individual's Health Condition and Availability of Beds	
Average Processing Time	**1 year**	**5 years**

Financial Results

Exhibit 2**:** VBA Benefits Granted

No. of Cases Granted	Monthly Benefit Award Granted	One-Time Lump Sum Awarded	Food Supplement Cost Avoidance	MaineCare Cost Avoidance
75	$77,418 (annualized: $929,016)	$237,330	$37,164	$489,924

Exhibit 3**:** VBA Projected Benefits to be Granted

No. of Cases Granted	Monthly Benefit Award Granted	One-Time Lump Sum Awarded	Food Supplement Cost Avoidance	MaineCare Cost Avoidance
55	$33,207 (annualized: $398,484)	$150,000	TBD	TBD

Terms of Exhibit 2 & 3[1]

No. of Cases Granted - All referrals sent to MVS or other community agencies that resulted in a monthly benefit award for the veteran or family.

[1] Exhibit 3 is a projection of benefits to be received by the veteran and/or family member once the claim is processed by the VA.

Monthly Benefit Award - Total number of referrals that resulted in a monthly benefit for the veteran and/or family. This number represents the combined monthly benefit received.

One-Time Lump Sum -All claims are subject to retroactive payment from the date a veteran files a claim. This number represents the combined retroactive payments received by the veterans and families.

Food Supplement & MaineCare Cost Avoidance- Cost avoidance gained as a result of the veteran and/or family member obtaining federal VA benefits.

Exhibit 4**:** MaineCare Long-Term Care (LTC) Savings

No. of Cases under VA Contract	Monthly Benefit	MaineCare LTC Savings
4	$9,505 (annualized: $114,060)	$400,000

Terms of Exhibit 4

No. of Cases converted to VA Contract- Veterans with a service-connected disability rating between 70-100% is eligible for the VA to pay all of their long-term care services. This number represents the total number of cases the project facilitated coordination of federal payment for long-term care services.

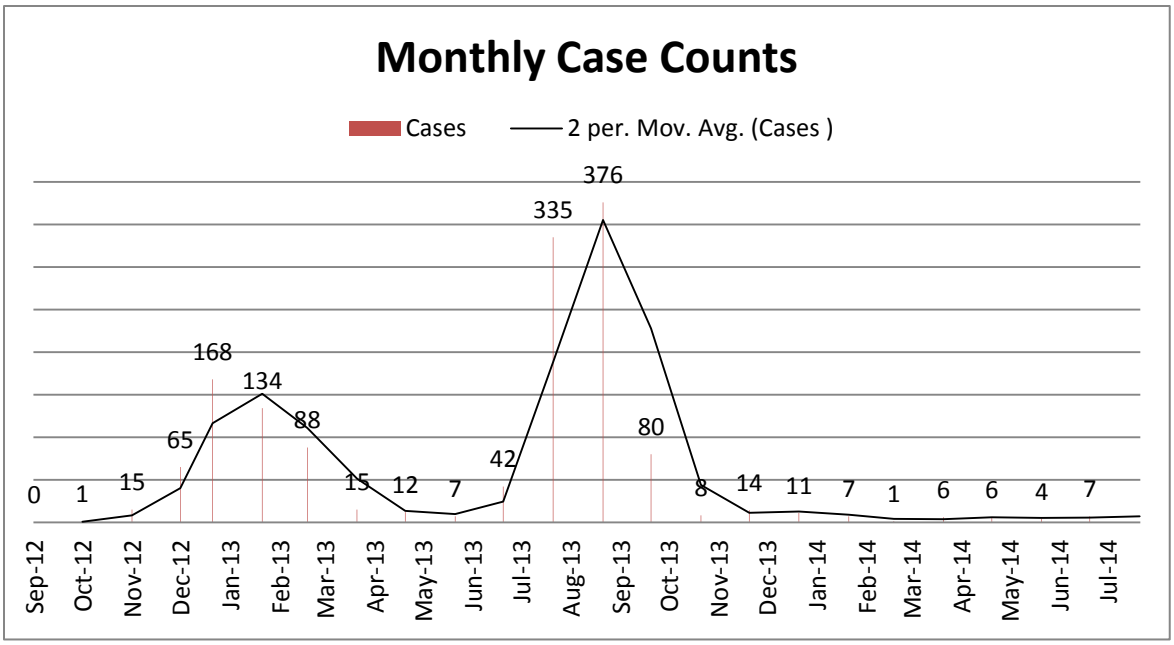
Monthly Benefit - MaineCare long-term care recipients are responsible for paying towards their cost of care for stays of a full calendar month. When the veteran enters into a VA contracted facility the veteran or family member no longer has to pay towards the cost of care; the VA pays for all of their long-term care services. This number represents the total monthly benefit the veteran is able to keep.

MaineCare LTC Savings - This number represents financial savings to the state as a result of the veteran moving off of MaineCare long-term care benefits and onto federal long-term care benefits. MaineCare benefits are closed once the veteran is contracted with the VA.

Exhibit 5**:** Veteran income not reported by Veterans and/or Family Members

No. of Cases Impacted	Food Supplement Cost Avoidance	MaineCare Cost Avoidance	TANF Cost Avoidance
1,323	$677,775	$4,372,769	$8,712

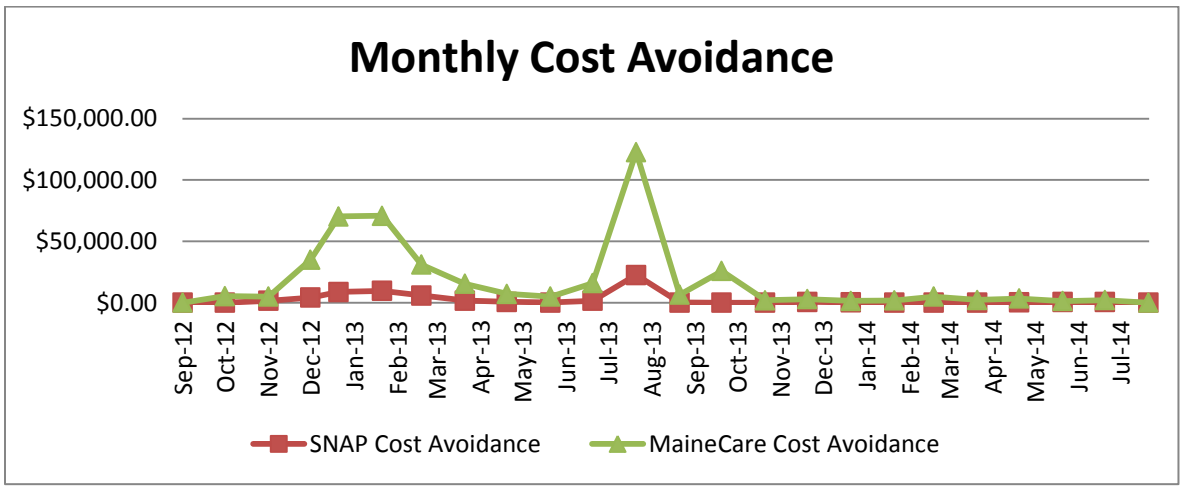
Exhibit 6: Monthly Case Counts



Terms of Exhibit 6

This exhibit displays the total number of cases identified for under reported VA income in concert with total number of monthly claims processed by the VA.

Exhibit 7: Monthly Cost Avoidance



Terms of Exhibit 7

This exhibit displays the total number of monthly cost avoidance for under reported VA income along with total number of monthly claims processed by the VA.

Feedback from Veterans and Family Members

"I am extremely grateful for all your help. Dad's placement wouldn't have happened without it. I have been spreading the word about this program."

"I am very thankful for the help received through DHHS. Six months ago I wouldn't have moved my husband into a VA contracted facility. I am thankful I did and now I can meet my needs financially. And the follow up letter received from DHHS after my husband's placement was lovely."

"Thank you both for all your help with reinstating Mom's VA benefits. Dad is smiling."

Conclusion

The program is off to a respectable start. We are laying the foundation for future savings. With scarce resources, DVAs are performing exceptionally well. They are building cohesive relationships with key players such as Maine Veteran Services, Disabled American Veterans, American Legion, Veterans of Foreign Wars and other agencies dedicated to helping our veteran population receive all the benefits they have earned. As we guide veterans to obtaining greater federal benefits, we are also shifting costs from state to federal funding.

Reviewing other states' best practices, it was noted by several states that savings cannot be estimated until the program is operational for at least one biennium. We will keep the Joint Committee informed as the pilot program moves forward, to facilitate the evaluation of the efficacy of a longer-term commitment to the initiative.

Cc: Kathleen Newman, Deputy Chief of Staff, Governor's Office
Holly Lusk, Senior Health Policy Advisor, Governor's Office
Carlisle McLean, Chief Legal Counsel, Governor's Office
Peter Steele, Director of Communications, Governor's Office
Richard W. Rosen, Acting Commissioner, Dept. of Administrative and Financial Services
Melissa Gott, State Budget Officer, Department of Administrative and Financial Services

NET Briefing Memo– August 4, 2014

Background

In November 2010, CMS informed the Department that Maine's Non-Emergency Transportation (NET) system was not compliant with federal requirements. At this time, the Department investigated options presented by CMS and determined that an at-risk brokerage model would be most advantageous. This model is where an agency serves as a broker of NET rides and contracts with transportation providers. The broker manages the ride delivery and receives a flat, or capitated rate that must cover all transportation costs.

After multiple discussions with stakeholders, DHHS opted for a regional system, utilizing the existing eight (8) Department of Transportation transit regions. Through the procurement process, the Department identified three brokers. Logisticare, LLC was awarded Region 8 (York County and Southern Oxford County), Penquis Community Action Program was awarded Region 3 (Penobscot and Piscataquis Counties), and Coordinated Transportation Solutions (CTS) was awarded the remaining six regions. Overall, eight contracts were negotiated and executed with these companies.

The Department's challenges with one broker since implementation of this new model on August 1, 2013 have been well-documented and the Department decided to not renew the contract with CTS and put services out to bid in the six regions that it served. In the spring of 2014, contracts were awarded to Logisticare in Regions 1, 2, 6 and 7, while Penquis CAP was chosen for Region 4 and Waldo CAP for Region 5.

In preparation for this transition, utilizing lessons learned, the Department undertook a thorough readiness review process which analyzed the providers' transportation provider networks, call center operations capacity, contract requirements (disaster recovery plans, payment and performance bonds), member communications, and IT systems, including insuring the ability of the broker to provide trips to major providers successfully. Also as part of this process, the Department had each broker provide a list of contracted transporters and their vehicle capacity to demonstrate their ability to handle anticipated trip demand. Some examples of areas the Department reviewed are outlined below.

- **System interoperability** –The ability to send all needed trip data to transportation providers in a format which can be imported by the provider, as well as the provider's ability to completely and successfully input trip data sent by broker.

- **Call Center capacity** – Number of calls offered, number of calls answered, average time a caller waits in the queue before reaching a live operator, the number of abandoned calls (where the caller disconnects before speaking to a live operator), the percentage of calls answered within 60 seconds, etc.

- **Network capacity** – Documentation of available vehicles to demonstrate enough capacity to deliver anticipated trip demand, e.g. number of vehicles available by provider type and the number of trips anticipated to be provided by provider type, etc.

- **Business capacity** – Overall operational functionality and data security measures.

Payment and Performance Bonds and Contract Values

As part of the contract terms, the new brokers were required to secure payment and performance bonds. On July 14, 2014, the Department received the bonds from Penquis CAP. Logisticare and Waldo CAP provided their bonds on July 15, 2014. This contract requirement has been fulfilled.

Contract Values

Region	Broker	Contract Value
1	LogistiCare	$ 3,400,669.32
2	LogistiCare	$ 3,160,613.40
3	Penquis CAP	$ 7,800,000.00
4	Penquis CAP	$ 6,441,415.56
5	MidCoast Connector / Waldo CAP	$ 3,980,355.12
6	LogistiCare	$ 7,242,737.04
7	LogistiCare	$ 8,983,057.32
8	LogistiCare	$ 6,858,728.28

The Non-Emergency Transportation program is responsible for delivering nearly 2 million rides annually to MaineCare members and the program relies heavily on volunteer drivers. During the past year, Coordinated Transportation Solutions' payments were adjusted to support and sustain the volunteer network over the six regions they served in order to ensure the delivery of the maximum number of rides to MaineCare clients.

When the Department made a decision to not renew the CTS contract based on performance, CTS had legitimate concerns about their current employees needing to pursue other employment options prior to the end of the CTS contractual relationship with Maine DHHS. In order to establish new brokers, the Department worked to ensure an effective transition between CTS and the new transportation brokers. Key to successful transition was the continued operation of the existing call center, so the Department took the necessary steps to ensure it was operational and continued to perform consistent with the needs of MaineCare members. As the transition continues, the Department will continue to put MaineCare recipients' transportation needs at the forefront of all decision-making.

Performance Metrics

The Department's most recent metrics (week ending 7/19/14) of the brokers' performance are attached to this update.

Current Status

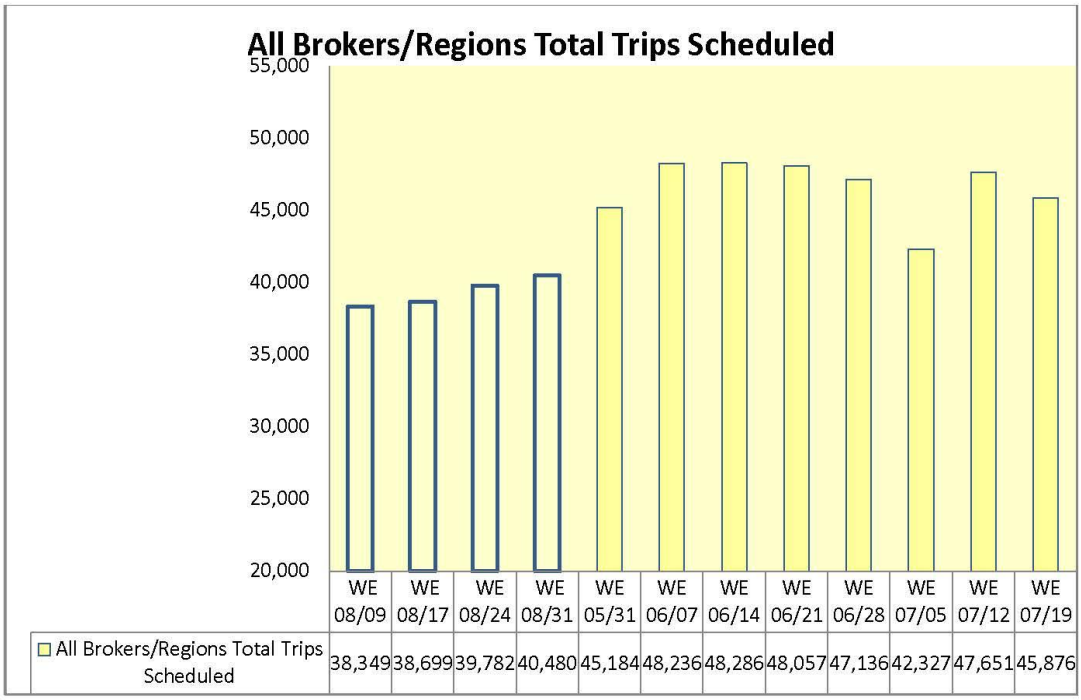
On July 25, 2014, the new call centers in these six regions became operational and staff began scheduling rides needed for services on or after August 1. CTS is continuing to provide transitional support for the next three months, while provided rides through the end of July. Their call center will remained operational through the end of July and they routed callers to the new brokers for their regions. MaineCare members have been well-informed regarding this change and how to have their transportation needs met. Providers have also received notice and information about this transition.

Following below is the contact information for each broker, based on the service area(s) they cover.

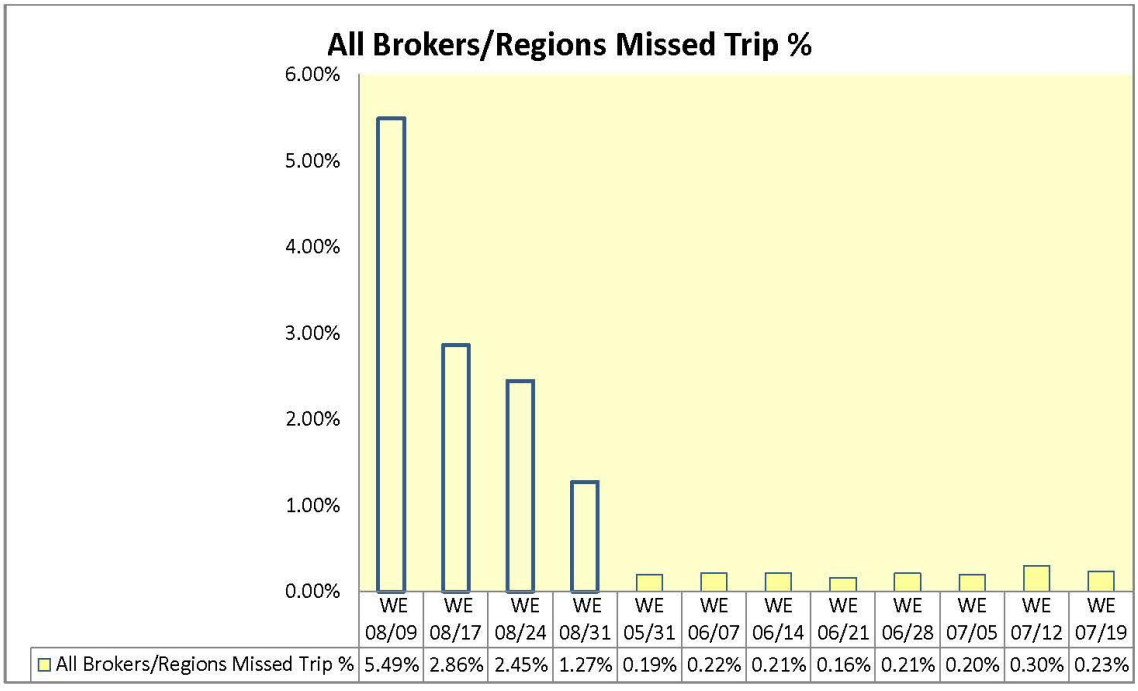
Non-Emergency Transportation Broker List

County/Towns	Broker
Androscoggin County – All Towns	Logisticare: 855-608-5180
Aroostook County – All Towns	Logisticare: 855-608-5174
Cumberland County – Brunswick and Harpswell	MidCoast Connector: 855-930-7900
Cumberland County – All Other Towns	Logisticare: 855-608-5178
Franklin County – All Towns	Logisticare: 855-608-5180
Hancock County – Town of Danforth	Logisticare: 855-608-5174
Hancock County – All Other Towns	Logisticare: 855-608-5176
Kennebec County – All Towns	Penquis CAP: 844-736-7847
Knox County – Town of Isle au Haut	Logisticare: 855-608-5176
Knox County – All Other Towns	MidCoast Connector: 855-930-7900
Lincoln County – All Towns	MidCoast Connector: 855-930-7900
Oxford County – Towns of Porter, Hiram, Brownfield, Denmark, Sweden, Fryeburg, Lovell, Stow, and Stoneham	Logisticare: 877-659-1302
Oxford County – All Other Towns	Logisticare: 855-608-5180
Penobscot County – Town of Patten	Logisticare.: 855-608-5174
Penobscot County - All other Towns	Penquis CAP: 855-437-5883
Piscataquis County – All Towns	Penquis CAP: 855-437-5883
Sagadahoc County – All Towns	MidCoast Connector: 855-930-7900
Somerset County- All Towns	Penquis CAP: 844-736-7847
Waldo County – All Towns	MidCoast Connector: 855-930-7900
Washington County – All Towns	Logisticare: 855-608-5176
York County- All Towns	Logisticare: 877-659-1302

MaineCare Non-Emergency Transportation: Broker Performance Metrics
Week ending 7/19/14

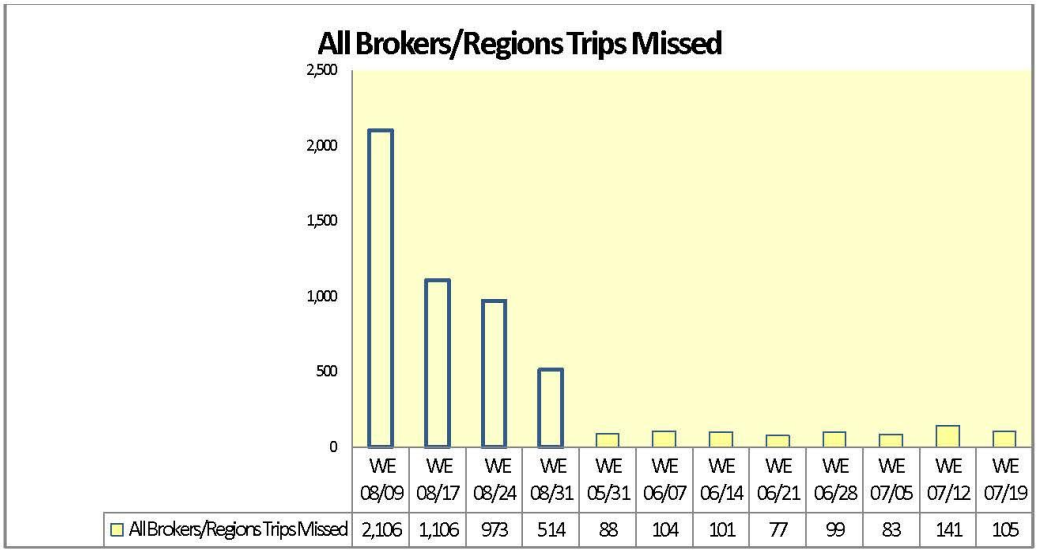


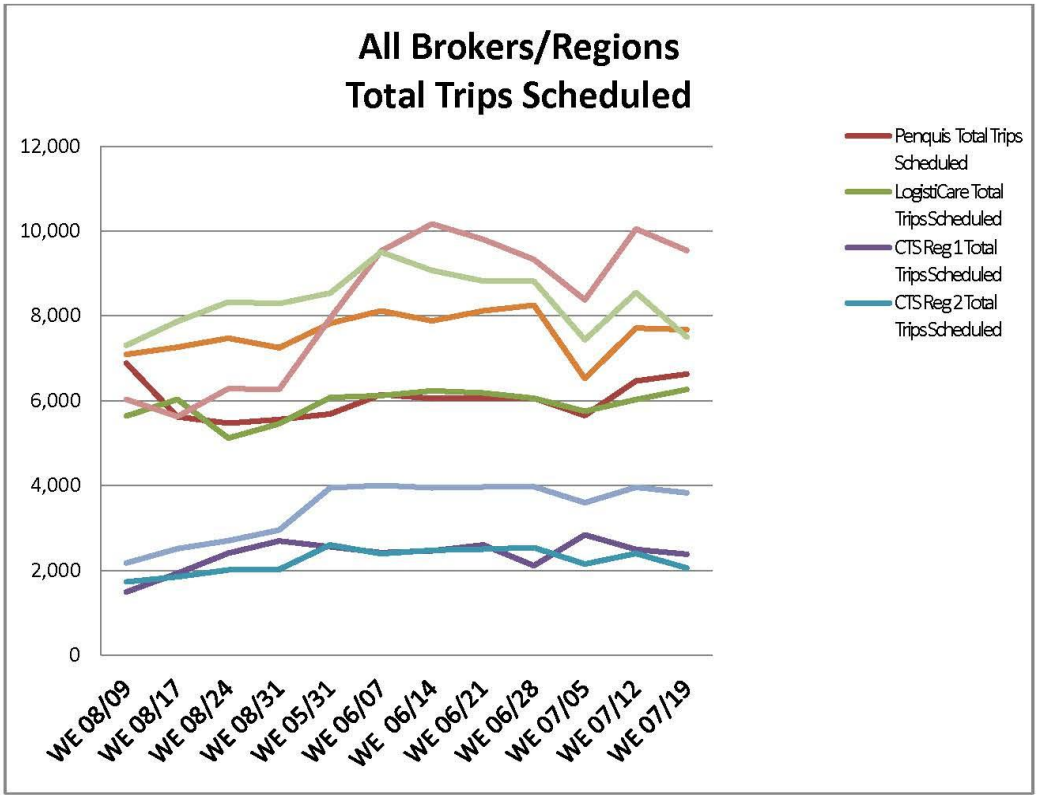
	WE 08/09	WE 08/17	WE 08/24	WE 08/31	WE 05/31	WE 06/07	WE 06/14	WE 06/21	WE 06/28	WE 07/05	WE 07/12	WE 07/19
All Brokers/Regions Total Trips Scheduled	38,349	38,699	39,782	40,480	45,184	48,236	48,286	48,057	47,136	42,327	47,651	45,876



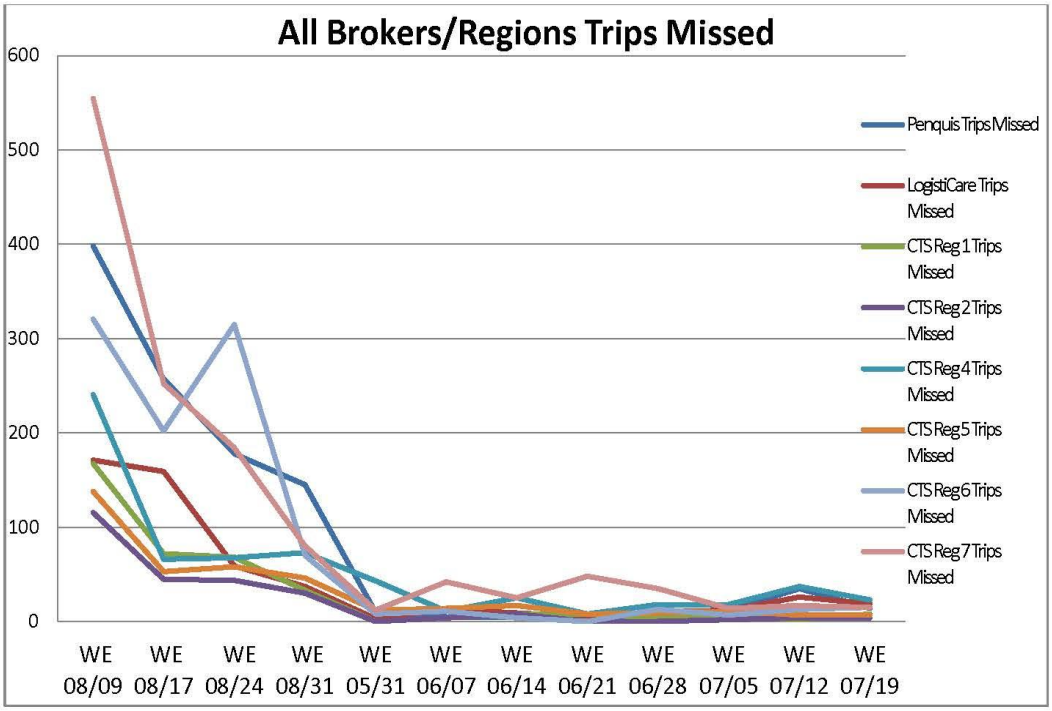
	WE 08/09	WE 08/17	WE 08/24	WE 08/31	WE 05/31	WE 06/07	WE 06/14	WE 06/21	WE 06/28	WE 07/05	WE 07/12	WE 07/19
All Brokers/Regions Missed Trip %	5.49%	2.86%	2.45%	1.27%	0.19%	0.22%	0.21%	0.16%	0.21%	0.20%	0.30%	0.23%

MaineCare Non-Emergency Transportation: Broker Performance Metrics
Week ending 7/19/14

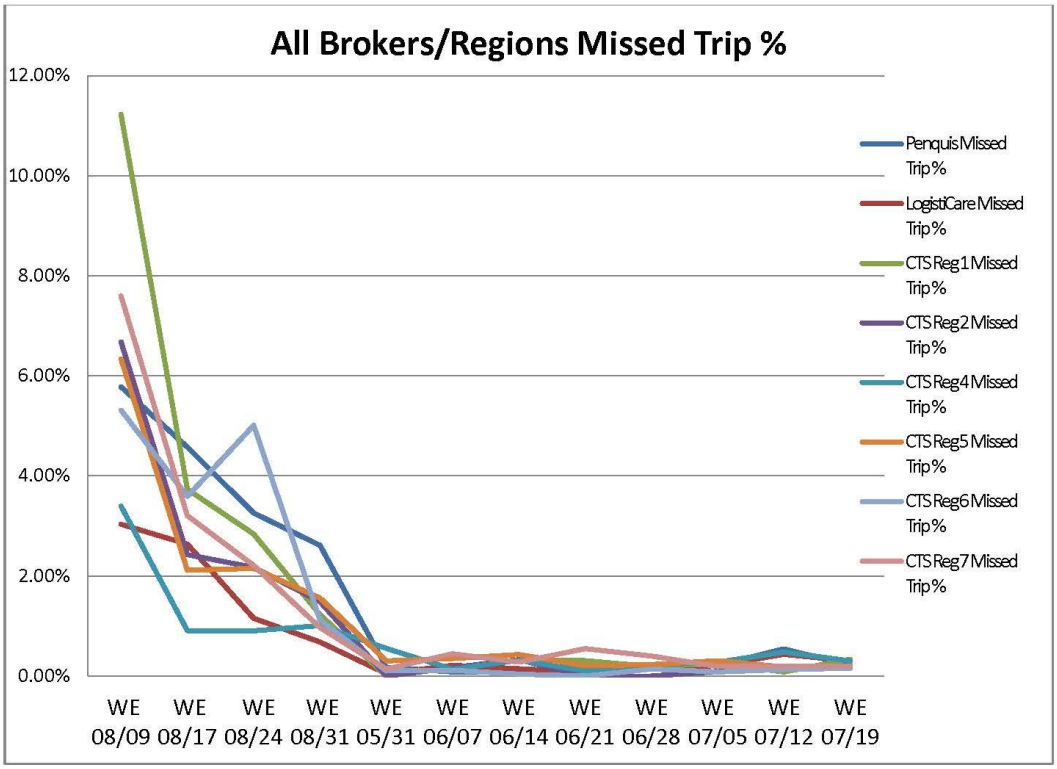




MaineCare Non-Emergency Transportation: Broker Performance Metrics
Week ending 7/19/14



MaineCare Non-Emergency Transportation: Broker Performance Metrics
Week ending 7/19/14



LogistiCare Solutions LLC
Brokerage Reporting Monthly Call Center Metrics

	Monthly Aug 2013	Monthly Sep 2013	Chg in Rpting Period	Monthly Sep 2013	Monthly Oct 2013	Chg in Rpting Period	Monthly Oct 2013	Monthly Nov 2013	Chg in Rpting Period	Monthly Nov 2013	Monthly Dec 2013	Chg in Rpting Period	Monthly Dec 2013	Monthly Jan 2014	Chg in Rpting Period	Monthly Jan 2014	Monthly Feb 2014	Chg in Rpting Period	Monthly Feb 2014	Monthly Mar 2014	Chg in Rpting Period
Total Calls Received	6669	5291	(1378)	5291	5439	148	5439	4550	(889)	4550	4992	442	4992	6115	1123	6115	6023	(92)	6023	5358	(665)
Abandonment Rate [≤5%]	3.9%	2.9%	(25.6%)	2.9%	2.3%	(20.7%)	2.3%	1.4%	(39.1%)	1.4%	1.9%	35.7%	1.9%	1.5%	(21.1%)	1.5%	1.8%	20.0%	1.8%	1.1%	(38.9%)
Avg Speed to Answer [ASA]	0:26	0:23	(11.5%)	0:23	0:16	(30.4%)	0:16	0:13	(18.8%)	0:13	0:12	(7.7%)	0:12	0:14	16.7%	0:14	0:15	7.1%	0:15	0:12	(20.0%)
Average Talk Time	5:50	4:46	(18.3%)	4:46	4:35	(3.8%)	4:35	4:23	(4.4%)	4:23	4:08	(5.7%)	4:08	4:57	19.8%	4:57	4:40	(5.7%)	4:40	4:58	6.4%
Service Level [≥90%]	90.0%	93.0%	3.3%	93.0%	97.0%	4.3%	97.0%	96.0%	(1.0%)	96.0%	98.0%	2.1%	98.0%	95.0%	(3.1%)	95.0%	96.0%	1.1%	96.0%	98.0%	2.1%

Continued from above

	Monthly Mar 2014	Monthly Apr 2014	Chg in Rpting Period	Monthly Apr 2014	Monthly May 2014	Chg in Rpting Period	Monthly May 2014	Monthly June 2014	Chg in Rpting Period
Total Calls Received	5358	5268	(90)	5268	4794	(474)	4794	4751	(43)
Abandonment Rate [≤5%]	1.1%	1.0%	(9.1%)	1.0%	1.5%	50.0%	1.5%	1.4%	(6.7%)
Avg Speed to Answer [ASA]	0:12	0:11	(8.3%)	0:11	0:13	18.2%	0:13	0:15	15.4%
Average Talk Time	4:58	4:13	(15.1%)	4:13	3:55	(7.1%)	3:55	4:01	2.6%
Service Level [≥90%]	98.0%	98.0%	0.0%	98.0%	97.0%	(1.0%)	97.0%	98.0%	1.0%

Call Center Measures
Requirement #4:
Abandonment Rate ≤ 5%
Requirement #5:
Service Level ≥ 90%
Compliant with Metrics
Non-Compliant with Metrics

Penquis Community Action Program
Brokerage Reporting Monthly Call Center Metrics

	Monthly Aug 2013	Monthly Sep 2013	Chg in Rpting Period	Monthly Sep 2013	Monthly Oct 2013	Chg in Rpting Period	Monthly Oct 2013	Monthly Nov 2013	Chg in Rpting Period	Monthly Nov 2013	Monthly Dec 2013	Chg in Rpting Period	Monthly Dec 2013	Monthly Jan 2014	Chg in Rpting Period	Monthly Jan 2013	Monthly Feb 2014	Chg in Rpting Period	Monthly Feb 2014	Monthly Mar 2014	Chg in Rpting Period
Total Calls Received	9414	8509	(905)	8509	9307	798	9307	8860	(447)	8860	9989	1129	9989	10650	661	10650	9154	(1496)	9154	10440	1286
Abandonment Rate [≤5%]	4.8%	3.2%	(33.3%)	3.2%	2.0%	(37.5%)	2.0%	2.3%	15.0%	2.3%	2.9%	26.1%	2.9%	4.8%	65.5%	4.8%	2.6%	(45.8%)	2.6%	3.0%	15.4%
Avg Speed to Answer [ASA]	0:43	0:33	(23.3%)	0:33	0:18	(45.5%)	0:18	0:21	16.7%	0:21	0:17	(19.0%)	0:17	0:16	(5.9%)	0:16	0:12	(25.0%)	0:12	0:12	0.0%
Average Talk Time	2:43	2:40	(1.8%)	2:40	2:45	3.1%	2:45	2:21	(14.5%)	2:21	2:04	(12.1%)	2:04	2:17	10.5%	2:17	2:08	(6.6%)	2:08	2:12	3.1%
Service Level [≥90%]	87.3%	90.8%	4.0%	90.8%	96.6%	6.4%	96.6%	95.3%	(1.3%)	95.3%	97.1%	1.9%	97.1%	98.0%	0.9%	98.0%	99.2%	1.2%	99.2%	98.5%	(0.7%)

Continued from above

	Monthly Mar 2014	Monthly Apr 2014	Chg in Rpting Period	Monthly Apr 2014	Monthly May 2014	Chg in Rpting Period	Monthly May 2014	Monthly June 2014	Chg in Rpting Period
Total Calls Received	10440	10753	313	10753	9721	(1032)	9721	9390	(331)
Abandonment Rate [≤5%]	3.0%	3.9%	30.0%	3.9%	2.5%	(35.9%)	2.5%	3.2%	28.0%
Avg Speed to Answer [ASA]	0:12	0:13	8.3%	0:13	0:10	(23.1%)	0:10	0:13	30.0%
Average Talk Time	2:12	2:21	6.8%	2:21	2:18	(2.1%)	2:18	2:35	12.3%
Service Level [≥90%]	98.5%	98.9%	0.4%	98.9%	99.4%	0.5%	99.4%	98.7%	(0.7%)

Call Center Measures
Requirement #4:
Abandonment Rate ≤ 5%
Requirement #5:
Service Level ≥ 90%
Compliant with Metrics
Non-Compliant with Metrics

CTS--All Regions
Brokerage Reporting Monthly Call Center Metrics

	Monthly Aug 2013	Monthly Sep 2013	Chg in Rpting Period	Monthly Sep 2013	Monthly Oct 2013	Chg in Rpting Period	Monthly Oct 2013	Monthly Nov 2013	Chg in Rpting Period	Monthly Nov 2013	Monthly Dec 2013	Chg in Rpting Period	Monthly Dec 2013	Monthly Jan 2014	Chg in Rpting Period	Monthly Jan 2014	Monthly Feb 2014	Chg in Rpting Period	Monthly Feb 2014	Monthly Mar 2014	Chg in Rpting Period
Total Calls Received	36,552	26,692	(9860)	26,692	25,642	(1050)	25,642	22,620	(3022)	22,620	23,769	1149	23,769	26,008	2239	26,008	22,005	(4003)	22,005	24,871	2866
Abandonment Rate [≤5%]	50.0%	18.0%	(64.0%)	18.0%	2.0%	(88.9%)	2.0%	5.0%	150.0%	5.0%	2.0%	(60.0%)	2.0%	4.0%	100.0%	4.0%	3.0%	(25.0%)	3.0%	2.0%	(33.3%)
Avg Speed to Answer [ASA]	15:10	3:32	(76.7%)	3:32	0:17	(92.0%)	0:17	0:35	105.9%	0:35	0:15	(57.1%)	0:15	0:28	86.7%	0:28	0:25	(10.7%)	0:25	0:16	(36.0%)
Average Talk Time	8:43	6:53	(21.0%)	6:53	5:47	(16.0%)	5:47	5:46	(0.3%)	5:46	5:47	0.3%	5:47	6:09	6.3%	6:09	6:10	0.3%	6:10	6:21	3.0%
Service Level [≥90%]	12.0%	58.0%	383.3%	58.0%	90.0%	55.2%	90.0%	83.0%	(7.8%)	83.0%	92.0%	10.8%	92.0%	86.0%	(6.5%)	86.0%	92.0%	7.0%	92.0%	93.0%	1.1%

Continued from above

	Monthly Mar 2014	Monthly Apr 2014	Chg in Rpting Period	Monthly Apr 2014	Monthly May 2014	Chg in Rpting Period	Monthly May 2014	Monthly June 2014	Chg in Rpting Period
Total Calls Received	24,871	25,334	463	25,334	23,072	(2262)	23,072	23,132	60
Abandonment Rate [≤5%]	2.0%	4.0%	100.0%	4.0%	5.0%	25.0%	5.0%	5.0%	0.0%
Avg Speed to Answer [ASA]	0:16	0:33	106.3%	0:33	0:41	24.2%	0:41	0:42	2.4%
Average Talk Time	6:21	6:41	5.2%	6:41	6:38	(0.7%)	6:38	6:39	0.3%
Service Level [≥90%]	93.0%	86.0%	(7.5%)	86.0%	80.0%	(7.0%)	80.0%	78.0%	(2.5%)

Call Center Measures
Requirement #4:
Abandonment Rate ≤ 5%
Requirement #5:
Service Level ≥ 90%
Compliant with Metrics
Non-Compliant with Metrics

Testimony of
Department of Health and Human Services
Mary C. Mayhew, Commissioner

Before the Joint Standing Committee on Appropriations and Financial Affairs

Department of Health and Human Services Finances

February 12, 2014

Good Afternoon Senator Hill, Representative Rotundo, and members of the Joint Standing Committees on Appropriations and Financial Affairs, I am Mary Mayhew, Commissioner of the Maine Department of Health and Human Services and I am here today to present information regarding the status of the Department of Health and Human Services' budget.

I want to first address issues pertaining to Riverview Psychiatric Center. I addressed several of these issues when I last presented to this Committee in late January and similar information has been shared with the Health and Human Services Committee.

Since September, when CMS decertified Riverview Psychiatric Center, the Department has been focused on corrective action to bring RPC back into full certification standing. One of the issues related to certification is whether or not the Department can utilize federal Disproportionate Share Hospital (DSH) and Institution for Mental Disease (IMD) Payments to fund RPC as it did prior to RPC being decertified.

The Department believes that since Riverview is defined under federal statute as an Institution for Mental Disease (IMD) which pertains to any entity that has 16 or more beds and is primarily providing treatment for individuals with mental illness, that the hospital Medicare and Medicaid certification with Medicare should not affect our ability to continue to claim federal DSH dollars. In the Congressional Research Service Report that was provided to this Committee, I'm sure you noted that in the table pertaining to current DSH funding for the states, Maine's DSH funding is listed entirely under the IMD category. Again, IMDs are not necessarily hospitals nor do they need to be certified as a hospital as participating in the Medicare program. Riverview and Dorothea Dix are both IMDs. The DSH allocation funding for the states is divided between the overall cap DSH allocation and then further limits the amount within this cap that can be expended on IMDs. Maine does not claim any of the hospital DSH funding, those funds were committed in early 2001 to cover the costs associated with the childless adult waiver. Maine has drawn the DSH IMD funds subject to the IMD cap. As such we firmly believe that CMS is incorrect in their initial communication to the Department regarding the DSH funding request we recently submitted. The Department is consulting with the Attorney General's office and outside legal counsel to further verify this opinion. If CMS ultimately disagrees with this opinion, there is the potential for a future finding that requires the Department to reimburse CMS for the use of DSH dollars. This would be based on CMS retroactively disallowing the use of DSH while Riverview is decertified as a hospital. This is a formal process involving the disallowance of claims that would then be appealed by the state.

The Department projects to use a total of $17.32 million in DSH funds in SFY '14.

- RPC used $2.3 million between the beginning of the fiscal year, July 1, and decertification in September
- From September 2, through December 31 of 2013, RPC drew and utilized $6.35 million in federal DSH funds
- From January 1, 2014 through the end of the fiscal year, the Department projects RPC will utilize an additional $8.69 million in DSH funds

The $2.3 million was used while RPC was certified, and those funds are not at question. The $6.35 million was utilized during the period of decertification. If CMS chose to disallow this amount, the Department would contest that decision, based on the opinion expressed above. However, if this amount was ultimately disallowed, general funds would be needed to replace that amount. The timing of this potential formal disallowance is unknown. Previous precedence would indicate that it could be multiple years before this impact would be verified and quantified and the appeal resolved.

Finally, the $8.69 million needed for January 1 through June 30, 2014, will follow a similar path. The Department believes we can utilize DSH for RPC despite the decertification period. However, if CMS ultimately disallows the draw and expenditures, general fund would be needed for this amount.

If you agree with the Department's position related to DSH, we will further reduce the general fund request for Riverview by approximately $400,000 and submit the revised initiatives to you.

DSH Funding Related to Census Mix
AFA REFERENCE #: F-A-7240 FY15 DSH $(2,296,811) GF $2,296,811

Disproportionate Share (DSH) funding is available up to the level of uncompensated care at a DSH eligible IMD subject to the overall state IMD cap. Riverview and Dorothea Dix calculate their level of uncompensated care based on the bed days of uncompensated classifications.

Uncompensated classifications include those determined to meet charity care definitions, those eligible for Medicaid and those eligible for Medicare when their stay is not covered by Medicare. Effective July 1, 2012, the uncompensated care does not include bed days for jail transfers, those committed for competency evaluations (In-patient evaluations) and those committed for competency restorations (IST).

Initiatives to Address Certification
Contracted Psychiatrist
AFA REFERENCE #: F-A-7235 FY14

This initiative adds a psychiatrist at the Riverview Psychiatric Center through the existing Dartmouth Healthcare contract to assist with the increased forensic population and the higher acuity levels of those forensic clients. This Doctor would be assigned to a specific unit and would be needed to testify in court. The additional clinical capacity is required to ensure the health and safety of the patients.

Increasing regulatory requirements related to the roles and responsibilities of the Clinical Director diminish the capacity to take on the increased caseload, as well as fulfilling the responsibilities of the Clinical Director. The increase in forensics requires a high level of clinical expertise and leadership to provide consistent multi-disciplinary care to facilitate thorough and safe patient evaluation, treatment and discharge planning. The psychiatrists' role as the primary provider has resulted in patient health and safety as quality care needs to be provided according to evidence-based practice. Stability of the highly acute patients is achieved more quickly because the psychiatrists are unifying members of the treatment team ensuring that treatment plans are followed.

Contracted Nurses
AFA REFERENCE #: F-A-7236

Riverview has experienced a shortage of nursing staff to cover all shifts. This initiative will fund contracted nurses to provide needed coverage for patient health and safety until the hospital can fill vacant positions.

Dartmouth Consulting Contract
AFA REFERENCE #: F-A-7222

This funding will support Riverview by consultant services of Dartmouth Medical School (DMS) for quality improvement, evidenced base practice and case consultation. DMS is the leader in the field of psychiatric management. Services include:

1. Access to internal medicine and psychiatry grand rounds;
2. Access to DMS expertise in
   a) Quality Improvement,
   b) Evidenced- base practice and research in serious and persistent mental illness,
   c) Shared Decision-making (Recovery-oriented care);
3. Access to Dartmouth specialists for telephone consultation;
4. Visits 6 times per year from a different Dartmouth expert for case consultation;
5. Serve as the Internal Review Board (IRB) for research related to human subjects; and,
6. Access to the Dartmouth medical library

Dartmouth Consulting Contract
AFA REFERENCE #: F-A-7216

This request provides funding to contract for a Director of Psychology. The previous two directors had very short tenures (the most recent barely 6 months). Exit interviews with the hospital Medical Director indicate that the salary of the state position was not competitive within the community. A management review confirmed that the salary structure for the Director was not commensurate with the level of complexity and responsibility. Additionally when we advertised the most recent vacancy we received only one applicant found to be unsuitable for the state line Psychologist IV. To continue to provide quality services, we need the position filled. The most viable solution is to identify and recruit suitable candidates through a contract.

MOU with the Department of Public Safety
AFA REFERENCE #: F-A-7221

The state Department of Public Safety will provide 24/7 law enforcement on the RPC campus through the Capitol Police. The MOU allows for 4 officers and one sergeant supervisor and is in place of the Correction Officers currently on the Lower Saco Unit. The duties of the officer is to ensure that the laws regarding hospital contraband are enforced; to assist with campus issues regarding hospital property and grounds ensuring that it is a safe environment for staff, clients, and visitors; to investigate any criminal activity that occurs in the hospital or on the campus; to assist staff in any event that typically requires a call to 911; and, to participate in Joint Commission-required hospital disaster drills and staff training regarding potential disaster or emergency situations. The presence on the campus allows for a quicker response time in emergencies and provides for consistency to follow up in criminal investigations.

Retrofit facility to accommodate forensic population
AFA REFERENCE #: F-A-7218

The number of forensic clients continues to rise and the overflow has gone beyond the 44 beds previously designated for the forensic population. The special management/care unit (SCU) has some extreme acuity level clients, which require the additional staffing and resources for safety and security reasons. Retro fitting of the Lower Saco Unit would require a study, the design, and then construction. Maintaining clients in an acute care psychiatric hospital bed is costly, but the consequences of no action in this regard have far higher costs.

Interpreter Services
AFA REFERENCE #: F-A-7239

The State of Maine Department of Health and Human Services entitles clients to free interpreters. Joint Commission and CMS require that hospitals provide interpretive services to all clients while hospitalized. This would include American Sign Language as well as language interpretation. The average length of stay for civil clients is around 60 days and for forensic clients much longer. As a result, one client requiring these services is extremely costly as interpreters have to be present during any significant treatment event, treatment team meetings, discussion with treatment team members, during group and individual therapy, as well as to allow the client time to interact with peers.

Legal Contract
AFA REFERENCE #: F-A-7238

There is no current statute that allows hospitals to medicate clients who are not criminally responsible (NCR) against their will, unless they pose a danger to themselves or others and then the timeframe is limited to seventy-two hours. This restriction contributes to a protracted length of hospitalization. There is a provision in the rights of recipients that allows for an administrative mediation hearing. Clients have the right to legal representation as part of this hearing process. After consultation with the State of Maine's Attorney General's Office,

Riverview was advised to negotiate a contract with Pine Tree Legal to provide Riverview clients assistance in medication hearings. This request is for 100% General Funds on an ongoing basis.

(1) FTE Psychologist III
AFA REFERENCE #: F-A-7219

This initiative establishes one Psychologist III position related to professional service work in psychological assessment and psychotherapy. Responsibilities include conducting psychological assessments and psychotherapy program to analyze and change the functioning and behavior of institutional and clinical patients; providing in-service training to staff and interns; and conducting psychological research. This class is differentiated from the lower levels of the psychologist series in that it is licensed to perform psychotherapy on patients. Work is performed under limited supervision.

Repairs to comply with JC and CMS safety
AFA REFERENCE #: F-A-7237

Riverview Psychiatric Center is certified by the Joint Commission that provides scheduled reviews of the hospital facility. During the last visit in Fall 2013, the Joint Commission noted several facility citations for safety and security. Environment of Care standards for hospitals are constantly changing based on sentinel events that occur. The hospital design ten years ago was best practice at the time, but it is not in some areas now. As a result of changing standards, funds are needed to ensure that the hospital maintains a safe environment for staff, clients, and visitors that is in compliance with regulatory standards. These funds will allow for changes, updates, and upgrades to address the survey results. One example is a sink fixture which--compliant when installed--is now considered a safety risk to clients who can wrap items around the fixture with the intent of causing bodily harm.
The costs associated with providing services to the increasing forensic population are not allowable for reimbursement by the OSR sources while at the same time the cost of providing services to a forensic patient is higher than the costs of services for a civil patient.

Nurse Parity stipends
AFA REFERENCE #: F-A-7244

DDPC and RPC continue to struggle with recruitment and retention of its nursing staff. This has resulted in shortages of staff, mandated overtime and the ongoing need for contracted nursing services. This stipend will assist in recruitment and retention of nursing staff. A nursing salary review was prepared by Dix consulting issued August 8, 2013 showing a need for this stipend to increase competiveness with other entities recruiting the same staff.

Specialized Training
AFA REFERENCE #: F-A-7223

This initiative would provide the necessary funds to provide staff of Riverview Psychiatric Center with the opportunity to gain, develop, and renew skills, knowledge and abilities to provide state of the art consumer-centered inpatient psychiatric care to patients/clients with

serious mental illness for compliance with constitutional, statutory, and regulatory standards. In addition this initiative will allow for Riverview Psychiatric Center to conduct staff training and education that includes existing clinical staff and expert trainers which focuses on issues and topics of special needs and interest such as: working with clients who have especially challenging or complex needs, reducing seclusion and restraint practices, understanding the nature of mental illness, the impact of trauma and evidence-based practices.

As we reported previously, we are reducing the projected MaineCare shortfall by $30 million over the two-year biennial budget for SFYs '14 and '15. We have re-run the forecast based on the 6 months of actuals for SFY '14. DHHS has produced a forecasting tool that is grounded in the State's accounting system. This tool utilizes the functional classes of MaineCare program costs. The cost history used includes SFY 2006 – SFY 2014 and was analyzed for outliers. The resulting dataset was then processed through the Holt Winters forecasting algorithm to produce future data points that minimize the total variance present across the entire dataset. This helps reduce human subjectivity while producing objective data driven estimates. This most recent forecast that is the basis for this revision is now updated to reflect 6 months of actuals in SFY 14.

We are reducing the GF shortfall projected for the remainder of SFY '14 by $7.2 million from $52.4 million to $45.2 million. The GF budget for SFY '14 is $726 million and we are projecting a need of $772 million. This reflects an increase in total spending of .8% as compared to a national average healthcare growth of 4% projected average growth national in the next 10 years of 5.8% and a projected average national Medicaid growth in the next 10 years of 8.1%

We are reducing the projected general fund shortfall for SFY '15 by $22.8 million from $55.5 million to $32.7 million. We are projecting a GF need of $773 million; the current legislatively authorized budget for SFY '15 is $740.2 million. This reflects a 1% increase in total spending for the state's Medicaid program as compared to national average healthcare growth of 4% and projected Medicaid growth in the next 10 years of 8.1%

These GF requests are based on projected total expenditures of $2.54 billion in SFY '14 and $2.57 billion in SFY'15 a total spending increase in all funds of less than $$22 million from SFY '13 to '14 and approximately $27 million from "14 to '15. This reflects a projected .8% increase in spending over '13 and 1.07% increase from '14 to '15. National health care spending is projected to increase on average of 5.7% and Medicaid is projected to increase on average of 7%. Had Maine experienced a similar growth trend we would be requesting significantly more to support the budget.

The Medicaid program is an entitlement program and outside of our waivers there are no caps on overall program spending or on individual spending making predicting and controlling spending growth a challenge. Estimates and forecasts are just that. This is a healthcare entitlement program. There are limited levers to control spending.

Even with those challenges in managing a healthcare entitlement program, we have seen significant success. The Department projects that we will realize more than $22 million in state general fund savings in SFY '14 and more than $38 million in projected savings (reduced spending against the projected increase) in SFY '15. Many of these initiatives reflect that

incredible work and commitment of staff throughout the Department to advance of our efforts to improve the health status of MaineCare members through improved coordination of care delivery, reduction of inappropriate utilization of health care services and increased focus on high cost utilizers. We have seen significant results from the work that occurred through our care management efforts in the Office of MaineCare services in working with high utilizers of emergency department services in collaboration with hospitals and other community providers – again focused on a patient-centered approach to evaluating opportunities to reduce personal barriers to primary care and improved care coordination. Since the inception of the program we have managed more than 1700 members. We had one member with 141 ED visits in 12 months. We are now turning our attentions to high utilizers of inpatient services again with the focus on a patient-centered approach to better understand what is driving avoidable hospital admissions and the opportunity to build on the establishment of our health homes and community care teams.

Today we have over 150 primary care practices and 10 Community Care Teams in Health Homes Initiative. 75 of these practices receive support from other payers as part of Maine's multi-payer Patient Centered Medical Home (PCMH) Pilot.

The PCMH and Health Home models provide support to practices for activities such as care coordination, intensive care management and patient and family support that a fee for service system does not otherwise support. All patients enjoy enhanced access to their practice through after-hours care, flexibility in scheduling appointments and improved coordination through the use of Electronic Health Records. Patients with chronic conditions and other high needs receive intensive supports from the practice and Community Care Team to manage their illness and address other social factors that have a large negative impact on their health.

In April, the Department will be implementing its Behavioral Health Homes initiative, which partners the Health Home practices with community mental health organizations in order to serve members with Serious Mental Illness.

Through the MaineCare Accountable Communities Initiative, the Department will engage in shared savings arrangements with provider organizations that commit to coordinating the care of all patients who rely on those organizations as their point of access to healthcare services. Accountable Communities that demonstrate cost savings and meet quality performance benchmarks will share in savings generated under the model.

Six Accountable Communities have applied to participate in the first round of the initiative. The Department is working on rulemaking with the Attorney General's Office with the target implementation date of May 1, 2014. An estimated 50,000 members will be attributed through these Accountable Communities in 2014. An additional 25,000 members, while not directly attributed, receive some of their care through these Accountable Communities and will also benefit from improved systems of care coordination. In whole, almost 30% of the MaineCare population will benefit from the Accountable Communities Initiative in this first round.

Accountable Communities will result in such improvements as:

- reductions in inpatient readmissions
- less non-emergent Emergency Department use

- more effective use of Electronic Medical Records and real-time data through Maine's Health Information Exchange,
- increased investment in care management for members with chronic conditions, and
- more emphasis on preventive care.

We have developed and implemented the supports intensity scale in the Office of Aging and Disability Services to more appropriately align resources based on the needs of the consumer to ensure the greatest level of independence. Additionally we are implementing a single assessing agency regarding the development of person-centered plans. We are continuing to evaluate the development of a PACE model and evaluate other initiatives to support access to lower cost community-based services to reduce or delay the need for 24/7 residential or nursing facility services.

Through an Administrative Services Organization to utilize appropriate clinical oversight and prior-authorization for clinical services for children and adults related to behavioral and developmental services.

We are committed to continuing our efforts to reforming the healthcare delivery system to efficiently provide the right level of care in the right location that produces the best patient outcome at the right cost. We are projecting an increase in spending of .8% for this year over last and a little more than 1% increase for SFY '15. This has occurred at a time when we are also trying to ensure that the true costs of the program are accounted for by ensuring that providers' bills are paid and that providers are paid accurately and timely.

Thank you for your time. I am happy to answer any questions.