Attachment D

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Department of Health and Human Services
Commissioner's Office
221 State Street
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August 2, 2013

Senator Rebecca J. Millett, Chair
Representative W. Bruce MacDonald, Chair
Members, Joint Standing Committee on Education and Cultural Affairs
#100 State House Station
Augusta, ME 04333-0100

Dear Senator Millett, Representative MacDonald, and members of the Joint Standing Committee on Education and Cultural Affairs:

I understand that there has been a recent request to brief your Committee regarding school-based services and recent audits that have been performed by DHHS at the direction of the Office of Program Evaluation and Government Accountability (OPEGA) and the Office of Inspector General (OIG). At this point in time, we cannot discuss the specific details of the audits. Some of the audits are ongoing, and for the audits that are complete, schools have the opportunity to appeal.

This letter is to help provide you with a level of understanding of the history of school-based audits and the process. When final decisions have been made on all appeals, I would be happy to brief the Committee on the results.

Background

In 2010, the Centers for Medicare and Medicaid Services (CMS) began an assessment of the Medicaid services provided in school systems. During this assessment, it was discovered that many of the services provided were primarily educational in nature and did not fit the definition of medical necessity as required by CMS. Also, many of these services were being delivered by staff that did not hold the required credentials.

At this time, MaineCare began to address the issue by changing policy to ensure that all Medicaid funding was aligned with Federal regulations, with the hope of avoiding future audit findings from the Federal government. In order to resolve these new challenges, DHHS and the Department of Education (DOE) began collaborating to facilitate open communications with Maine's public schools, Special Purpose Private Schools (SPPS), Child Development Services (CDS) site providers and contracted providers. The collaborative work between Departments encouraged positive progress toward smoother administration and policy redesign of school-based services.

Despite this progress, DHHS still had a responsibility to further ensure that all claims paid were appropriate and allowable. OPEGA directed DHHS to conduct a review of CDS. They noted in the final report that greater coordination was needed between DHHS, CDS and DOE to ensure that MaineCare dollars were spent appropriately. OPEGA specifically noted on pages 58 and 59 of its report that:

> *"DHHS' Program Integrity Unit, in conjunction with MDOE, should analyze MaineCare claims paid for services provided to children in the CDS program to determine whether there are indicators of fraud, abuse or error associated with the risks OPEGA identified. OPEGA will share with DHHS and MDOE our suggestions for specific analysis and tests that we believe would be worthwhile. The Program Integrity Unit should then follow up with an investigation of any potential fraud or abuse identified.*
>
> *Additionally, we recommend that the DHHS Internal Audit group assess the effectiveness of the preauthorization process conducted by the Office of MaineCare Services with regard to Section 28 providers and services associated with children in the CDS program. We believe this assessment would be worthwhile to guard against the possibility that federal funds are being used for services that might ultimately be viewed as ineligible by federal CMS and, therefore, have to be repaid in the future."*

In addition, the OIG recently reviewed the Portland school system to determine if payments to schools from the Medicaid program were appropriate and allowable. In their findings, they noted that:

> *"Of the 120 student months in our random sample, 56 had services, totaling $24,793 ($15,966 Federal share), that were not adequately supported, were provided by unqualified providers, or both. Based on our sample results, we estimated that the State agency improperly claimed $1,039,046 ($667,569 Federal share) for Medicaid payments made to the Portland School Department."*

The OIG further claimed that the inappropriate billing was a result of inadequate claims monitoring by DHHS. They recommended that the Department "strengthen its oversight of the Maine Medicaid school-based health services program to ensure that claims for school-based health services comply with Federal and State requirements."

Based on the recommendations from State and Federal oversight agencies, and out of a desire to ensure that DHHS maintain adequate program integrity measures, the Office of Program Integrity began individual audits of school billing practices throughout Maine several months ago. "Ex Parte Communication" laws prevent the DHHS from participating in detailed discussion of these audits in either a public or private format. Out of concern for due process for

cases that are actively under appeal and review, we cannot speak about individual cases or about the scope of potential violations and issues within those cases.

We would be happy to provide further information when the audits are complete and we can discuss the details. In the meantime, DHHS is committed to collaboratively participating with the schools through this audit process. It is our hope that the process is a positive experience for all parties and that it will help provide confidence for the Department and the schools as they bill for Medicaid services in the future.

Sincerely,

Mary C. Mayhew
Commissioner

MCM/klv

cc: Stephen Bowen, Commissioner, Department of Education
Holly Lusk, Senior Policy Advisor, Governor's Office

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December 10, 2013

To: Senator Margaret M. Craven, Chair
Representative Richard R. Farnsworth, Chair
Members of the Joint Standing Committee on Health and Human Services

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

Re: DHHS Responses to questions regarding the MaineCare Non-emergency Transportation for December 10th HHS Committee meeting

MaineCare non-emergency transportation

1. Please provide monthly data through the end of November on rides requested, rides scheduled, rides given, rides not provided, rides for which the member did not show up, and complete data on telephone inquiries and complaints, complaint line waiting time, service time, hang-ups, reimbursement to all 3 brokerage contractors.

Response: Please see Attachments A – C

2. Please provide a copy of the plan or correction filed by CTS and any response from DHHS.

Response: Please see the series of emails sent on December 5 with the subject line, "CTS Corrective Action Plan."

3. Please provide information on any contractual requirement for a performance bond, information on which contractors provided performance bonds and information on what DHHS would use a performance bond for.

Response: Penquis and LogistiCare secured payment and performance bonds, CTS is currently in the process of working with a bond company to secure as required by the contract.

4. What amounts were paid to contractors providing MaineCare non-emergency transportation services in State FY2011-12 and 2012-13 and how many rides were provided by each contractor during those fiscal years?

Response: Please see Attachment D

5. Is there work going on, particularly in rural areas, that would allow sharing riders in a vehicle for (1) a MaineCare member needing a ride to a medical appointment, (2) an elderly person needing a ride to the supermarket, and (3) a child needing a ride for educational or health care purposes?

Response: As long as the transporter and broker can assure that MaineCare did not subsidize the ride for a non-MaineCare recipient or service these shared rides are allowed to occur. The transporter would need to assure MaineCare that each member was charged for their ride.

Attachment A

	Metrics for CTS	Status for Week ending 8/9/13	Status for Week ending 8/17/13	Status for Week ending 8/24/13	Status for Week ending 8/31/13	Status For Week ending 9/7/13	Status For Week Ending 9/14/13	Status For Week Ending 9/21/13	Status For Week Ending 9/28/13	Status For Week Ending 10/5/13	Status For Week Ending 10/12/13	Status For Week Ending 10/19/13	Status For Week Ending 10/26/13	Status For Week Ending 11/2/13	Status For Week Ending 11/9/13	Status For Week Ending 11/16/13
1	Total Calls Accepted	8,695	8,856	7,694	6,753	6,133	6,261	6,281	6,220	6,134	5,932	5,270	5,535	5,530	6,154	5,361
2	The number of call in which the caller disconnected before speaking to a live representative	5,073	4,978	3,392	1,743	2,289	921	1,014	200	401	152	102	88	119	352	180
3	The number of calls directed to a live representative within a 60 seconds of connecting	54	133	391	1,383	762	2,979	3,226	5,289	4,485	5,075	4,704	5,019	4,870	4,621	4,619
4	The average call-wait times	0:23:27	0:19:08	0:13:25	0:05:57	0:10:00	0:03:05	0:02:56	0:00:26	0:00:58	0:00:22	0:00:16	0:00:14	0:00:18	0:00:46	0:00:20
5	Number of Trips Scheduled	25,823	27,045	29,197	29,466	21,722	30,424	31,361	34,641	36,866	35,634	36,040	36,626	35,451	33,539	32,545
6	The number of reported incidences in which members were not provided a return trip (reported incidences should include broker reports, member grievances and complaints in which grievances were not filed.)	30	12	7	0	0	1	0	0	0	0	0	0	0	0	0
7	The number of trips that were classified in brokers reports as having been missed	1,537	690	736	332	449	394	403	551	505	593	620	136	135	133	116
8	Cancelled Trips by Member in advance	1,837	2,698	2,350	3,260	3,387	2,972	2,663	2,928	3,173	3,741	6,203	3,156	2,544	2,466	4,331
9	Cancelled Trips at Door	105	118	122	54	70	60	59	53	39	254	268	155	165	159	87
10	The number of trips that failed to meet "trip timeliness" performance measures	4,406	5,471	5,335	5,331	2,860	3,268	2,807	2,395	1,280	7,563	6,606	6,927	5,482	1,786	965
11	The number of trips that met "trip timeliness" performance measures	5,429	6,722	6,493	6,417	3,853	4,528	3,802	3,450	1,934	9,373	8,056	8,442	6,847	3,030	1,759
12	The average length of time for processing reimbursement for transportation provided by members, members' friends or members' family	10 days	10 days	11 days	13 days	13 days	14 days	14 days	14 days	14 days	14 days	14 days	14 days	14 days	14 days	14 days

Notes on each Metric

1 Total calls into call center
2 Call where member disconnected (abandon)
3 Calls answered within 60 seconds
4 Average speed of Answer
5 Total number of trips scheduled
6 Estimate based on calls regarding members being stranded without a way to get home
7 Estimate based on calls regarding missed trips handled by CTS Customer Service Team
8 Based on data provided from Transportation Provider Network. Will be updated as additional claims data is received and/or inputed into reservation system
9 Based on data provided from Transportation Provider Network. Will be updated as additional claims data is received and/or inputed into reservation system
10 Based on data provided from Transportation Provider Network. Will be updated as additional claims data is received and/or inputed into reservation system
11 Based on data provided from Transportation Provider Network. Will be updated as additional claims data is received and/or inputed into reservation system
12 Average process time to cutting check and into mail from reciept of claim

Attachment B

August 1st-
Nov 9th

Logisticare Call Center Statistics

								Trip Performance Statistics				**Trip Timeliness Statistics**							
Week Ending	**Total Offered Calls**	**Total Answered Calls**	**Short Abandons <15 secs**	Long Abandons >15 secs	Total calls answered >60 secs	% of calls answered <60 secs	Average Speed of Answer (Secs)	# of Trips Scheduled (Gross)Legs	# of Trips Scheduled (NET) Legs	Reported Instances of Stranded Trips	Number of trips Missed or Cancelled	# of trips Billed & Processed to date:	# Trips on time	# 1-5 minutes late	# 6-10 minutes late	# 11-15 minutes late	# 16 to 30 minutes late	# 31 to 45 minutes late	# over 45 minutes late
8/3/2013	703	661	12	30	560	85%	0:31	2,245	1,633	0	157	596	497	23	18	5	11	10	32
8/10/2013	1922	1824	28	70	1510	83%	0:38	5,934	4,229	0	352	1397	1198	52	29	22	37	16	43
8/17/2013	1474	1426	21	27	1266	89%	0:26	6,174	4,665	0	159	1010	892	42	18	6	28	8	16
8/24/2013	1217	1179	19	19	1060	90%	0:27	5,433	4,318	0	59	361	340	4	6	4	4	0	3
8/31/2013	1348	1296	31	21	1232	95%	0:17	5,457	4,418	0	37	358	346	3	2	2	4	0	1
9/7/2013	1103	1071	17	15	964	90%	0:20	5,131	3,988	0	33	333	313	5	5	0	7	1	2
9/14/2013	1372	1324	35	13	1278	97%	0:19	5,687	4,926	0	25	341	326	5	3	0	5	2	0
9/21/2013	1289	1246	22	21	1166	94%	0:20	5,887	4,979	0	52	262	245	5	4	1	3	3	1
9/28/2013	1315	1285	18	12	1274	99%	0:20	5,986	5,220	0	41	185	174	2	1	3	5	0	0
10/5/2013	1259	1236	19	4	1207	98%	0:14	4,631	3,972	0	30	27	25	1	0	0	1	0	0
10/12/2013	1237	1204	25	8	1159	96	0:15	6034	5300	0	3	467	448	5	1	2	7	2	2
10/19/2013	1134	1111	19	4	1083	97%	0:13	6062	4827	0	17	342	329	1	6	0	2	3	1
10/26/2013	1106	1085	16	5	1070	99%	0:11	6031	5391	0	16	300	291	0	3	0	4	2	0
11/2/2013	1121	1098	12	11	1044	95%	0:14	6227	5720	0	28	186	172	2	1	3	5	2	1
11/9/2013	1150	1137	10	3	1098	97%	0:14	6080	5301	0	7	69	58	0	2	1	4	2	2
11/16/2013	1157	1141	8	8	1123	98%	0:11	6554	5298	0	5	13	13	0	0	0	0	0	0

Attachment C

PENQUIS TRANSPORTATION BROKERAGE
WEEKLY PERFORMANCE DATA

Period		Item a		Item b	Item c	Item d	Item e	Item f		Item g	Item h
Start Date	End Date	Abandoned Calls	Call Offered	Answer w/in 60 sec	Avg Wait	Member Stranded	Miss/Cancel/Reason	Meets Timeliness	Does Not Meet	Reimbursement Timeliness	Trips Legs Scheduled
1-Aug	3-Aug	52	731	579	0:01:07	None, ever	See Below	2,734	93	See attached report	2,855
4-Aug	10-Aug	121	2,237	1,901	0:00:47	None, ever	See Below	7,148	239	See attached report	7,467
11-Aug	17-Aug	158	2,166	1,748	0:01:03	None, ever	See Below	7,932	231	See attached report	8,281
18-Aug	24-Aug	52	2,072	1,948	0:00:25	None, ever	See Below	8,100	204	See attached report	8,410
25-Aug	31-Aug	64	1,947	1,778	0:00:32	None, ever	See Below	7,762	265	See attached report	8,198
1-Sep	7-Sep	68	1,722	1,479	0:00:45	None, ever	See Below	6,323	216	See attached report	6,777
8-Sep	14-Sep	61	2,083	1,893	0:00:33	None, ever	See Below	7,173	215	See attached report	7,805
15-Sep	21-Sep	64	2,066	1,895	0:00:30	None, ever	See Below	7,061	232	See attached report	8,017
22-Sep	28-Sep	50	2,156	2,029	0:00:23	None, ever	See Below	6,826	209	See attached report	8,129
29-Sep	5-Oct	71	2,070	1,944	0:00:28	None, ever	See Below	5,611	164	See attached report	7,262
6-Oct	12-Oct	26	2,061	2,018	0:00:15	None, ever	See Below	6,335	231	See detail below	7,216
13-Oct	19-Oct	69	1,888	1,760	0:00:26	None, ever	See Below	6,662	215	See detail below	6,877
20-Oct	26-Oct	20	2,060	2,033	0:00:11	None, ever	See Below	7,026	232	See detail below	7,258
27-Oct	2-Nov	26	2,095	2,045	0:00:16	None, ever	See Below	6,665	318	See detail below	6,983
3-Nov	11/9/2013 *	42	2,363	2,311	0:00:17	None, ever	See Below	6,151	210	See detail below	6,361
10-Nov	11/16/2013 *	100	2,023	1,780	0:00:37	None, ever	See Below	4,736	91	See detail below	4,827

* Data reported may be incomplete. Trip reporting is based on data entered after drivers return completed trip logs. Most drivers submit completed trip logs within two weeks for reimbursement purposes.

Cancellation By Reason Data - Weekly

Start Date	End Date	CBB	CBD	CBN	CXC	CXM	CPG	CXP	NSCBC	CXL	NSNSD
1-Aug	3-Aug	52	96	37	3	227	48	28	0	86	0
4-Aug	10-Aug	62	295	186	7	473	90	64	4	108	153
11-Aug	17-Aug	86	177	86	8	577	87	84	1	58	155
18-Aug	24-Aug	89	211	124	11	636	110	82	1	41	171
25-Aug	31-Aug	40	194	77	8	548	108	42	3	67	114
1-Sep	7-Sep	427	103	85	31	423	89	58	0	88	125
8-Sep	14-Sep	145	113	78	30	520	81	58	1	77	146
15-Sep	21-Sep	58	46	82	19	463	126	76	2	79	139
22-Sep	28-Sep	42	84	71	10	458	109	45	0	61	126
29-Sep	5-Oct	75	136	81	9	497	106	72	2	86	123
6-Oct	12-Oct	40	123	83	6	480	84	58	2	52	160
13-Oct	19-Oct	281	81	60	6	459	87	56	2	28	149
20-Oct	26-Oct	126	95	67	22	445	125	81	0	37	127
27-Oct	2-Nov	75	45	70	6	519	98	32	7	53	112
3-Nov	9-Nov	57	98	49	5	377	109	41	7	38	129
10-Nov	16-Nov	299	175	99	14	389	107	69	3	53	136

Cancellation Codes

CBB	Cancel By Broker	Does NOT mean no transportation provided. Used when we reschedule a trip to correct information.
CBD	Cancel No Driver	Cancelled due to a lack of available transporters
CBN	Cancel - No Show	Cancelled trip because the consumer did not show up when the ride arrived
CXC	Cancel by Caseworker	Caseworker cancelled the trip
CXM	Cancel by Member	Member called to cancel the trip
CPG	Cancel Parent/Guardian	Parent or Guardian of the Member called to cancel the trip
CXP	Cancel By Provider	Medical or Care provider cancelled the trip
NSCBC	No Show Cancel by Client	
CXL	Cancel Late	Late cancellation of the trip, after dispatched
NSNSD	No Show at Door	Member did not show up when ride arrived at their door

Item G : Promptness of Payments

The average length of time for processing reimbursements for transportation provided by a member, friend or family.

All reimbursement requests received by August 9 at 9am were paid on August 16th.
All reimbursement requests received by August 23 at 9am were paid on August 30th.
All reimbursement requests received by September 5th at 9am were paid on September 13th.
All reimbursement requests received by September 20th were paid on September 27th.
All reimbursement requests received by October 17rd were paid on October 25th.
All reimbursement requests received by November 1st were paid on November 8th.
All reimbursement requests received by November 14th will be paid on November 22nd.

Attachment D

Total Trips and expenditures by State Fiscal Year

Time Period: SFY 2012

Provider	Trips	Total Expenditures
ALLIED MEDICAL SERVICE	9,300	$423,075.85
AROOSTOOK REGIONAL TRANSPORTATION SYSTEM, INC.	207,272	$3,041,642.26
C3 TRANSPORT LLC	10,651	$524,110.52
CITY OF PORTLAND MAINE	469	$14,406.98
COASTAL TRANS, INC.	89,595	$1,478,831.53
COMMUNITY CONCEPTS INC	312,031	$6,091,868.79
DELTA AMBULANCE CORP.	1,142	$44,689.50
FREEPORT TRANSIT, INC.	9,176	$157,453.53
KVCAP TRANSPORTATION	338,926	$5,357,290.86
MERMAID TRANSPORTATION CO. INC	3,849	$179,601.10
PENQUIS C.A.P., INC.	216,905	$6,276,955.80
PLEASANT RIVER AMBULANCE SERVICE	22	$3,231.36
REGIONAL TRANSPORTATION PROGRAM, INC	142,686	$4,389,575.97
SEACOAST CHAIR CAR SERVICE LLC	3,341	$167,820.26
STERLING AMBULANCE	1,312	$60,589.94
United Ambulance	21,904	$886,167.62
WALDO COMMUNITY ACTION PARTNERS	81,292	$1,384,575.32
WASHINGTON HANCOCK COMMUNITY AGENCY, INC.	121,449	$2,149,877.71
WEST TRANSPORTATION, INC.	63,710	$102,886.19
WESTERN MAINE TRANSPORTATION SERVICES	131,497	$1,846,427.65
YORK COUNTY COMMUNITY ACTION CORPORATION	210,780	$3,386,545.54
Grand Total	**1,977,309**	**$37,967,624.28**

Time Period: SFY 2013

Provider	Trips	Total Expenditures
ALLIED MEDICAL SERVICE	5,049	$233,668.68
AROOSTOOK REGIONAL TRANSPORTATION SYSTEM, INC.	203,201	$2,971,059.77
C3 TRANSPORT LLC	11,317	$576,096.32
COASTAL TRANS, INC.	74,334	$1,252,532.56
COMMUNITY CONCEPTS INC	287,890	$5,560,862.14
DELTA AMBULANCE CORP.	2,104	$79,728.22
FREEPORT TRANSIT, INC.	5,976	$113,397.36
KVCAP TRANSPORTATION	329,321	$5,208,963.80
MERMAID TRANSPORTATION CO. INC	4,690	$215,735.24
PENQUIS C.A.P., INC.	251,844	$5,743,393.32
PLEASANT RIVER AMBULANCE SERVICE PROGRAM, INC	7 226,490	$1,286.18 $4,216,237.04
SEACOAST CHAIR CAR SERVICE LLC	2,638	$133,703.15
STERLING AMBULANCE	978	$46,744.64
United Ambulance	36,121	$1,406,273.28
WALDO COMMUNITY ACTION PARTNERS	67,976	$1,201,215.40
WASHINGTON HANCOCK COMMUNITY AGENCY, INC.	102,359	$1,936,421.71
WEST TRANSPORTATION, INC.	42,240	$59,786.40
WESTERN MAINE TRANSPORTATION SERVICES	145,205	$1,850,537.09
YORK COUNTY COMMUNITY ACTION CORPORATION	203,099	$3,120,453.18
Grand Total	**2,002,839**	**$35,928,095.48**

FINAL
REPORT

MaineCare Children's Outpatient Mental Health Services — An Assessment of Administrative Costs and Their Drivers

Report No. SR-CMH-08

a report to the
Government Oversight Committee
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

February
2009

GOVERNMENT OVERSIGHT COMMITTEE

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*Temporarily assigned to the GOC during the absence of Rep. Everett McLeod, Sr.

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ABOUT OPEGA & THE GOVERNMENT OVERSIGHT COMMITTEE

The Office of Program Evaluation and Government Accountability (OPEGA) was created by statute in 2003 to assist the Legislature in its oversight role by providing independent reviews of the agencies and programs of State Government. The Office began operation in January 2005. Oversight is an essential function because legislators need to know if current laws and appropriations are achieving intended results.

OPEGA is an independent staff unit overseen by the bipartisan joint legislative Government Oversight Committee (GOC). OPEGA's reviews are performed at the direction of the GOC. Independence, sufficient resources and the authorities granted to OPEGA and the GOC by the enacting statute are critical to OPEGA's ability to fully evaluate the efficiency and effectiveness of Maine government.

Legislators, committees, or members of the public should make their requests for reviews to members of the Committee or OPEGA directly.

Copies of OPEGA's reports are free.
Reports are available in electronic format at:
http://www.legislature.maine.gov/opega/

Hard copies of reports may be obtained by contacting OPEGA at:

(207) 287-1901

Office of Program Evaluation & Government Accountability

82 State House Station • Augusta, ME • 04333-0082

Report Highlights

OPEGA Report No. SR-CMH-08

MaineCare Children's Outpatient Mental Health Services — An Assessment of Administrative Costs and Their Drivers

What questions was this OPEGA review intended to answer?

- How much of the funding for outpatient services for children is expended on the administrative costs of DHHS and providers versus direct delivery of services?
- What are the primary factors driving the administrative costs?

What was OPEGA's overall conclusion?

Of the approximately $18.5 million spent on outpatient children's mental health services (CMH services) in FY 2008, we estimate about 73%, or $13.5 million is associated with the cost of directly delivering the services to children. Approximately 19% ($3.4 million) can be attributed to providers' administrative costs, and the remaining 8% ($1.4 million) represents the administrative cost of program management performed by the Department and its contracted Administrative Service Organization (ASO).

Primary drivers of administrative costs for DHHS are the contract with the ASO and costs incurred by the Office of MaineCare Services in processing provider claims. Providers surveyed reported that certain administrative requirements imposed upon them by the State, and the ASO in particular, represented significant efforts for them.

The State has moved to standardized reimbursement rates for CMH outpatient services and providers are working to adapt by managing their costs to a supportable level. By lowering or raising the standard rate, the State affects the level of costs providers can afford to bear.

The provider network will continue to adapt to the implementation of care management efforts and standardized rates. We encourage DHHS and the Legislature to closely monitor whether the current standard rate, or administrative requirements on providers, should be further adjusted to achieve additional savings or to address any unintended changes in the availability and quality of services.

What actions has OPEGA suggested?

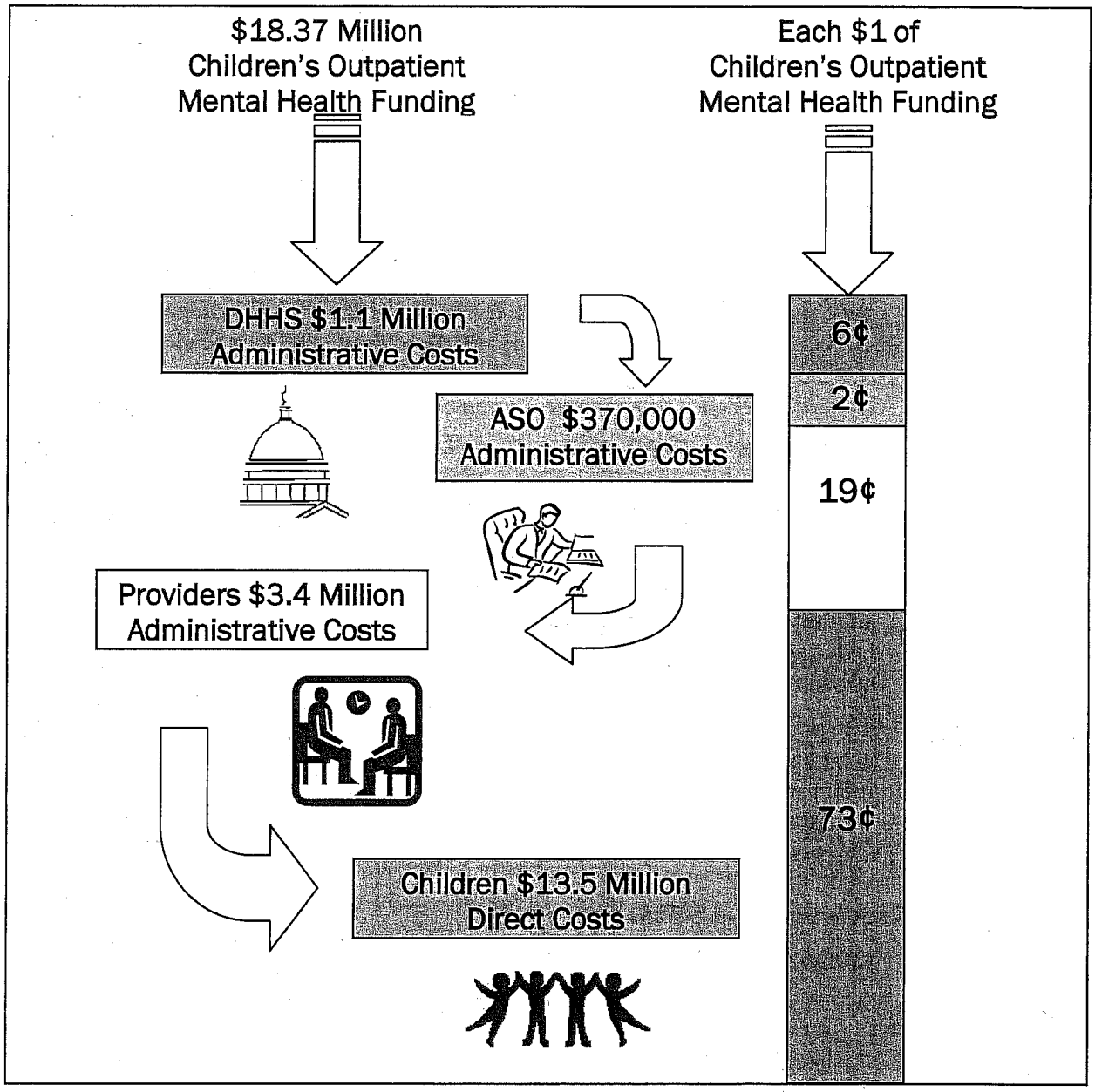
OPEGA suggested the Legislature consider taking action to:

- ⇨ Assess the cost-effectiveness of the contract DHHS has entered with the ASO, APS Healthcare.
- ⇨ Formally monitor the effects of the current standard rate and administrative requirements of the care management effort on the CMH network to ensure any unintended changes in the availability or quality of services can be addressed promptly.
- ⇨ Determine whether to revive the currently inactive Children's Mental Health Oversight Committee authorized by 34-B MRSA §15004-2.
- ⇨ Monitor developing actions by DHHS and the Service Center to begin collecting federal reimbursement for appropriate costs not reimbursed in prior years.

To get a copy of the full report, or for more information visit the website listed at the bottom of this page or contact OPEGA at (207)287-1901.

February 2009

Estimated Portion of Each FY 2008 Dollar that Went to Direct Services and Administrative Costs for MaineCare Children's Outpatient Services



Recommendations

1

More Detailed Review of Contract with APS Would be Prudent

When the 123rd Legislature passed PL 2007, Chapter 240, Part CC, it expected estimated savings of $6 million in General Fund and just over $16 million total during FY 2008. Expected savings for FY 2009 were $8.5 million in General Fund and about $23 million total. Table 7 shows the detail of savings booked as part of that public law. We also note that the Governor's Proposed Biennial Budget for 2010 – 2011 includes several budget initiatives related to PL 2007, Chapter 240, Part CC.

Table 7. Savings Estimates Excerpted from PL 2007, Chapter 240, Part CC

SECTION TOTALS	2007-08	2008-09
GENERAL FUND	($6,000,000)	($8,500,000)
FEDERAL EXPENDITURES FUND	($10,348,774)	($14,732,479)
SECTION TOTAL - ALL FUNDS	($16,348,774)	($23,232,479)

DHHS has contracted with APS Healthcare to serve as the ASO. The contract became effective September 1, 2007 and ends on July 31, 2009 unless extended. The cost of the contract for all services is approximately $3.6 million in FY08, $5 million in FY09 and $406,688 in FY10. Seventy-five percent of the contract is paid for with Federal funds with the State funding the other 25%.

OPEGA inquired about whether and how actual savings realized from APS's contract were being tracked. DHHS provided a Cost Impact Analysis for the ASO prepared for DHHS by the Muskie School of Public Service. This analysis bases cost savings on changes in trends in MaineCare spending for behavioral services as a whole and by individual services. We note that there are a number of factors that could contribute to changes in the total cost of behavioral services, and outpatient CMH services specifically, from one year to another including:

- changes in MaineCare eligibility that may affect how much outpatient treatment children may receive annually;
- changes in the number of MaineCare eligible children seeking outpatient services;
- implementation of standardized rates; and
- changes in provider requirements or environmental factors that may affect the number of providers willing to offer the services.

Consequently, savings shown in this analysis cannot be directly attributed to the efforts of the ASO.

In addition, our survey of providers indicated that many providers have concerns about the administrative burdens imposed by APS, not just related to outpatient

services, but for all behavioral health services. These concerns may be mostly the frustrations of dealing with new procedures, but they do raise the question of whether the benefits (cost savings and improved outcomes) of the contract with APS actually exceed the total costs associated with their work: not just their contract costs, but also the costs imposed on the provider network.

Given the cost of the APS contract, the significant savings expected from the ASO and providers' concerns about associated administrative burdens (which OPEGA has not validated), we believe it would be prudent to conduct a more detailed review of the contract to assure that the State's desired outcomes for the care management effort are being achieved in the most cost-effective manner possible.

Recommendation for Legislative Action:

The Legislature should consider directing OPEGA (or some other entity) to perform an in depth evaluation of the contract and services provided by APS. Such an evaluation should review the detail of results APS has achieved, the administration of the contract with APS, and the costs that the provider network has absorbed as a result of APS's requirements.

Outpatient Provider Network Needs Ongoing Monitoring

Maine's relatively recent move to a standard rate for outpatient services has changed the interaction between the State and the provider network. There is no longer negotiation to ensure that individual providers' rates are adequate to cover their specific expenses. With this new dynamic, it will be increasingly important for the State to actively and consistently monitor the health of the provider network: following the evolution of the network, staying alert for any access or quality issues, and monitoring the implementation of efforts to improve efficiencies and reduce administrative burdens.

In our discussions with DHHS, they mentioned several avenues that currently exist for monitoring the quality of services provided – some of them more objectively based than others. Adequately assessing the geographic availability of outpatient services for children, however, is currently a difficult task due to a lack of objective data and processes for collecting it.

Recommendation for Legislative Action:

The Legislature should consider two potential approaches for monitoring the health of the outpatient provider network, the quality of service children are receiving and on-going efforts to increase efficiencies in providers' administrative requirements. One would be for the Joint Standing Committee on Health and Human Services to establish a formal and regular process specifically focused on monitoring these items. As an alternative, the Legislature could assign this formal oversight to the now inactive Children's Mental Health Oversight Committee. Although the Committee has been inactive for some time (see Finding 3), its statutorily set membership seems well suited to carry out this sort of monitoring.

With either approach, the Health and Human Services Committee and DHHS should agree upon the data to be collected and reported that will allow for a sufficient understanding of changes in the provider network and meaningful,objective measures of availability and quality of services. Data collection processes and procedures should have adequate controls built in to assure that data collected is complete and reliable.

Continued Need for Children's Mental Health Oversight Committee Should be Determined

The Children's Mental Health Oversight Committee required by 34-B MRSA §15004-2 appears to have stopped meeting and no longer receives reports or makes reports to joint standing committees of the Legislature as required in statute. It appears that a number of the Committee's seats have not received legislative appointments for some time, and as a result the Committee has ceased to function. Statute contains a number of specific duties for the Committee, some of which no longer appear relevant.

Recommendation for Legislative Action:

The Legislature may want to consider either removing the Children's Mental Health Oversight Committee from statute, or else taking steps to revive the Committee and ensure its effectiveness. An active Oversight Committee could potentially assist the Department and the Legislature in monitoring how changes in the newly standardized rates are impacting the provider network and tracking the implementation of initiatives to reduce administrative burdens on providers.

If the Legislature decides to reactivate the Committee it should review, and update as appropriate, the Committee's current statutory responsibilities. The Legislature should also consider adding the Committee to the list of committees in 5 MRSA Chapter 379 so that the Secretary of State's office can monitor and report on the Committee's annual activity and vacant seats as it does for all other committees listed in that chapter.

DHHS Cost Allocation Plan Should Include Rate Setting Unit

The DHHS Rate Setting Unit performs work related to federal programs but had none of their costs allocated to Medicaid in the Department's FY 2008 Cost Allocation Plan. This results in less federal matching dollars for the Department and requires the Unit to be fully funded by the General Fund. Issues with the CAP have been noted previously by the Department of Audit, and the DHHS Service Center has been working actively over the past few years to make improvements to the plan and maximize federal reimbursements. The Service Center estimates that allocating the Rate Setting Unit's applicable costs to Medicaid could result in additional federal reimbursement of approximately $110,000, but not more than $148,000 annually.

Recommendation for Legislative Action:

DHHS and the Service Center are taking steps to ensure the Rate Setting Unit's costs are allocated to federal programs as appropriate to maximize federal revenue in future fiscal years. The Joint Standing Committee on Health and Human Services (HHS) may want to follow up on the status of this action during the second session of the 124th Legislature to make sure the State has collected all appropriate federal reimbursement associated with the Rate Setting Unit. In addition, by the second session the State Department of Audit will likely have completed its thorough audit of DHHS's new CAP plan. Although that audit may not touch on the Rate Setting Unit specifically, the HHS Committee may want to invite the State Auditor before the Committee to report on the Department's new CAP as a whole.

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
John E. Baldacci, Governor
Brenda M. Harvey, Commissioner

Department of Health and Human Services
Commissioner's Office
221 State Street
11 State House Station
Augusta, Maine 04333-0011
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TTY: 1-800-606-0215

February 23, 2009

Beth Ashcroft, Director
Office of Program Evaluation and Government Accountability
#82 State House Station
Augusta, ME 04333-0082

Dear Ms. Ashcroft:

The Department of Health and Human Services appreciates having the opportunity to respond to the Office of Program Evaluation and Government Accountability's report entitled "MaineCare Children's Outpatient Mental Health Services – An Assessment of Administrative Costs and Their Drivers". The Department was given the opportunity to comment on a preliminary draft of the report, and we were pleased to note that some revisions were made as a result of the Department's comments. We appreciate the courtesy and professionalism which OPEGA brings to their work, and we hope the comments we are providing here will provide additional information and perspective that will be helpful to legislators.

On page 14 of the report, OPEGA states: "there are some differences in perspectives between providers and DHHS on the administrative burdens and this is not entirely unexpected given the cultural shift that a care management effort creates. However, we have not researched the specific points made to us by either group and are not in a position to validate them." We think it is unfortunate that OPEGA has adopted this stance, and we believe it diminishes the value of the report. In several instances, the Department provided information and documentation that would have enabled OPEGA to make a determination concerning specific issues identified in the report. For example:

- OPEGA has reported (on page 13) the providers' contention that the "multiple" pages of information required for continuing stay reviews of children's outpatient services is extremely burdensome, even after the Department provided a copy of the actual one-page form that is required. It is impossible to perform a utilization review function without requiring some information from providers, and a minimal amount of information is currently being required.
- The report contains the allegation that "changes to MaineCare requirements mean providers are constantly asking administrative and technical staff to update data submission forms, codes and processes." There have been two instances of such changes in MaineCare requirements for outpatient services that were necessitated by the need to replace local codes with HIPAA-compliant billing codes (as part of the conversion to a new claims processing system). We do not mean to understate the significance of these changes for providers, but two instances certainly do not amount to a "constant" problem. We believe this may be a view held by providers of multiple services and is outside the scope of this review.

- Regarding rates for children's outpatient services, the report notes that the Department contracted with Deloitte to assess the reasonableness of MaineCare reimbursement rates for behavioral health services. Further, the report correctly points out that Deloitte's analysis supported the reasonableness of the cost-based standard rates that were originally developed and proposed by the Department in 2007. However, in the face of all the data that has been developed, the extensive and well documented process of discussion with providers that has occurred, and the comprehensive analysis that was done by a firm with national scope and expertise in the area of rate-setting, the report concludes (on page 11) that OPEGA "did not participate in [Deloitte's] effort, or in their meetings with providers, so we can not evaluate the validity of their work or the extent to which they considered providers' input about actual costs providers were experiencing."

It is difficult to understand why OPEGA has been willing to report subjective provider concerns that excessive administrative burdens are being imposed or that rates may be either too high or too low, and reluctant to draw a conclusion based on the voluminous objective data that is available on the issues that have been raised. It is not enough to say (as the report does on page 19) that OPEGA has not validated provider concerns about administrative burdens when there is clear evidence that at least some of the most prominent concerns described in the report are certainly not valid. Without validating claims and counter-claims, the OPEGA report gives unwarranted credibility to assertions and allegations that are not supported by facts.

The Department does not object to the recommendations contained in the report, but we would offer the following comments regarding those recommendations:

- Recommendation 1 calls for a more detailed review of the contract with the Administrative Services Organization (ASO). While such a review may help to answer questions raised in the report, the primary reasons that OPEGA has presented for recommending this review is to assess the costs and benefits of this initiative in light of provider concerns about the administrative burdens it imposes. In response to this recommendation, we would note that the decision to implement a utilization management initiative for behavioral health services was a policy decision made by the Legislature based on the need to control escalating costs. It only began operating in December of 2007. For the first three months providers registered their clients and services and received automatic authorizations. Actual clinical reviews generally began 3 to 12 months (depending on the service) after the initial registration became effective (less for inpatient and PNMI services). Claims for services are generally submitted and processed one to three months after the service is provided. In other words, the initial year of operation is an implementation period and the impact of an ASO initiative manifests itself over time. We therefore suggest that it is too soon to effectively evaluate the ASO initiative, and that such an evaluation should wait until the initiative has been fully operational for a reasonable period of time and more data is available.

  On the other hand, we would welcome a review if the Legislative Committee would like to focus on the question of administrative burdens, how the burdens imposed by the Maine ASO compare to burdens imposed by other utilization management programs in the public and private sectors, and what the Department and the ASO have done to mitigate administrative burdens on Maine providers.

- Recommendation 2 calls for monitoring of the outpatient provider network. In response to this recommendation, the Department would note that the Children's Cabinet already exists and has general responsibility for monitoring children's services. If the Children's Mental Health Oversight Committee is to be re-activated, it will be important to coordinate roles and functions in order to prevent duplication.

  In addition, the recommendation calls for collecting complete and reliable data to support monitoring of the availability and quality of services. The lack of waiting list data for children's outpatient services is one of the specific issues mentioned earlier in the report. We would note that collecting waiting list data from the large number of outpatient service providers in Maine would only result in the compilation of duplicated, inaccurate and outdated data. In order for waiting list data to be meaningful, it must be collected and maintained in a central location on a "real time" basis. Doing this requires a substantial commitment of resources and imposes significant burdens on providers. Our only point here is that before imposing new data collection requirements, there should be a determination that there is a clearly identified problem or need to be addressed. In this instance, the report itself notes (on page 15) that "no systemic issues with either availability or quality of children's outpatient services were brought to OPEGA's attention".

Thank you for the consideration of our comments.

Sincerely,

Brenda Harvey

Brenda M. Harvey
Commissioner

BMH/klv

cc: Geoff Green, Deputy Commissioner, DHHS
Muriel Littlefield, Deputy Commissioner, DHHS
Russ Begin, Deputy Commissioner, DHHS
Jim Beougher, Director, Office of Child and Family Services, DHHS
Joan Smyski, Office of Child and Family Services, DHHS
Lucky Hollander, Legislative Liaison, DHHS

Department of Health and Human Services
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Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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TTY Users: Dial 711 (Maine Relay)

September 16, 2013

To: Beth Ashcroft, Director, Office of Program Evaluation and Government Accountability

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

Re: Request regarding Children's Mental Health

Question: What is the current status of the Children's Mental Health Oversight Committee that is authorized/required under 34-B MRSA Section 15004? Recommendation 3 in our report notes the fact that we had found in 2009 that it had been inactive and I believe statute calls for the Department to staff that Committee. Is the Committee still inactive and, if so, has there been any discussion within the Department about re-activating it? If it is active, could you direct me to someone who could brief me on the Committee's activities?

Response: Please see below, the email from Justin Barnard (also see **Attachment A**), our Assistant Attorney General to Dr. Lindsey Tweed below. The Committee is to be convened by the Legislature and staffed by DHHS.

> Dr. Tweed,
>
> As we discussed, my read of the statute suggests that the primary responsibility for convening the Children's Mental Health Oversight Committee lies with the Legislature. The President of the Senate and Speaker of the House are responsible for appointing 13 of the 16 Committee members (the remaining three being the Commissioners, or designees thereof, of Corrections, Education, and Health and Human Services) as well as selecting the Committee's cochairs. The Department's sole responsibility, under the statute, is to provide staffing assistance to the Committee once it has been convened.
>
> I would, of course, counsel that the Department lend the Legislature whatever assistance it requests in reconvening the Committee. Please let me know if you have any additional questions."
>
> Best,
> Justin B. Barnard
> Assistant Attorney General
> Office of Attorney General

Question: How many juvenile mental health beds are there in the State and where are they? Is there typically a waiting list for them and how long is the list?

Response: There are 3 types of beds we have: crisis units, hospitals, and residential treatment. 43 are crisis unit beds and 97 are (in-state) hospital beds. Please see **Attachment B** for details on the location of beds.

For residential treatment, we have 396 licensed beds. Not all the beds are active, though; providers decide how many of their licensed beds they actually staff. Knowing the number of actual residential beds that are actually staffed and available to youth requires a hand count; we did do such a count and there were 365 active beds.

Current Active MH/ID Residential In-State Beds

Total	**365**
AMHC	10
Becket	38
CHCS	8
Harbor Family Services	28
Kidspeace	30
NFI North	50
Northern Lighthouse	6
Port Resources	5
Spurwink	110 (*This number fluctuates on a daily basis based on acuity, staffing issues)
Sweetser	75
Opportunity Alliance	5

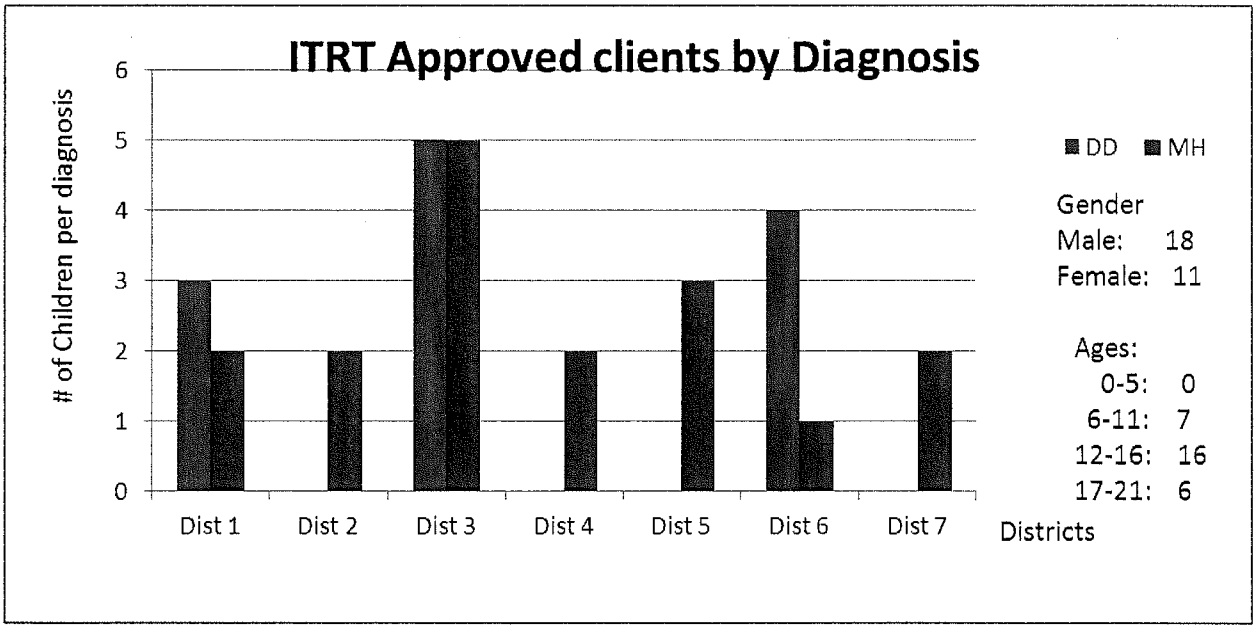
Also, we maintain a list of youth who have been approved for residential treatment but have not been admitted. We compile that data on a weekly basis. Most, but not all, are actively waiting for a residential bed; the 2nd section of the 3rd attachment details in what type of setting the approved-not admitted youth currently are.

Current Number of Youth approved for Residential Treatment (Wait List)

*It is important to note that a residential approval gives a 60 day time period for the youth to be admitted to a program. Therefore, some families seek approval and first attempt to treat the youth in the home with community based mental health programs (Such as Section 65 Home and Community Based Treatment or Section 28 Rehabilitative Community Based Service). Therefore, for some youth captured here, they are being successfully treated in the community and have chosen not to access an available bed at this time.

*In addition, some youth that are in psychiatric hospitals or CSU settings may continue to meet inpatient or crisis level of care, therefore need further stabilization before they can access an available bed

Current Wait List = 26 Youth
Details of wait list:
1 Youth is accessing Adult Services, rather than Children's residential
1 Youth is committed to Long Creek Youth Development Center
3 Youth are in the Hospital
2 Youth are in a Crisis Stabilization Unit
2 Youth are detained at Long Creek or Mountain View Youth Development Center
4 Youth are currently in Residential Treatment and waiting for transfer to a new program
1 Youth has runaway
1 Youth is detained in Cumberland County Jail (currently unable to be released)
11 Youth are in their home/community
The distribution across our 8 Districts of the youth authorized but not admitted as of 8/23 is provided in the chart below.



*This data is being reported point in time. Children are approved and wait for placement daily. Admissions also take place daily. The mean # of days approved and waiting is 40 (with 4 being the lowest and 124 being the highest) Diagnosis: MH- Mental Health MH1 or MH2; DD- Developmental Disability DD1 or DD 2

There were substantially more youth approved but not admitted during the spring; the number was typically in the 30's or 40's.

Question: How many children are sent out of State annually (or in some other timeframe you have data on) for services while they wait for a juvenile bed in State?

Response: No children are sent out of state for residential treatment because they are waiting for an in-state residential bed. Youth are sent to out of state residential programs (typically Easter Seals in Manchester, NH) because our in-state providers have said they cannot safely treat the youth.

Out of State Residential Treatment

*Currently no youths have been placed out of state due to our residential wait list specifically. There are some high needs youth with developmental disabilities (Intellectual Disabilities and/or Autistic Disorders) whom have had to be placed out of state because at the time of their approval the programs whom could normally serve that severe a youth were at capacity. So, out of state placement was due to a combination of high acuity and a small number of in-state beds that can serve high acuity members.

*Once a youth is placed out of state, we have had families/guardians that are pleased with their current residential program and have not wanted to transfer to a program back in Maine. Some of these youth could have been transferred back, but the guardian has had choice over that decision.

Attachment A

From: Barnard, Justin
Sent: Tuesday, August 27, 2013 9:31 AM
To: Tweed, Lindsey
Subject: RE: GOC Questions About Children's Mental Health

Dr. Tweed,

As we discussed, my read of the statute suggests that the primary responsibility for convening the Children's Mental Health Oversight Committee lies with the Legislature. The President of the Senate and Speaker of the House are responsible for appointing 13 of the 16 Committee members (the remaining three being the Commissioners, or designees thereof, of Corrections, Education, and Health and Human Services) as well as selecting the Committee's cochairs. The Department's sole responsibility, under the statute, is to provide staffing assistance to the Committee once it has been convened.

I would, of course, counsel that the Department lend the Legislature whatever assistance it requests in reconvening the Committee. Please let me know if you have any additional questions.

Best,

Justin B. Barnard
Assistant Attorney General
Office of Attorney General
6 State House Station
Augusta, ME 04333
207-626-8540

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Attachment B

DATE	UNIT	LOCATION	TOTAL	AVAILABLE BEDS	AVAILABLE	USED	AGE	SEX	WING	NOTES
08/23/13	NEW DAY	CALAIS	6	4	67%	33%	7 to 17	M/F		CRISIS UNIT
08/23/13	AMHC	FORT FAIRFIELD	6	4	67%	33%	4 to 17	F/M		CRISIS UNIT
08/23/13	SOJOURN HOUSE	BANGOR	6	4	67%	33%	5 to 17	F/M		CRISIS UNIT/Depending on level
08/23/13	CRISIS & COUNCELING	WINSLOW	5	5	100%	0%	5 to 17	M/F	ADOLESCENT	CRISIS UNIT
08/23/13	TURNER FAMILY	TURNER	4	3	75%	25%	5 to 17	M/F		CRISIS UNIT
08/23/13	SWEETSER	BELFAST	7	2	29%	71%	0 to 18	M/F		CRISIS UNIT
08/23/13	SWEETSER	SACO	9	2	22%	78%	0 to 18	M/F		CRISIS UNIT
			43	**24**	**56%**	**44%**				
08/23/13	NORTHERN MAINE	FORT KENT	7	0	0%	100%	4 to 18	M/F	PEDIACTRIC	HOSPITAL
08/23/13	SPRING HARBOR CHILD	PORTLAND	14	2	14%	86%	15to17	M/F	NORTHE	HOSPITAL
08/23/13	SPRING HARBOR ADOL	PORTLAND	14	0	0%	100%	15to17	M/F	1 NORTHWEST	HOSPITAL
08/23/13	SPRING HARBOR DD	PORTLAND	12	0	0%	100%	4 to 18	M/F	DD UNIT/DEVELOP DELAYS	HOSPITAL
08/23/13	ACADIA ADOL/CHILD	BANGOR	32	3	9%	91%	12to20	M/F	PEDIACTRIC	HOSPITAL
08/23/13	ST. MARY'S ADOL	LEWISTON	18	2	11%	89%	up-18	M/F	ADOLESCENT	HOSPITAL
			97	**7**	**7%**	**93%**				
08/23/13	HAMPSTEAD	NH	18	4	22%	100%	10to18	M/F	ADOLESCENT	OUT OF STATE HOSPITAL
08/23/13	HAMPSTEAD	NH	16	0	0%	100%	5 to14	M/F	DD/YOUNGER	OUT OF STATE HOSPITAL
08/23/13	HAMPSTEAD	NH	16	0	0%	100%	14 to18	M/F	DD/OLDER	OUT OF STATE HOSPITAL
08/23/13	BRATTLEBORO	VT	12	2	17%	83%	5 to12	M/F	CHILD	OUT OF STATE HOSPITAL
08/23/13	BRATTLEBORO	VT	21	4	19%	81%	13 to18	M/F	ADOLESCENT	OUT OF STATE HOSPITAL
08/23/13	ANNA JAQUES	MA	12	7	58%	42%	4 to17	M/F	FREE STANDING CHILD/ADOL	OUT OF STATE HOSPITAL
			95	**17**	**18%**	**82%**				

Report Highlights

OPEGA Report No. SR-CDS-11

To get a copy of the full report, or for more information, visit the website listed at the bottom of this page or contact OPEGA at (207) 287-1901

July 2012

Child Development Services – Implementing Comprehensive Program Management, Encouraging Responsible Stewardship of Resources, and Developing Data to Support Management Decisions Could Improve Efficiency and Cost Effectiveness

Issues OPEGA noted during this review:

- Organizational structure and limited capabilities in key management functions hinder comprehensive management, transparency and oversight of program.
- MDOE and CDS have not placed sufficient emphasis on ensuring efficient and cost-effective use of resources in the implementation of the CDS program.
- MDOE has not adequately monitored CDS' finances nor ensured that CDS' biennial budgets reflect projected actual resource needs.
- CDS does not track actual service units provided by its direct service staff against children's Plans and does not consistently monitor staff productivity.
- Electronic data necessary, or useful, for managing the program is not always reliable or captured in a consistent manner.
- Contract management is decentralized and professional administrative services are not always competitively procured.
- Program revenue sources have not been maximized.
- Lack of coordination between MDOE, CDS and DHHS creates risk of potential fraud and abuse in the MaineCare program associated with billing for CDS program services.

What questions did this review focus on, and what are OPEGA's answers?

1. *What entities have a role in overseeing and managing the CDS program and what is each role? Which entities have responsibilities with regard to budget development and monitoring? How effectively does each carry out those responsibilities? Are there any gaps or overlaps/duplications in oversight or management that could negatively impact finances, or transparency and accountability?*

   The organizational structure of the CDS System is unlike any OPEGA has encountered in Maine State Government, and is particularly atypical for State-administered, federal programs that require such significant General Fund support. MDOE is the lead agency responsible for the CDS program. The program is managed and implemented, however, by other entities with varying degrees of statutorily defined independence from MDOE.

   OPEGA identified a number of issues that hinder the clear and comprehensive management of the CDS program on a statewide basis. These issues include: lack of strong accountability mechanisms; blurring of roles and responsibilities; weaknesses in processes for developing and monitoring the program budget; and weaknesses in key management functions resulting from limited reliable data, as well as limited analytic and fiscal management capabilities. These same issues also impair transparency and effective oversight, particularly at the legislative level.

   Recent statutory changes approved by the Legislature in April 2012 address some of the structural and accountability issues OPEGA noted in this review. However, additional systemic changes are needed to improve the management and oversight of the CDS program and the System through which it is implemented.

Report Highlights continued

OPEGA Report No. SR-CDS-11

2. *What processes and controls does CDS use to manage and contain program costs when establishing plans and providing services to children? Are they sufficient to assure that services are reasonable and necessary to produce the desired outcome, and that related billings are accurate and appropriate? Do they assure CDS' human and financial resources are utilized efficiently and productively, and that costs are otherwise minimized to the extent possible?*

   Defining what is appropriate and necessary for producing desired outcomes can be challenging as each child's situation is unique. The federal Individuals with Disabilities Education Act requires that "appropriate" services be provided. Under the law, there is a broad range of what might be considered an appropriate level of service in any particular case. IDEA also requires a child's service plan be established through consensus of the child's "Team" which must include the child's parents or guardians, a CDS representative with authority to commit funds, and certain other specialists depending on the child's needs.

   The level of planned services agreed to, and decisions about how they will be delivered, are key cost drivers in the CDS program. Consequently, the culture and philosophy at CDS, as well as the knowledge and skill level of the CDS Team members and the level of guidance provided to them are important factors for ensuring the provision of appropriate services and responsible stewardship of State and federal resources.

   OPEGA found the culture throughout the CDS System is appropriately focused on compliance and quality service for children, but does not place sufficient emphasis on fiscal impacts in the provision of services. Adequate support mechanisms are not in place to help ensure that reasonable desired outcomes for children are achieved in an efficient and cost-effective manner. Processes and controls are generally adequate to ensure that payments to providers and insurance billings for CDS staff time are accurate and appropriate. However, processes and controls are not adequate to ensure the efficient and productive use of financial and human resources. Therefore, CDS does not minimize costs to the extent possible in determining and delivering appropriate services.

3. *How much of the funding for CDS is expended on administrative costs versus service delivery costs? What are the primary components of service delivery costs for direct delivery of services? How do administrative and service delivery costs compare among CDS sites? What are the reasons for any significant trends of differences in costs and do they suggest any opportunities to reduce costs?*

   OPEGA determined that administrative expenses accounted for 16.9% of all CDS program expenses in the time period FY2011.[1] Expenses associated with service delivery accounted for 78.4% during the period, encompassing expenses for both case management and direct service, which accounted for 12.5% and 65.9% of total expenses respectively.

   The direct services expense category is not only the primary cost component, but also the component that increased the most over the three year period. The two largest expense lines within the direct services category, and for CDS program expenses overall, were contracted provider services and salaries and benefits. Expenses for contracted provider services, not including transportation, increased by $3.8 million, or about 44%, between FY09 and FY11 and most of that increase appears related to a 2010 MaineCare rule change. Salaries and benefits expenses for direct services increased $3.7 million, or about 50%, in that same time period with the increase primarily due to additional CDS direct services staff.

   OPEGA conservatively estimates the annual fiscal impact of the MaineCare rule change on the CDS program as at least $7.6 million given impacts on both revenue and expenses. Our analyses show that revenue and/or expenses for four of the nine CDS regional sites were not as significantly impacted by the change as the others. While this may be due to factors that are unique to these sites and types of services they provide, further exploration of the reasons why these four were not as impacted may identify some opportunities to mitigate the financial impact to the CDS program system-wide.

[1] The scope of this review was FY07 – FY11. Limited detailed financial data for FY07 and FY08 confined OPEGA's analysis of expenses to the three year period FY09 – FY11.

OPEGA Report on Child Development Service

Summary of Recommendations and Planned Actions

Finding 1: Organizational Structure and Capabilities in Key Management Functions Should be Reassessed and Adjusted as Necessary

MDOE and SEIU (State Intermediate Educational Unit or CDS Central Office) should continue to re-assess the CDS System structure and relationships among the entities involved.

MDOE should initiate additional changes as necessary to create clear lines of authority and defined roles and responsibilities that facilitate sound program management, accountability and quality service delivery. MDOE and the SIEU should also determine the data, systems, tools and staff skill sets needed for more comprehensive, system-wide management of the CDS program and take steps to expand those capabilities in the SIEU.

Summary of Planned Management Actions

The new organizational structure for CDS only recently became law. The intent on the part of both CDS and MDOE is, in the near term, to fully implement the new organization model, and continue to find ways to more fully standardize CDS' operating procedures and more fully integrate them with MDOE's operating procedures. Moving forward, CDS and MDOE will assess how well these new structures are working, and will seek to make additional adjustments to the structure as needed.

Finding 2: Greater Emphasis Needed on the Responsible Stewardship of Resources in the Delivery of Appropriate, Quality Services

MDOE and the SIEU should emphasize the responsible stewardship of State and federal resources in delivering appropriate services to children. This adjustment in culture and mindset should be promoted and supported throughout the CDS System when establishing the service levels in children's Plans and considering the most efficient and cost-effective means of providing those services.

Summary of Planned Management Actions

The SIEU will revise polices/ procedures, and provide training to CDS personnel and stakeholders (i.e. parents, contracted providers), on making appropriate determinations of services based on consistent standards that meet IDEA and MUSER requirements in the most cost-effective way.

Finding 3: MDOE Should Adjust Budget Processes and More Actively Monitor CDS Program Finances

MDOE and the SIEU should improve budget and fiscal monitoring processes.

A system-wide budget that accurately reflects projected program resource needs should be developed and used as the basis for the Governor's Biennial Budget proposal to the Legislature.

MDOE should require formal written financial reports from the SIEU comparing actual to budgeted expenses including explanations for budget variances.

MDOE should also require additional written detail on expenditures, or explanation of current fiscal situation as necessary, to adequately support the release of funds to the SIEU.

Lastly, MDOE should consider its need for independent and better access to the financial detail for the CDS program and, if desired, take steps to obtain that access.

Summary of Planned Management Actions

CDS will create a system-wide budget using Zero Based Budget procedures comparable to those used by State agencies. Further development of fiscal reports will allow for actual system-wide costs to be compared to the budget. The SIEU will provide monthly budget to actual reports to the Commissioner and Deputy Commissioner to support the release of funds.

Finding 4: CDS Should Improve Monitoring of Staff Resources Used in Delivering Services

CDS should develop standard methods to track and monitor CDS direct service staff time by activity and services provided, as well as related costs. Data on service units provided by CDS employees should be compared against children's Plans and entered in Case-e. CDS should establish a consistent and appropriate process for calculating and monitoring staff productivity and costs per unit of service provided.

CDS should use that data to develop site and system-wide budgets, understand the true cost of services provided by CDS staff and to make choices about the most cost-effective ways to deliver quality services.

Summary of Planned Management Actions

CDS will investigate human capital management options and will adopt a new process to more closely manage human resources costs. CDS will develop a procedure to compare planned services to actual services delivered by CDS employed staff. CDS will develop a set of uniform standards that are to be used by site managers to determine if a site needs additional direct service staff.

Finding 5: Key Data Important for Managing Program Should be More Reliable and Consistent

The SIEU should improve or establish necessary policies, processes and procedures to ensure that critical data captured in CDS' computer applications is current, standardized and accurate. The following data, in particular, should be addressed: Case-e planned services data when CDS staff is to be the provider including service type, frequency and intensity of service units, and service provider name; Case-e MaineCare and insurance eligibility information; vendor/provider names in both Case-e and Great Plains; Great Plains account codes, and Case-e contracted provider rates.

Access to view and change this data should be limited to only those CDS employees who need such access to perform their jobs.

Summary of Planned Management Actions

The SIEU agrees with the recommended actions which have been part of our ongoing quality improvement strategies. The SIEU will continue reinforcement of policies and procedures through training and monitoring to increase timeliness, consistency and reliability of information entered into the data systems.

Finding 6: Contract Management for All Contracts Should be More Centralized and Professional Administrative Services Should be Competitively Procured

Contract management for contracted direct service and transportation providers should be centralized. See report or TM for additional details.

Professional services should be contracted for via competitive procurement processes.

CDS should employ, rather than contract with, individuals who provide regular, ongoing administrative services in order to ensure compliance with federal labor and tax laws.

Summary of Planned Management Actions

CDS is currently defined as a quasi-independent State entity under the recently enacted legislation stemming from LD 1843. To comply with the requirements now established in 5 MRSA §12022(3), the SIEU must develop a request for proposal process by December 31, 2012 and will fully implement a centralized competitive contracting process by July 1, 2013.

Finding 7: CDS Should Explore Potential Opportunities to Maximize Revenue and Mitigate Fiscal Impact of MaineCare Rule Change

CDS should maximize all potential revenue sources by improving capability for billing individual insurance companies where additional revenue would justify the additional expense.

Sliding fee scales being used for Part C in other states should be explored and assess whether Maine's scale should be restructured. Sliding fee scale should be implemented more consistently system-wide or MDOE and the SIEU should consider abolishing this potential revenue stream altogether so that families across the State are treated equitably.

CDS should also explore opportunities for maximizing revenue from MaineCare/insurance companies within the requirements of existing Medicaid/insurance laws and regulations. Billing to MaineCare for Section 28 services and new laws allowing services to be billed to private insurers are areas to be explored.

Summary of Planned Management Actions

The SIEU has developed a draft Family Cost Participation Policy with sliding fee scale to be reviewed by MDOE and the Attorney General's Office and submitted for proposed rule making. The SIEU continues to collaborate with MaineCare and private insurance companies to determine appropriate reimbursement/ billing policies and procedures for third party payors.

Finding 8: DHHS and MDOE Should Address Risks of Potential Fraud and Abuse in MaineCare Program Associated with Claims for CDS Services

DHHS' Program Integrity Unit, in conjunction with MDOE, should analyze MaineCare claims paid for services provided to children in the CDS program to determine whether there are indicators of fraud, abuse or error associated with the risks OPEGA identified. The Program Integrity Unit should then follow up with an investigation of any potential fraud or abuse identified.

Additionally, the DHHS Internal Audit group should assess the effectiveness of the preauthorization process conducted by the Office of MaineCare Services with regard to Section 28 providers and services associated with children in the CDS program.

Summary of Planned Management Actions

CDS will continue to collaborate with DHHS to ensure that risks of fraud and abuse in the MaineCare program associated with children served by CDS are mitigated to the extent reasonable.

Historically, DHHS Program Integrity Unit has reviewed this service for medical necessity and welcomes any analysis OPEGA has conducted as part of their review. To the extent any potential fraud or abuse is identified, the Program Integrity Unit will follow up.

The DHHS Internal Audit Unit will work with the Office of MaineCare Services in regard to preauthorization process for Section 28 providers and services associated with children in the CDS program.

DHHS will continue efforts to improve coordination with MDOE and CDS and establish policies, processes and procedures.

STATE OF MAINE
DEPARTMENT OF EDUCATION
23 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0023

PAUL R. LEPAGE
GOVERNOR

JAMES E. RIER, JR.
ACTING COMMISSIONER

Questions from November 23, 2013 H&HS Committee Meeting and Responses from Child Development Services December 10, 2013

Child Development Services

69. Please provide information on changes and improvements in the Child Development System.

- CDS has a new website that can be found at: www.maine.gov/doe/cds/

- Tremendous improvement in financial accounting practices has been achieved since CDS is now functioning as a single entity. Along with long overdue software upgrades and a management reporter application, financial reporting is systematic, concise and efficient. Staff productivity has increased significantly and as a result of the RFP process the annual audit fees for the current year end audit have been reduced by almost half from prior years.

- Close monitoring of regional site budgets including a rigorous review process when sites indicate the need to hire more Special Education teachers, Educational Technicians or Therapists has resulted in improved fiscal management of the funds allocated to sites and a reduction in the overall number of employed staff.

- A new and improved relationship with contracted providers has been a major focus both at the state and local levels. A prime example being the successful transfer of The Reach School in South Portland that operated for 15 years as a CDS run preschool to Easter Seals of Maine- about 30 CDS employees have now become employed by Easter Seals in this huge shift that we all see as a win for families and children as well as our providers, employees and the CDS program. This will be a loss of Maine Care generated revenue to CDS - however it will be a large net savings to the CDS budget, greatly reducing our employee count and operational expenses.

- CDS has issued a Request for Proposals for an Early Childhood Intervention Management System (a new data system) that will remediate long-standing issues that have challenged the system for many years. A new data system will provide the consistency, integrity, availability and reliability of program and fiscal data to answer questions posed by stakeholders in a quick and efficient way. It will make the workload more manageable for those in the field is accessible to our contractor providers for child data entry, including attendance and invoicing and parents will be able to access their child's information through this new system. It will revolutionize how the CDS system functions. Proposals are due December 17, 2013 with the intention for a contract to begin work to be in place in March of 2014.

70. With regard to changes and improvements in CDS please provide information on the impact of those changes and improvements on children served by CDS, CDS service providers, school administrative units and the Maine Care system.

- Safe and reliable transportation of identified children to services continues to be a primary area of focus and is a major cost driver in the CDS system. We are monitoring and taking corrective action to seek out improved options for transporting children. We are working closely with the manager of Non-Emergency Transportation for Maine Care, and Children's Services at Maine Care to come up with strategies and mechanisms for improving transportation of young children so that CDS can guarantee children are transported appropriately and can get to where they need to be for interventions.

- Due to improved accounting practices and a routine allocation schedule of revenue transfers we have reduced provider complaints about untimely payment to almost non-existent.

- CDS has greatly increased the number of our contracted vendors who are paid via the Automated Clearing House (ACH) process - effective January 1, 2014. ALL vendors will be paid in this manner and emailing remittance information will be standard. A reduction on postage costs will be realized through this initiative.

- Independent Provider contracts are now being completely administered directly from the state office having been updated and revised, the process is now 100% uniform statewide and is already showing a huge improvement in consistency and understanding of what is required of contractors and how payment will be authorized.

- Through the State Personnel Development Grant, CDS has been able to secure the services of the renowned expert in Early Intervention, Dr. Robin McWilliam, of the Siskin Children's Institute and Assistant Professor of Special Education at U Maine Oromo, Deborah Rooks-Ellis to further our work in Early Intervention under Part C of the Individuals with Disabilities Education Act (IDEA). We are training CDS staff to become Routines Based Interviewers (RBI) and have developed an Implementation team that will bring Routines Based Early Intervention to practitioners (both employees of CDS and contractors). Next summer we will send several Early Intervention staff to the national institute to become certified trainers in the RBI process.

- The Governor's Office has appointed a new State Interagency Coordinating Council for Part C, which is a federally-required component of the IDEA. They convened last November and have held numerous meetings throughout the year. They have engaged with our Technical Assistance providers to guide them in their new configuration and have several initiatives underway. For further information about this advisory panel, agendas, and minutes please visit: http://www.maine.gov/doe/specialed/idea/index.html

- The Governor's Office appointed a new Part B State Advisory Panel which began meeting May 15, 2013. The purpose of this advisory panel is to provide policy guidance with respect to special education and related services for children with disabilities ages 3-20 in the state. This is a federally-requirement component of the IDEA.

To: Helen Baily

Fr: J. Harper

Date 12/2/13

RE: RPC progress on meeting CMS plan and respond to oversight committee for new prison mental health unit.

Pursuant to you requests I have reviewed that past twelve months of incident data to determine whether it supports the Superintendents claim that RPC clients are more violent and that there is a pattern of overcrowding at RPC.

I used the RPC meditech data base for this analysis which therefore assumes that RPC's own data is correct and has not be "fixed" in any way. Further I have limited the data analysis to the SCU (special care units) which regularly house the most aggressive or dysfunctional patients. (Attachment #1 includes all units data and attachment #2 includes the initial data that I have analyzed.

During the previous twelve months there have been 788 "coercive events" at RPC on the SCU's. That is over two per day. Of all of these events 501 were perpetrated by three clients. The common element amongst these three individuals is that they have been viewed as a complex cases (two of which are believed to suffer from the effects of traumatic brain injury) the third is in need of a highly structured and specialized neuro-behavioral program.

If I expand this evaluation to the top seven clients initiating aggressive acts I would need to point out that only 2 of these would meet the standard of LD 1515. So if the intention of the MSP unit would be to reduce violent acts or assaults at RPC it would have negligible effects. One of the two clients suffers from organic brain damage (extensive dementia) and should not be at RPC as they need a specialized behavioral dementia unit.

I would like to point out for reference that the patient who attacked the MHW and caused severe damage to her hand as well as trauma, would not even meet any of the search criteria I employed. This was an isolated incident but one that seasoned staff should have seen coming..

The most potentially violent patients at RPC are the patients that the staff does not know. Untrained staff, staff shortages for each shift, poor mentoring and vacillating unit management create an unsafe clinical environment. When staff do know a patient and are able to act on that knowledge they are able to have foresight into a patients behaviors prior to in appropriate and potentially violent actions by the patient.

A significant reduction of violence and aggressive patient actions could, in all most all cases, could be reduced if the staff were not burned out by mandated overtime, given proper basic training in psycho social approaches to recovery, assigned to specific units and not floated onto an unknown unit with unknown patients, provided proper mentoring on skill application to specific patients and empowered to disengage when they believe patients are not acting as previously identified.

The most proven way to reduce violence is to provide the proper staff, activities and treatment to the patient.

Number of Riverview Coercive Events by Location, Month and Legal Status

Nov-12	UNIT		LKCIV	LKSCU	LSFOR	LSSCU
LEGAL STATUS		INVOL-CIV	2			
		ICDCC		11		1
	INVOL CRIM	T-15 DCOBS		1		4
	INVOL CRIM	T-15 SOBS		1	1	31
	INVOL CRIM	NCR				11
	INVOL CRIM	IST				

Dec-12	UNIT		LKCIV	LKSCU	LSFOR	LSSCU	UK
LEGAL STATUS		INVOL-CIV					2
		ICDCC	3	7			1
	INVOL CRIM	T-15 DCOBS		7		3	
	INVOL CRIM	T-15 SOBS		1	3	30	
	INVOL CRIM	NCR		2		20	
	INVOL CRIM	IST					
	ICRDCC	T-15 SOBS				1	

13-Jan	UNIT		LKCIV	LKSCU	LSFOR	LSSCU	UK
LEGAL STATUS		INVOL-CIV					
		ICDCC	2	2		1	1
	INVOL CRIM	T-15 DCOBS					
	INVOL CRIM	T-15 SOBS			1	26	4
	INVOL CRIM	NCR	6	2			
	INVOL CRIM	IST		1	1	4	1
	ICRDCC	T-15 SOBS					

Feb-13	UNIT		LKCIV	LKSCU	LSFOR	LSSCU	UK
LEGAL STATUS		INVOL-CIV					1
		ICDCC	1				
	INVOL CRIM	T-15 DCOBS					
	INVOL CRIM	T-15 SOBS			3	10	2
	INVOL CRIM	NCR		11		8	
	INVOL CRIM	IST			3	3	
	ICRDCC	T-15 SOBS					

Mar-13	UNIT		LKCIV	LKSCU	LSFOR	LSSCU	UK
		VOL	1				
LEGAL STATUS		INVOL-CIV					
		ICDCC		5			2
		ICDCC-PTP		2			
	INVOL CRIM	T-15 DCOBS				1	
	INVOL CRIM	T-15 SOBS				20	
	INVOL CRIM	NCR		11	2	4	
	INVOL CRIM	IST				1	
	ICRDCC	T-15 SOBS					

Apr-13	UNIT		LKCIV	LKSCU	LSFOR	LSSCU	UK
		VOL					
LEGAL STATUS		INVOL-CIV					
		ICDCC	1	10		1	
		ICDCC-PTP					
	INVOL CRIM	T-15 DCOBS					
	INVOL CRIM	T-15 SOBS				5	
	INVOL CRIM	NCR		40		10	
	INVOL CRIM	IST					
	ICRDCC	T-15 SOBS					

May-13	UNIT		LKCIV	LKSCU	LSFOR	LSSCU	UK
		VOL					
LEGAL STATUS		INVOL-CIV					
		ICDCC	7	16			
		ICDCC-PTP					
	INVOL CRIM	T-15 DCOBS					
	INVOL CRIM	T-15 SOBS				9	
	INVOL CRIM	T-15 S1ST				3	
	INVOL CRIM	NCR		17		71	
	INVOL CRIM	IST					
	ICRDCC	T-15 SOBS					

1c

Jun-13	UNIT		LKCIV	LKSCU	LSFOR	LSSCU	UK
		VOL					
LEGAL STATUS		INVOL-CIV					
		ICDCC	2	25			
		ICDCC-PTP					
	INVOL CRIM	T-15 DCOBS					
	INVOL CRIM	T-15 SOBS		3		3	
	INVOL CRIM	T-15 S1ST					
	INVOL CRIM	NCR				35	
	INVOL CRIM	IST				12	
	ICRDCC	T-15 SOBS					

Jul-13	UNIT		LKCIV	LKSCU	LSFOR	LSSCU	UK	US
		VOL						
LEGAL STATUS		INVOL-CIV						
		ICDCC	1	24		1	1	
		ICDCC-PTP						
	INVOL CRIM	T-15 DCOBS						
	INVOL CRIM	T-15 SOBS				5	3	
	INVOL CRIM	T-15 S1ST					1	
	INVOL CRIM	NCR				7		2
	INVOL CRIM	IST				7		
	ICRDCC	T-15 SOBS						

Aug-13	UNIT		LKCIV	LKSCU	LSFOR	LSSCU	UK	US
		VOL		1				
LEGAL STATUS		INVOL-CIV						
		ICDCC	1	20		2		
		ICDCC-PTP						
	INVOL CRIM	T-15 DCOBS						
	INVOL CRIM	T-15 SOBS				14	6	
	INVOL CRIM	T-15 S1ST						
	INVOL CRIM	NCR				3		1
	INVOL CRIM	IST						
	ICRDCC	T-15 SOBS						

1d

Sep-13	UNIT		LKCIV	LKSCU	LSFOR	LSSCU	UK	US
		VOL	2					
LEGAL STATUS		INVOL-CIV						
		ICDCC	6	43				
		ICDCC-PTP						
	INVOL CRIM	T-15 DCOBS						
	INVOL CRIM	T-15 SOBS	1			55		
	INVOL CRIM	T-15 S1ST						
	INVOL CRIM	NCR				6		
	INVOL CRIM	IST				6		
	ICRDCC	T-15 SOBS						

Oct-13	UNIT		LKCIV	LKSCU	LSFOR	LSSCU	UK	US
		VOL						
LEGAL STATUS		INVOL-CIV						
		ICDCC	2	54			2	
		ICDCC-PTP						
	INVOL CRIM	T-15 DCOBS						
	INVOL CRIM	T-15 SOBS				20		
	INVOL CRIM	T-15 S1ST						
	INVOL CRIM	NCR				10		
	INVOL CRIM	IST		2		5		
	ICRDCC	T-15 SOBS						

#2

		Nov-12		Dec-12		Jan-13		Feb-13		Mar-13		Apr-13		May-13		Jun-13		Jul-13		Aug-13		Sep-13		Oct-13		TOTAL Per Client
		LKSCU	LSSCU	LKSCU	LSSCU	LKSCU	LSSCU	LKSCU	LSSCU	LKSCU	LSSCU	LKSCU	LSSCU	LKSCU	LSSCU	LKSCU	LSSCU	LKSCU	LSSCU	LKSCU	LSSCU	LKSCU	LSSCU	LKSCU	LSSCU	
	UNIT TOTAL	13	47	17	54	5	31	11	21	18	26	50	16	33	83	28	50	24	20	21	19	43	67	56	35	788
Client FR Numbers	FR0000312892		29		28		23		10		19		5		7						10		55		17	203
	FR0000289611		11		16			11		11		38		17	40		21									165
	FR0000366310	11										10		14		24		23		19		24		10		135
	FR0000000299								7				6													13
	FR0000387175												4		6		5									15
	FR0000000919														26		6									32
	FR0000431429																					15		43		58

MEMORANDUM OF AGREEMENT
Between
Maine Department of Corrections
and
Maine Department of Health and Human Services
for the Placement and Transfer of Prisoners into the
Department of Corrections Intensive Mental Health Unit
DRAFT 11/25/2013

This Memorandum of Agreement ("MOA") is entered into this xx day of XXXX, 20xx by and between signatories Maine Department of Health and Human Services ("DHHS") and Maine Department of Corrections ("DOC').

RECITALS

WHEREAS, DHHS and DOC recognize the mutual benefit of utilizing the Department of Corrections Intensive Mental Health Unit for eligible prisoners who would otherwise be the responsibility of a jail or state mental health institute;

NOW THEREFORE, in consideration of these mutual covenants as to the procedures and scope of responsibilities for each party regarding the placement and transfer of such prisoners into the DOC Intensive Mental Health Unit;

A. DHHS agrees:

1. For an adult male prisoner referred by a jail to a state mental health institute for possible civil commitment, the Superintendent of the Riverview Psychiatric Center shall evaluate the eligibility of the prisoner for admission to a state mental health institute under Title 34-B, section 3863, and the availability of a suitable bed at the Center. If the Superintendent confirms the prisoner is eligible for admission and that no suitable bed is available, but that the prisoner is appropriate for referral to the Maine State Prison's Intensive Mental Health Unit, the Superintendent may refer the prisoner to the DOC Director of Treatment, or designee, for a determination whether to accept the prisoner for transfer to the Maine State Prison's Intensive Mental Health Unit;

2. For an adult male prisoner referred by the State Forensic Service for transfer from a jail in order to conduct an examination under Title 15, section 101-D, subsection 1, 2, 3, or 9, because the jail cannot provide an appropriate setting for the examination, but the Intensive Mental Health Unit can, the Superintendent of the Riverview Psychiatric Center may refer the prisoner, on behalf of the State Forensic Service, to the DOC's Director of Treatment, or designee, for a determination whether to accept the prisoner for transfer to the Maine State Prison's Intensive Mental Health Unit;

3. For an adult male prisoner committed by a court to the custody of DHHS for observation under Title 15, section 101-D, subsection 4, and with respect to whom the court has found the prisoner has a mental illness as a result of which the prisoner poses a likelihood of serious harm to others; there is not sufficient security at a state mental health institute to address the likelihood of serious harm; and there is no other less restrictive alternative to placement in a prison mental health unit, the Superintendent may refer the prisoner to the DOC's Director of Treatment, or designee, for a determination whether to accept the prisoner for placement into the Maine State Prison's Intensive Mental Health Unit;

4. The Superintendent may not refer any person who is currently the subject of a court finding of incompetent to stand trial or not criminally responsible by reason of insanity;

5. Upon referral, the Superintendent shall provide whatever supporting documentation is requested by the DOC Director of Treatment, or designee;

6. DHHS shall immediately accept the return of any prisoner placed in the Intensive Mental Health Unit for observation pursuant to 3. above whose placement has been terminated by DOC;

7. DHHS shall provide consultation services as needed related to the treatment of any male prisoner placed in or admitted to the Intensive Mental Health Unit, regardless of whether the prisoner was transferred to or placed in the unit pursuant to this Memorandum of Agreement; and

8. When the DOC is proposing to obtaining a court order for involuntary medication of any male prisoner placed in or admitted to the Intensive Mental Health Unit, DHHS shall make available a professional qualified to prescribe the medication to provide a second clinical opinion as to whether the recommendation for the medication is supported and, if necessary, to testify at the involuntary medication proceedings, regardless of whether the prisoner was transferred to or placed in the unit pursuant to this Memorandum of Agreement.

B. DOC agrees:

1. DOC shall determine whether to accept a prisoner within a maximum of 10 days from the referral from DHHS and the provision of any requested documentation;

2. DOC shall provide all transportation for any prisoner who has been accepted;

3. DOC shall provide all care, custody, and treatment of a prisoner who has been accepted into the Intensive Mental Health Unit until the prisoner's

DRAFT

return to the jail has been ordered by DOC or the prisoner's placement from DHHS has been terminated; and

4. DOC shall inform the jail it must immediately accept the return of any prisoner transferred to the Intensive Mental Health Unit for treatment or examination pursuant to A.1. or 2. above whose return has been ordered by DOC.

C. Both Parties agree that:

1. The DOC Commissioner, or designee, has the discretion to either approve or deny any request for the transfer or placement of a prisoner into the DOC Intensive Mental Health Unit and to order the return of a prisoner to a jail or terminate a prisoner's placement from DHHS at any time;

2. This MOA may be amended at any time by mutual agreement of the parties, provided that, for any amendment to be operative or valid it shall be reduced to writing and signed by both parties; and

3. This Agreement shall be construed, governed, and interpreted under the laws of the State of Maine, and if any provisions of this Agreement or parts thereof are held to be invalid under such laws, the other such provisions or parts thereof will nevertheless continue in full force and effect.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement as of the day, month and year first written above.

MAINE DEPARTMENT OF CORRECTIONS

By: _____ _____
Signature Date
Name:
Title:
Mailing Address:

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

By: _____ _____
Signature: Date
Name:
Title:
Mailing Address:

DRAFT

MEMORANDUM OF AGREEMENT
between
Maine Department of Corrections
and
Maine Department of Health and Human Services
for the Placement of Prisoners under Guardianship
DRAFT 11/25/2013

This Memorandum of Agreement ("MOA") is entered into this xx day of XXXX, 20xx by and between signatories Maine Department of Health and Human Services ("DHHS") and Maine Department of Corrections ("DOC').

RECITALS

WHEREAS, DHHS and DOC recognize the need, at times, for the appointment of DHHS guardians to make medication decisions for prisoners in the custody of DOC;

NOW, THEREFORE, in consideration of these mutual covenants as to the procedures and scope of responsibilities for each party regarding guardianship of prisoners in the DOC Intensive Mental Health Unit;

A. DHHS agrees:

1. For a male prisoner placed in or admitted to the Maine State Prison's Intensive Mental Health Unit, DHHS shall, upon referral from DOC, expedite the process of assessing the appropriateness of guardianship for the purpose of making medication decisions;

2. DHHS shall initiate an on-site guardianship evaluation within a maximum of 10 days from the referral from DOC;

3. As part of the evaluation, DHHS shall engage in a face to face discussion with the Intensive Mental Health Unit Treatment Team;

4. DHHS shall complete the evaluation and present it to the Intensive Mental Health Unit Treatment Team within 30 days;

5. DHHS shall participate in a case conference with members of the Intensive Mental Health Unit Treatment Team to deliver the evaluation findings;

6. If it is determined that the prisoner is appropriate for guardianship, DHHS shall expedite the application to the court for the appointment of a guardian, initially using the process for the court appointment of an emergency guardian, to be followed by timely application for the appointment of a permanent guardian; and

7. DHHS shall apply for the emergency guardianship within a maximum of 10 days from the determination that guardianship is appropriate

B. DOC agrees:

1. DOC shall make the prisoner, Intensive Mental Health Unit Treatment Team members, and prisoner/patient records available to DHHS;

2. DOC shall provide DHHS the appropriate, secure, confidential meeting space and office space to conduct and complete the evaluation; and

3. If it is determined the prisoner is appropriate for guardianship, DOC shall make the Intensive Mental Health Unit Treatment Team members available to provide witness testimony as needed for the emergency and permanent guardianship proceedings.

C. Both Parties agree that :.

1. This MOA may be amended at any time by mutual agreement of the parties, provided that for any amendment to be operative or valid, it shall be reduced to writing and signed by both parties; and

2. This Agreement shall be construed, governed, and interpreted under the laws of the State of Maine, and if any provisions of this Agreement or parts thereof are held to be invalid under such laws, the other such provisions or parts thereof will nevertheless continue in full force and effect.

IN WITNESS WHEREOF, the parties hereto have entered into this Agreement as of the day, month and year first written above.

MAINE DEPARTMENT OF CORRECTIONS

By: _____ _____
Signature Date
Name:
Title:
Mailing Address:

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

By: _____ _____
Signature: Date
Name:
Title:
Mailing Address:

DRAFT

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December 7, 2013

I have had multiple phone calls and discussions from volunteer drivers and clients complaining that the ride system for MaineCare recipients is still not working well. I had a patient last week who told me that she still is on hold for 20 minutes at a time trying to find a ride, but then "her baby starts crying and she cannot continue to hold and will call back to have the same thing happen again – she will call 3 or 4 times in a day and still not get through to a scheduler (she doesn't hold more than 20 minutes) and has given up on getting rides. I am enclosing testimony from Gary Dyer, Volunteer Driver from KVCAP, Madison, ME, since he felt it might be helpful in understanding the problems that the drivers are having. Gary is a constituent of mine from Madison who has been a volunteer driver for many years. He is quite concerned about the current ride system for MaineCare recipients and tells me the following:

My name is Gary Dyer of Madison and my phone number is 696-5742. I have been a volunteer driver for K.V.C.A.P. for nearly six years. Volunteers drive clients to and from medical appointments and are paid a mileage stipend for our services. I am not employed by K.V.C.A.P., nor do I represent them in any way. I am acting by myself to try to make things better for my clients. I am SOLELY RESPONSIBLE for everything contained in this information packet. I am uneasy about the possible repercussions of writing this, but I believe the C.T.S. has caused enough anguish and they should not continue to have the contract to provide these rides.

As a volunteer driver, I see on a daily basis the problems that are happening and feel that C.T.S. is not capable of doing its job to arrange for client rides to appointments. I don't like to say bad things about people, but it's a fact. I feel that the problem lies with management; it seems that they have not trained their workers properly, their computers seem to "have Alzheimer's," and they don't have a clue about the geography of the areas that we operate in.

The rides are booked through a C.T.S. call center in Lewiston. If the information that they pass along to K.V.C.A.P. for dispatching is wrong or incomplete, we need to call them. The main problem is that they can almost never find the information we, the drivers, need. I feel this organization has shown that they are not remotely capable of operating this call center.

C.T.S. GLITCHES

1. Often drivers get no more than a physical address
2. They say that they can only pass on what information is given by the client; no additional questions seem to be asked for clarification
3. When a specific place is mentioned and the client doesn't give more information, C.T.S. should ask for specifics, but they often do not

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4. When I have to pick up a client at a facility with multiple entrances (like Redington-Fairview General Hospital), I cannot find the client unless I know what entrance to go to
5. When a client goes to 325 Kennedy Memorial Drive in Waterville, which is a huge doctor's complex with multiple buildings, just recently have we been told which building to go to – A through E
6. We often will be given the address of an apartment complex and not told the apartment number. One recent example is a building with 8 apartments and I was not given the apartment number, called the client phone number listed on my sheet and the client hadn't lived there for 2 months! The person I spoke to at C.T.S. said I wasn't supposed to be there anyway – Mac's Taxi was! We both got "No Shows" = no pay
7. Usually when I call C.T.S. if I need additional information, as is recommended by K.V.C.A.P., C.T.S. cannot find the information that I need
8. They do not seem to want to improve their service. I have called them and made suggestions on how they could improve and now I am told not to call them directly anymore. I guess they think I'm telling them how to run their business. I do not feel that I have been threatening when I have called – I only ask questions that I need.

I listen to clients while a drive and I have not heard anything positive from them about C.T.S. and the current ride system. Clients get into my car raving about them on a daily basis. Examples include:

1. One client told me he has missed five of six counseling appointments and is in danger of losing his doctor!
2. A lady at an assisted living home was not going to go to her counseling appointment without reassurance of a return ride – she had been stranded TWICE. I was also the return driver, so she went
3. I often transport a young couple who live together, go to the same program on the same day and at the same time. It took this couple 2 months to get C.T.S. to understand that and stop ordering two separate cars to pick them up
4. I was recently given an address in Madison of "Meben Way." Only after a K.V.C.A.P. person managed to get past all of the privacy concerns were we able actually discern that it was actually "Edens Way Lane." The client had actually spelled the name of the street and given all of the information for his/her appointment to the C.T.S. person who took the call. The appointment was for Eastern Maine Medical Center in Bangor, but the only thing on the trip sheet was "489 State St., Bangor," with no other information about an entrance to go to. The actual address was 417 State Street! Fortunately, we were able to get the client to the provider for a prosthetic device. C.T.S. should have had this information on the trip sheet.
5. Another incident was an address for 221 Lakewood Rd., Madison. This was actually Yonder Hill Campground with 150 camping sites. No other address and no phone number was given to contact the person I was supposed to pick up. Fortunately, I was a little late and the person called back to see where the ride was, so the information was obtained at that point
6. A special needs client was originally scheduled to be picked up at 1:00 p.m. The client's mother called C.T.S. and asked for the pick up time to be changed to 2:31. C.T.S. assured her that the time was changed, but the trip sheet came through with

the original pick up time of 1:00. Fortunately, I was in the same town and place for another client, so K.V.C.A.P. authorized me to also pick up the first client as well

7. I was asked to pick up a client at an apartment building in Pittsfield. I called C.T.S. 3 times trying to figure out which apartment and where to meet the client. They didn't have the client's phone number and it was not on the trip sheet. When I finally found the client, she said that I was the 5th driver who had had a problem finding her and she said that she HAD given them her number.

Since C.T.S. has taken over this program, I hear only negative comments from our clients. I really miss the upbeat, respectful, appreciative clients that I transported before C.T.S. took over. I want them back.

----Gary Dyer

Representative Ann Dorney
District 86