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
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax (207) 287-3005
TTY Users: Dial 711 (Maine Relay)

October 13, 2015

To: Senator Eric L. Brakey, Chair
Representative Drew Gattine, 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 Response to questions from HHS FHM Committee

1. What are the State's current public health care and preventative health priorities and goals? What are the strategies for addressing those priorities?

   Response: The State Health Improvement Plan (SHIP) outlines the state's current health priorities and goals, as well as the strategies for addressing those priorities. As noted previously, the full document can be viewed at http://www.maine.gov/dhhs/mecdc/ship/. For a higher-level view of the health improvement plan, that webpage also contains an executive summary of the SHIP (http://www.maine.gov/dhhs/mecdc/ship/SHIP_ExecutiveSummary.pdf).

2. Can the Committee get more information on the 2013-2017 State Health Improvement Plan? Are there any other sources or documents that establish health priorities and goals for the state? Could the committee have an update on progress with respect to the priorities listed (immunization, obesity, substance abuse and mental health, tobacco use) in the document delivered to the committee on 9/28—is the department on track to meet these goals; how much has been spent; if the goals will not be met, what would help achieve them?

   Response: Public health work is a partnership among state and local entities. The Department alone is not responsible for progress towards a goal of preserving, promoting, and protecting health. As noted in the introductory Background section of the SHIP, it is "with many organizations, both public and private, sharing this goal, (that) an engaged public-private collaboration assures efficient and effective services and systems." For an update on the progress related to the priorities, please refer to the SHIP Implementation Plan http://www.maine.gov/dhhs/mecdc/ship/SHIP-Implementation-Plan-FINAL.doc and the documentation that has been provided by the Community partners that have also been asked to present today.

3. How have the needs of the state changed with respect to categories of spending from the FHM? Where should the state invest more?

   Response: Please see the attached budget fact sheet dated 2-16-2015. Primary care is the most effective way to address the public health challenges Maine faces today.

4. How does the Maine CDC determine its public health priorities? What national, state and local data points and national best practice information is used to determine these priorities?

   Response: Please see information provided at http://www.maine.gov/dhhs/mecdc/ship/. The section of the SHIP entitled "SHIP Prioritization Process" provides the methodology used. That section begins on page 16. Appendix C of the SHIP is entitled "Evidence-based References for Strategies" and provides the supporting detail for each strategy.

5. How are the priorities of programs funded by FHM but outside of the CDC (including DHHS programs) determined?

   Response: The approved biennial budget determines where FHM dollars will be utilized. For the 16-17 biennium, Public Law 2015 Chapter 267 governs this funding.

6. How do the Maine CDC public health priorities match up with Maine's leading causes of chronic disease, death and disability? Does FHM spending reflect those leading causes?

   Response: Please see information provided at http://www.maine.gov/dhhs/mecdc/ship/. The sections of the SHIP for each of the categorical priorities provides corresponding data used to match priorities with morbidity and mortality trends. The Department attempted to focus FHM spending on those leading causes. However; it should be noted that spending in and of itself does not address a problem. The recipients of those funds must also demonstrate efficacy and stewardship of these public dollars.

7. How does the Maine CDC's Partnership for a Tobacco Free Maine work plan match the federal CDC's Best [sic] Practice for Comprehensive Tobacco Control Programs, including recommended funding levels?

   Response: CDC's Partnership for a Tobacco Free Maine is structured to model the categories of the federal CDC's best practice for tobacco control programs. Currently, only two states (Alaska and North Dakota) fund tobacco control programs at 95% of the CDC's "recommended" level and that is reached only if federal funds are included in the total. More than 70% of all states do not even reach one-third of the CDC's recommended level of spending. The federal recommendations are unrealistic at best for any entity without unlimited resources.

8. How is the evidence base and success of each FHM program evaluated and reported to the public and the Legislature?

   Response: Consistent with 22 M.R.S. § 1511(13), a state agency that receives allocations from the fund and a contractor or vendor that receives funding allocated from the fund shall report by September 1st of each year to the Commissioner of Administrative and Financial Services providing a description of how those funds for the prior state fiscal year were targeted to the prevention and health-related purposes listed in law. The communication regarding the success of programs supported by FHM is both prolific and varied. There are formal mechanisms, including FHM-funded, DHHS-contracted evaluations of programming, some of which is available online or in state archives. Periodically, reports may be presented from the Office of Program Evaluation and Government Accountability to the Legislature. Less formal reports to the public and the Legislature also come in the form of social media, op eds, and marketing materials provided by advocates, although the rigor of evaluation for these messages has not been established.

9. Could the committee have specific information on each program within each office of DHHS? Funding level, services, number of people served, outcomes data information? Would the program people within DHHS be available to present that information and answer questions?

   Response: Please see Attachments 1 and 2. These orientation presentations were provided in January 2015. Copies of all office presentations can be provided upon request.

10. Not including FHM and federal funding, how many state dollars does Maine spend on the primary prevention of chronic illness?

    Response: Detailed clarification would be needed to answer this question.

11. Is DHHS on track to spend all of the FHM allocated to its programs by the end of the fiscal year? If not, can the Committee have a breakdown of which ones have not spent all of its allocations and the amounts unspent?

    Response: The Department has only concluded one quarter of the fiscal year, but currently spending is on track.

12. Is it possible to get a breakdown of the FHM funds that go to MaineCare initiatives? Are there specific uses for that funding, e.g. mental health, substance abuse, preventative care etc.? Are there performance measures attached to this spending, i.e. how is success measured?

    Response: FHM – Medical Care Services is transferred directly to Medicaid. It is then used to fund Medicaid reimbursable services that meet the requirements of the FHM statute.

13. Could the committee have an overview of how the HMP contracting works including data reporting requirements, audit and oversight of the vendors and contracts? A chart showing the relationship between DHHS, HMPs and subcontractors has also been requested.

Response: Contracting is a shared process between programs and the Maine DHHS Division of Contract Management (DCM); together, they provide contractual oversight of agreements including contract language and budget development. The Division of Contract Management exists to provide support to DHHS through the effective management of purchase of service agreements. A Division of 30 staff, it reviews, approves, and processed more than 2000 agreements per year. It also provides management tools for recording agreement information and performance as well as technical assistance regarding agreement development and management. DCM supports the program with review, approval and tracking of related contracts with an assigned agreement administrator.

The Department Agreement Administrator will monitor the timeliness, completeness, and accuracy of all financial expenditure reports, service delivery reports, performance based contracting reports, and all other reports required in Rider A of the agreement.

Compliance
The Department Agreement Administrator will require the provider to demonstrate compliance through documentation with any or all terms of the agreement. When a provider is out of compliance with the terms of an agreement, the following process may be followed.

The Department Agreement Administrator will notify the provider in writing of any agreement compliance issues identified by Department staff. The notice will include the agreement provision that is in noncompliance and a date by which the provider will comply;

If the compliance issues described in the notice mentioned above have not been addressed by the specified date, the Program Administrator and provider will meet, discuss, and document the compliance issues. The provider will develop a corrective action plan, which includes the actions required for compliance, date by which the provider will be in compliance, and consequences for noncompliance. The Department may require the provider to engage the services of a program consultant to assist with correcting the provider's failure to achieve agreement compliance. The Department Agreement Administrator reserves the right to select the consultant or to participate in the selection of a consultant. The corrective action plan will be approved by the Department and the Department Agreement Administrator will determine if the current agreement will be amended to incorporate the corrective action plan or if this will be done at the time of agreement renewal;

If the provider fails to undertake the corrective actions required for compliance with the agreement, the Department may terminate the agreement in accordance with Rider B.

Site Visits
The Department Agreement Administrator may conduct site visits at the provider's administrative offices and/or service delivery sites, as prompted by insufficient performance or other concerns, to observe, discuss, and evaluate the provider's capacity for carrying out the terms of the agreement. Follow-up action includes, but is not limited to, consultation with Department program management, corrective action plans, and special agreement requirements to address deficiencies.

Program Reviews
The provider will comply with program standards contained or referenced in the agreement. Program Reviews will be conducted when the need is determined by program management in collaboration with the Department Agreement Administrator. These reviews will be conducted by a team, as determined by program management. Program Reviews are comprehensive, resulting in a full assessment of the services provided, compliance with the terms of the agreement and program requirements, and other areas as needed. Program Reviews may be conducted onsite with the provider. If indicated, the Department may require the provider to develop a corrective action plan, subject to approval by the Department.

Technical Assistance and Training
The Department Agreement Administrator may provide technical assistance and training to providers on aspects of contracting with the Department, including, but not limited to, the proper completion of the agreement and financial reporting requirements.

14. More generally with respect to contracts using FHM funding, how are programs evaluated? When a contract is not meeting its deliverables, how is the vendor coached to perform and meet those deliverables?

    Response: Please refer to Question 13 above. For additional information, please refer to standard Rider language in State contracts. This is available online at http://www.maine.gov/dhhs/contracts/contract-2016/index.html.

15. Are contracts delivered in a timely manner (before or within one month of the contract start date)? If not, why not?

    Response: Maine DHHS does not intend to pursue arrangements that leave providers at risk. However, there are several external factors that impact the timing of the encumbrance of a contract including but not limited to the following:

    - The timing of state budget finalization and approval at the Legislature. Contracts cannot be developed for funding that is not secure.
    - Contract negotiations with providers, including budget and programmatic components.
    - Failure of the provider to return the agreement forms by the required submission date.
    - Incomplete contract components (such as budget pages).

- Confirmation that the provider's proposed costs to the Department comply with the administrative and cost principles contained in the applicable OMB Circulars.
- Confirmation that the provider is not debarred or excluded.
- No debt is owed to the Department other than as specified in an approved repayment plan.
- Department of Administrative and Financial Services (DAFS) approval, which involves the approval by the State Procurement Review Committee and/or the Director of the Division of Purchases, Bureau of General Services, Department of Administrative and Financial Services, as set forth in Executive Order No. 7 FY 10/11 issued by Maine Governor John E. Baldacci on March 16, 2010.

16. Could the committee get a specific breakdown of the specifics of FHM funding that goes to School Based Health Centers –smoking cessation, breakfast, MaineCare, others?

Response: A breakdown of the FHM funding is provided by the Office of Fiscal and Program Review. Recent analyses are available at http://legislature.maine.gov/legis/ofpr/appropriations_committee/materials/index.htm and http://legislature.maine.gov/legis/ofpr/tobacco_settlement_funds/fund_balance/fhmstat1617_127R1.pdf.

However, the Department is also aware that this and many of the questions posed above have been formally requested by legislators for OPEGA to review/audit (see also: https://assets.documentcloud.org/documents/2426599/opega-review-request-form.pdf) and is confident that OPEGA will pull this information together in a timely manner.

Attachment 3 also provides additional detail on the breakdown of spending in the FHM Community School Grant and Statewide Coordination Program for SFY 2014.

SFY 2014 Appropriation: FHM Community School Grants and Statewide Coordination
Program Name: Healthy Maine Partnerships

Program Description: Health promotion, education, and prevention services delivered through community coalition based structures to address tobacco, physical activity, and nutrition in Maine communities and schools.
*Outlined below are Fund for a Healthy Maine 14326 appropriation funds only; other funds not included.

Contractor:	Total Contract Amount:
ACAP (Healthy Aroostook)	$268,336
Sub-Contractor:	Sub-Contract Amount:
Cary Medical Center (Power of Prevention)	$120,000
Contractor:	Total Contract Amount:
Redington Fairview Hospital (Greater Somerset Public Health Collaborative)	$508,336
Sub-Contractor:	Sub-Contract Amount:
Healthy Communities of the Capitol Area	$120,000
Maine General Hospital (Healthy Northern Kennebec)	$120,000
Sebasticook Valley Hospital (Healthy Sebasticook)	$120,000
Contractor:	Total Contract Amount:
City of Portland (Healthy Portland)	$508,336
Sub-Contractor:	Sub-Contract Amount:
City of Portland (Healthy Casco Bay)	$120,000
The Opportunity Alliance (Healthy Rivers)	$120,000
The Opportunity Alliance (Healthy Lakes)	$120,000
Contractor:	Total Contract Amount:
Healthy Acadia	$268,336
Sub-Contractor:	Sub-Contract Amount:
Washington, County of (Washington County One Community)	$120,000
Contractor:	Total Contract Amount:
Mid-Coast Hospital (ACCESS Health	$508,336
Sub-Contractor:	Sub-Contract Amount:
Youth Promise (Healthy Lincoln County)	$120,000
Penobscot Bay YMCA (Knox County Healthy Communities)	$120,000
Waldo County General Hospital (Healthy Waldo County)	$120,000
Contractor:	Total Contract Amount:
River Valley Healthy Communities Coalition	$508,336
Sub-Contractor:	Sub-Contract Amount:
Central Maine Community Health (Healthy Androscoggin)	$120,000
Healthy Communities Coalition of Greater Franklin County	$120,000
Western Maine Health (Healthy Oxford Hills)	$120,000

Contractor:	Total Contract Amount:
Bangor Health and Welfare (Bangor Regional Public Health and Wellness)	$388,336
Sub-Contractor:	**Sub-Contract Amount:**
Katahdin Shared Services (Healthy Northern Penobscot)	$120,000
Mayo Regional Hospital (Piscataquis Public Health)	$120,000
Contractor:	**Total Contract Amount:**
University of New England (Coastal Healthy Communities Coalition)	$388,336
Sub-Contractor:	**Sub-Contract Amount:**
Goodall Hospital (Partners for Healthier Communities)	$120,000
York Hospital (Choose to be Healthy)	$120,000
Contractor:	**Total Contract Amount:**
Penobscot Indian Nation (Tribal HMP and Tribal Health Liaisons)	$383,336

Department of Health and Human Services

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Maine Center for Disease Control and Prevention

Legislative Orientation

Prepared for the

127th Legislative Session

January 2015

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

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

Maine Center for Disease Control and Prevention

Dr. Sheila G. Pinette, Director

Maine CDC, the State's public health agency, is responsible for promoting and protecting the health of Maine people.

We track the health of Maine's population and implement public health policies and programs that impact our most urgent health priorities.

We identify and mitigate environmental health hazards, provide valuable health information to the public, and prepare and respond to public health emergencies.

The Office At A Glance

Positions: 388

SFY '14 Expenditures: $119,573,447

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

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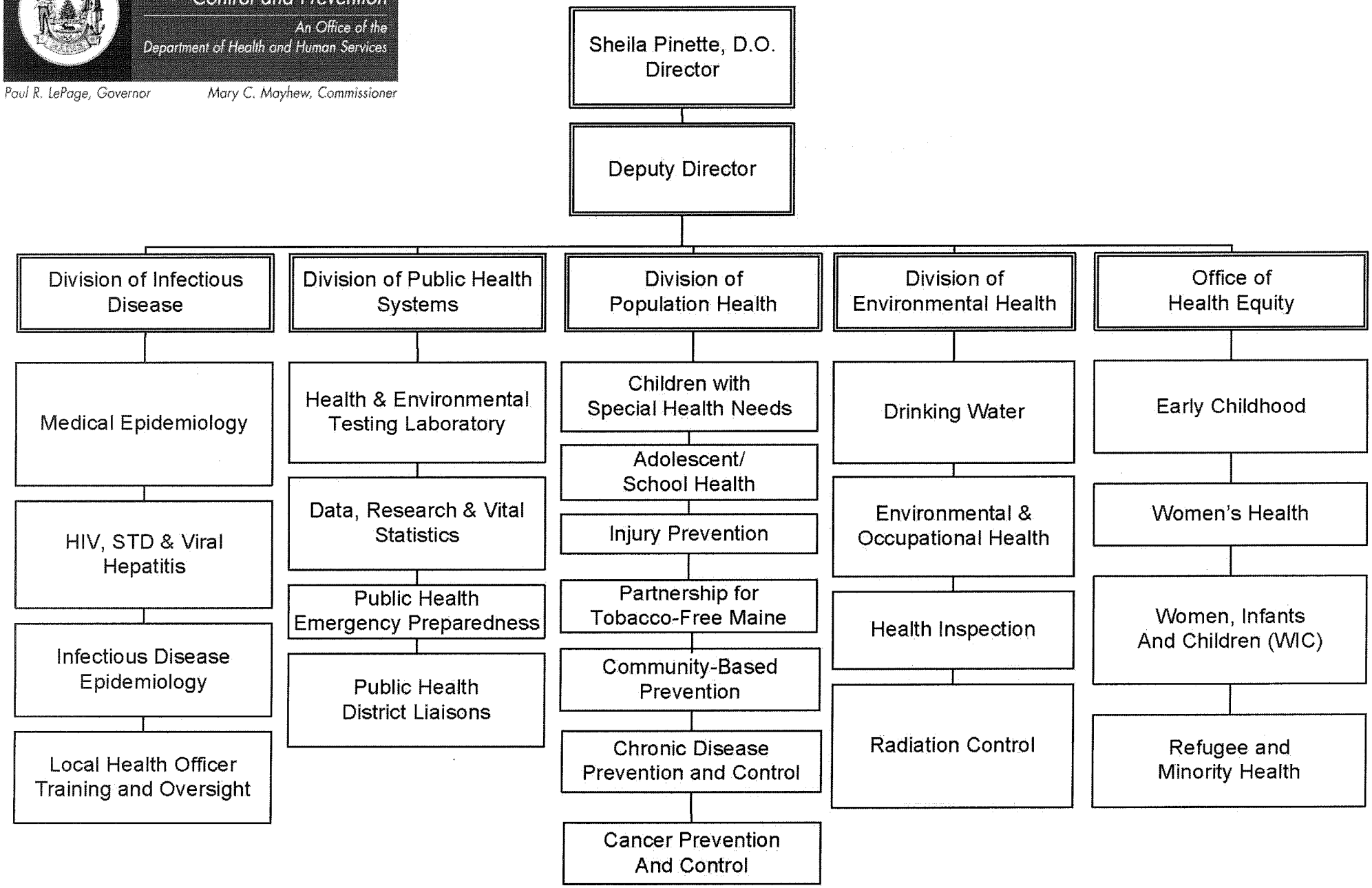

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

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

People We Serve
Services We Provide

- Systems for the early detection of disease, health conditions, and threats
- Methods for tracking and reporting health trends
- Planning for and rapid response to public health threats
- Promotion of safe and healthy environments for all Maine people
- Education about healthy behaviors that prevent disease, injury, disability, or loss of life
- Continuous quality improvement to achieve positive health outcomes
- Work to eliminate health disparities
- Response to public health concerns and complaints

Maine Center for Disease Control and Prevention
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People We Serve
Services We Provide

The Division of Infectious Disease

- Responds to infectious disease outbreaks and exposures
- Provides active surveillance for reportable infectious diseases
- Provides services for persons living with HIV or STDs and for those at risk
- Provides vaccines for all Maine children and selected vaccines for adults

The Division of Population Health

- Prevents chronic disease by promoting healthy behaviors
- Provides chronic disease education
- Supports children with special health needs
- Supports women of reproductive age and their families, enabling a healthy start for children

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

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People We Serve
Services We Provide

The Division of Public Health Systems

- Prevents, prepares for, and responds to public health emergencies
- Operates the health and environmental testing lab, available 24/7 to identify health hazards and bioterrorism threats
- Administers Maine's new electronic vital records systems
- Engages partners to conduct health improvement planning

The Division of Environmental Health

- Promotes safe food and drinking water in restaurants, schools and youth camps
- Performs emergency response to natural disasters and environmental hazards
- Supports actions to keep Maine homes and schools free of harmful levels of radon, lead, and carbon monoxide
- Inspects x-ray, mammography, and nuclear medicine equipment to ensure proper operation and safety

People We Serve
Services We Provide

The Office of Health Equity

- Works to address disparities among racial, ethnic and sexual minorities, Tribal Nations, people experiencing poverty, people of low education levels, low literacy or low English proficiency, women and children and people with disabilities
- Focuses on the health and development of children by improving early childhood systems
- Serves Maine's communities with WIC services
- Provides support for cultural and linguistic competencies

How We Measure Success

- Quality Improvement
  - Identifying "Opportunities for Improvement" in cross-disciplinary teams
  - Sharing ideas for efficiency and effectiveness applicable across divisions
- Performance Management
  - Monitoring agency and program progress toward key objectives using a shared performance management system
- Evidence-Based Programming
  - Using scientific methods, including best and promising practices
  - Validating outcomes with state and federal data sources
- Data Driven Decision Making
  - Reporting on performance, outcome measures, and health status indicators to guide our work
  - Monitoring disease trends for prevention, response, and education
- National Public Health Accreditation

On The Horizon

- Achieving national public health accreditation
- Instituting an integrated electronic health record and population-based healthcare system
- Addressing health data gaps and disparities
- Implementing Maine's State Health Improvement Plan
- Supporting Maine's local public health infrastructure

Maine Department of Health and Human Services

Prepared for the

Appropriations and Financial Affairs &

Health and Human Services Committees

127th Legislative Session

January 21, 2015

Mary Mayhew, Commissioner

Department of Health and Human Services

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

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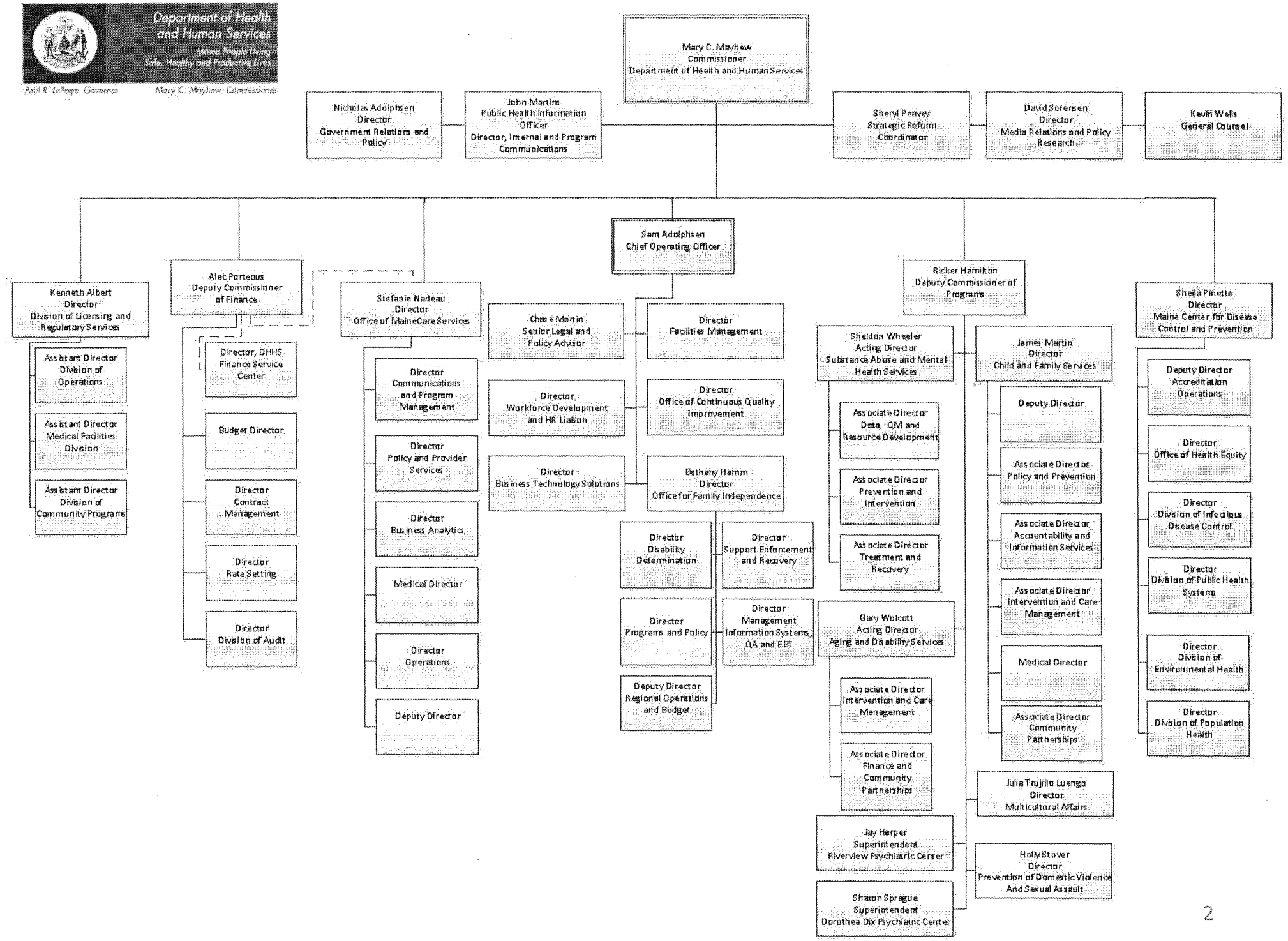
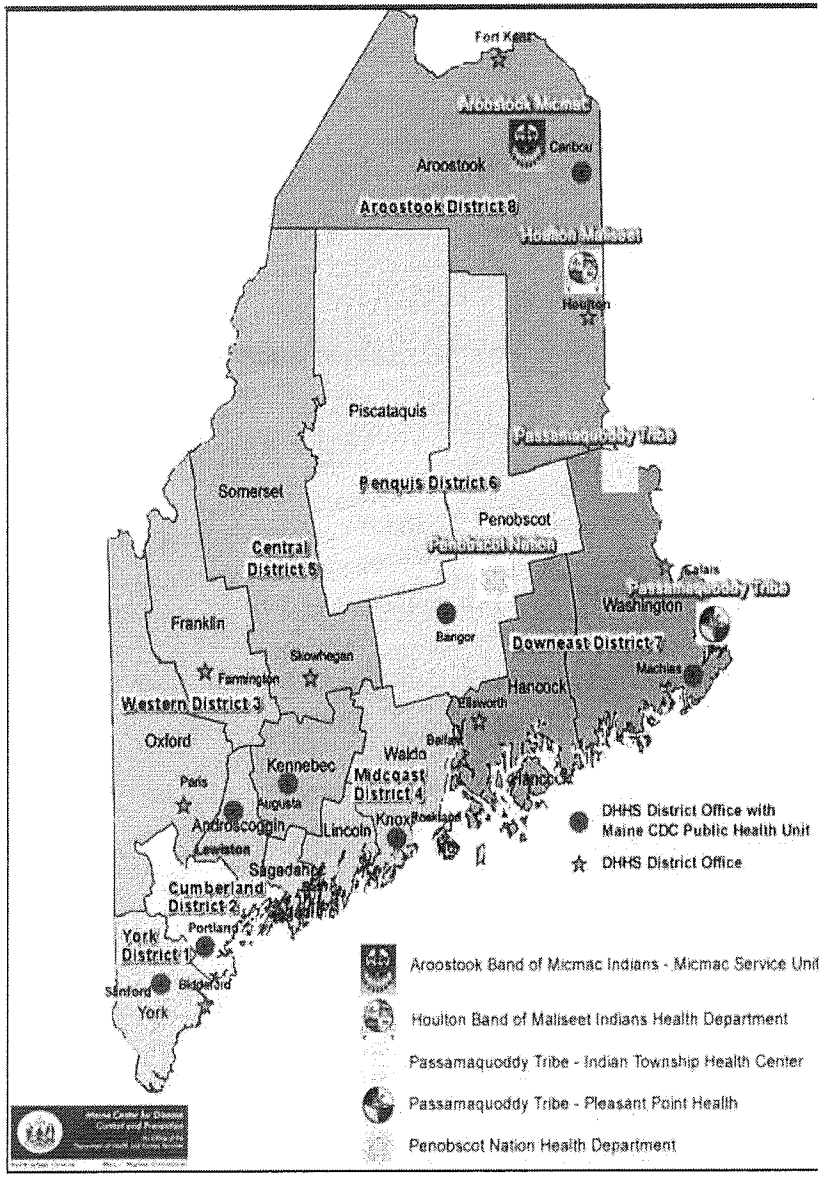


DHHS: State Map

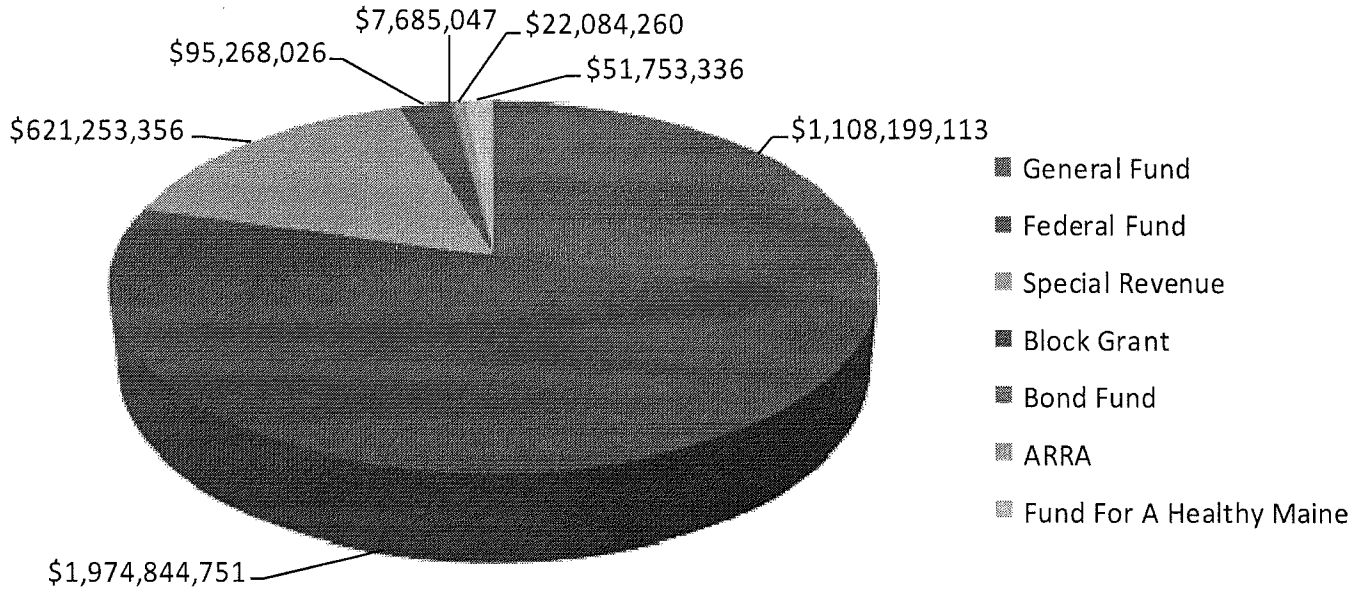


16 District Offices; 1 Itinerant Office, 9 Central/ Administrative Offices

Office	Divisions
Augusta District Office - 35 Anthony Avenue	OFI, OCFS, CDC, DO, FIRU, AHU
Bangor District Office - 396 Griffin Road	OFI, OCFS, CDC, DO, DLRS, AHU, OADS, SAMHS, FIRU
Biddeford District Office - 208 Graham Street	OFI, OCFS, OADS, DO, FIRU
Calais District Office - 392 South Street	OFI, CDC, DO
Caribou District Office - 30 Skyway Drive	OFI, OCFS, DO, OADS, CDC, SAMHS, FIRU
Ellsworth District Office - 17 Eastward Lane	OFI, OCFS, CDC, DO, OADS, DLRS
Farmington District Office - 114 Corn Shop Lane	OFI, DO, SAMHS, OADS
Fort Kent District Office - 137 Market Street	OFI, OCFS, CDC, DO, OADS
Houlton District Office - 11 High Street	OFI, OCFS, CDC, DO, OADS, DLRS
Lewiston District Office – 198-200 Main Street	OFI, OCFS, DO, CDC, SAMHS, DLRS, OADS, AHU, FIRU
Machias District Office - 38 Prescott Drive	OFI, OCFS, CDC, DO, OADS
S Portland District Office – 151 Jetport Boulevard	OFI, OCFS, OADS, DO, SAMHS, AHU, FIRU, CDC, OMCA, DLRS
Rockland District Office - 91 Camden Street	OFI, OCFS, OADS, DO, SAMHS, FIRU
Sanford District Office - 890 Main Street	OFI, OCFS, DO, CDC
Skowhegan District Office - 98 North Avenue	OFI, OCFS, OADS, CDC, DO, SAMHS, FIRU
South Paris District Office - 243 Main Street	OFI, OADS, CDC, DO, FIRU
Van Buren Itinerant Office - 2 Main Street	OADS
Augusta Central Office - 221 State Street	Commissioner, CDC, Contract Mgmt, Rate Setting, Audit, Program Integrity, Fraud, Office Services, Financial Service Center, Human Resources
Augusta Administrative Office – 220 Capitol Street	CDC
Augusta Administrative Office - 2 Anthony Avenue	OCFS, OCQI, OMCA
Augusta Administrative Office - 41 Anthony Avenue	SAMHS, DLRS, OADS
Augusta Administrative Office - 244 Water Street	OFI, OMS
Augusta Administrative Office - 286 Water Street	CDC
Augusta Administrative Office - 19 Union Street	OFI
Augusta Administrative Office - 242 State Street	OMS
Winthrop Administrative Office - 1705 Route 202	Disability Determination Services

DHHS: Financial Perspective

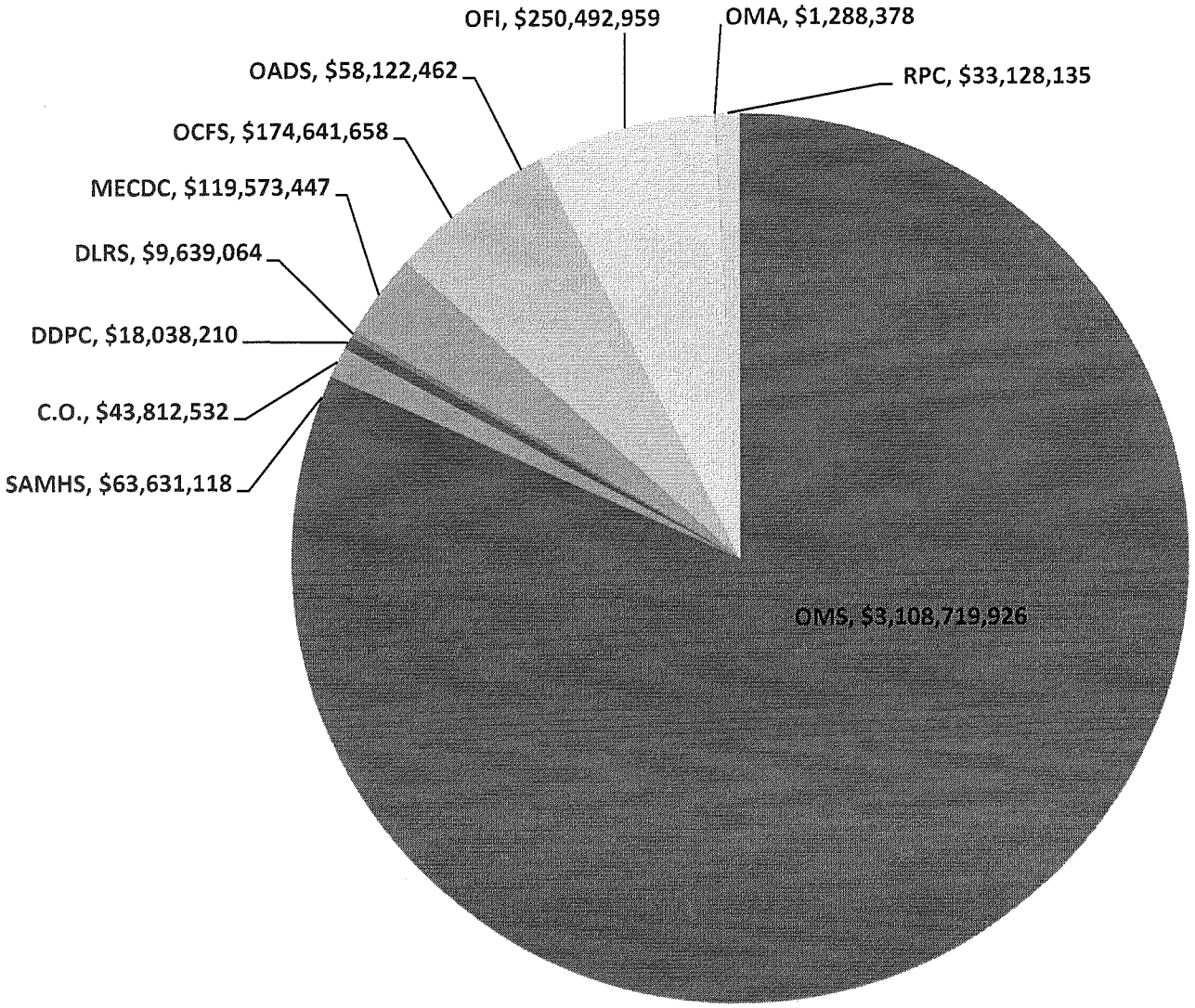
Total Expenditures for SFY 2014							
General Fund (010)	Federal Fund (013)	Special Revenue (014)	Block Grant (015)	Bond Fund (018)	ARRA (020)	Fund For A Healthy Maine (024)	Total Expenditures
$1,108,199,113	$1,974,844,751	$621,253,356	$95,268,026	$7,685,047	$22,084,260	$51,753,336	$3,881,087,889*



*This number includes $490 million in hospital settlement payments from services provided in previous years.

Financial Perspective: All Funds Used By Office

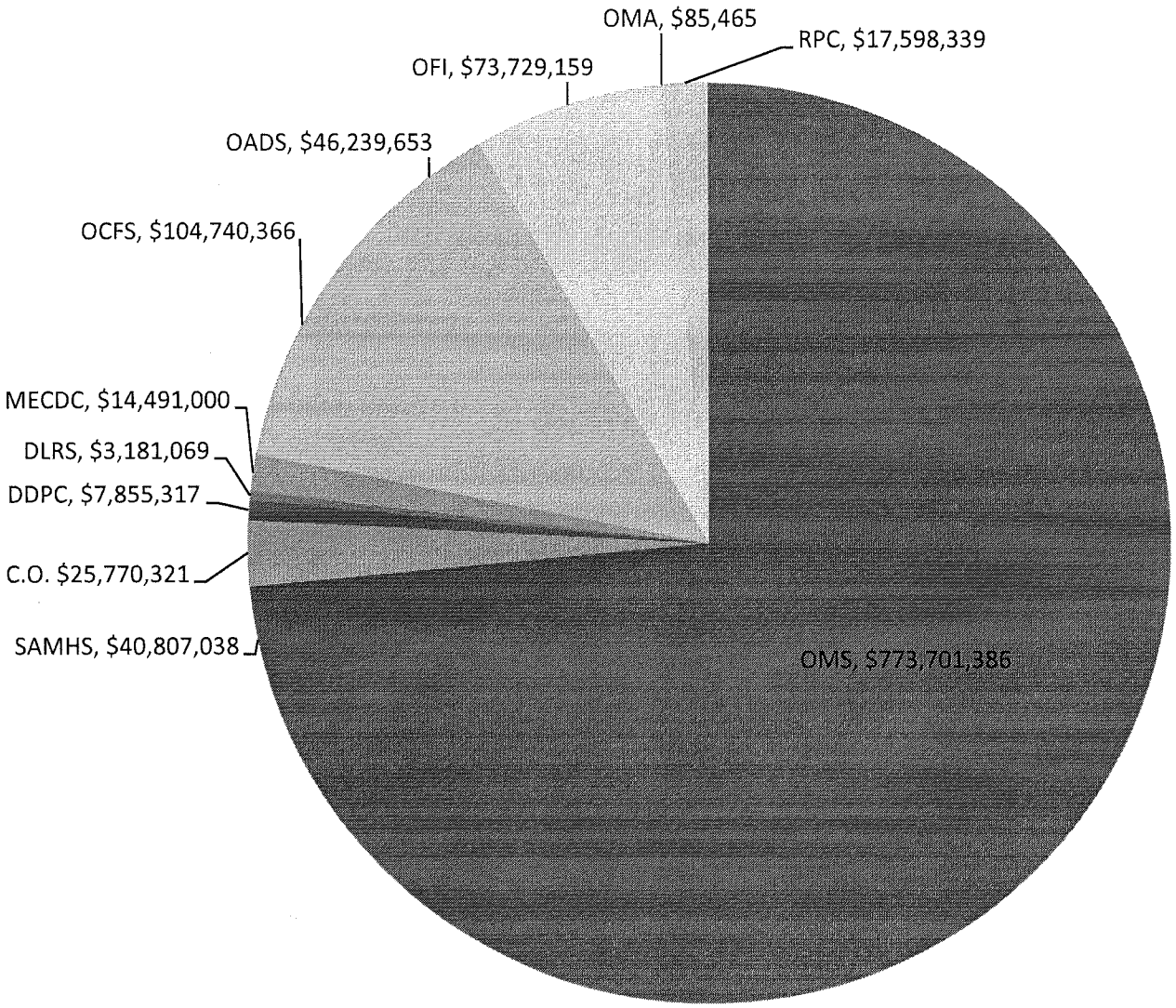
FY Ending June 2014



- OMS (Office of MaineCare Services)
- SAMHS (Office of Substance Abuse & Mental Health Services)
- C.O. (Commissioner's Office)
- DDPC (Dorothea Dix Psychiatric Center)
- DLRS (Division of Licensing & Regulatory Services)
- MECDC (Maine Center for Disease Control & Prevention)
- OCFS (Office of Child & Family Services)
- OADS (Office of Aging & Disability Services)
- OFI (Office for Family Independence)
- OMA (Office of Multicultural Affairs)
- RPC (Riverview Psychiatric Center)

Financial Perspective: General Funds Used By Office

FY Ending June 2014



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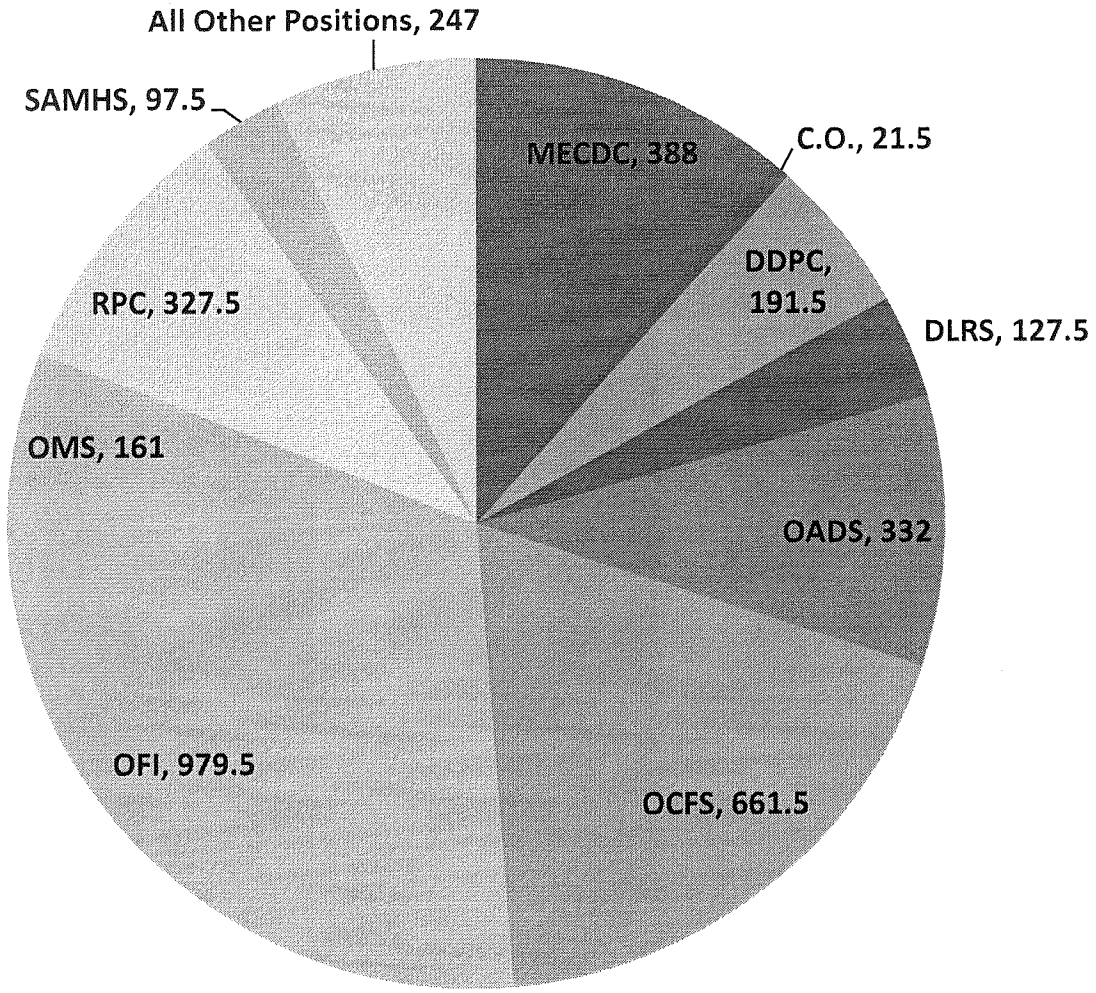
- RPC (Riverview Psychiatric Center)

DHHS Staffing: Hospitals & Major Office/Division

FY Ending June 2014



- MECDC (Maine Center for Disease Control)
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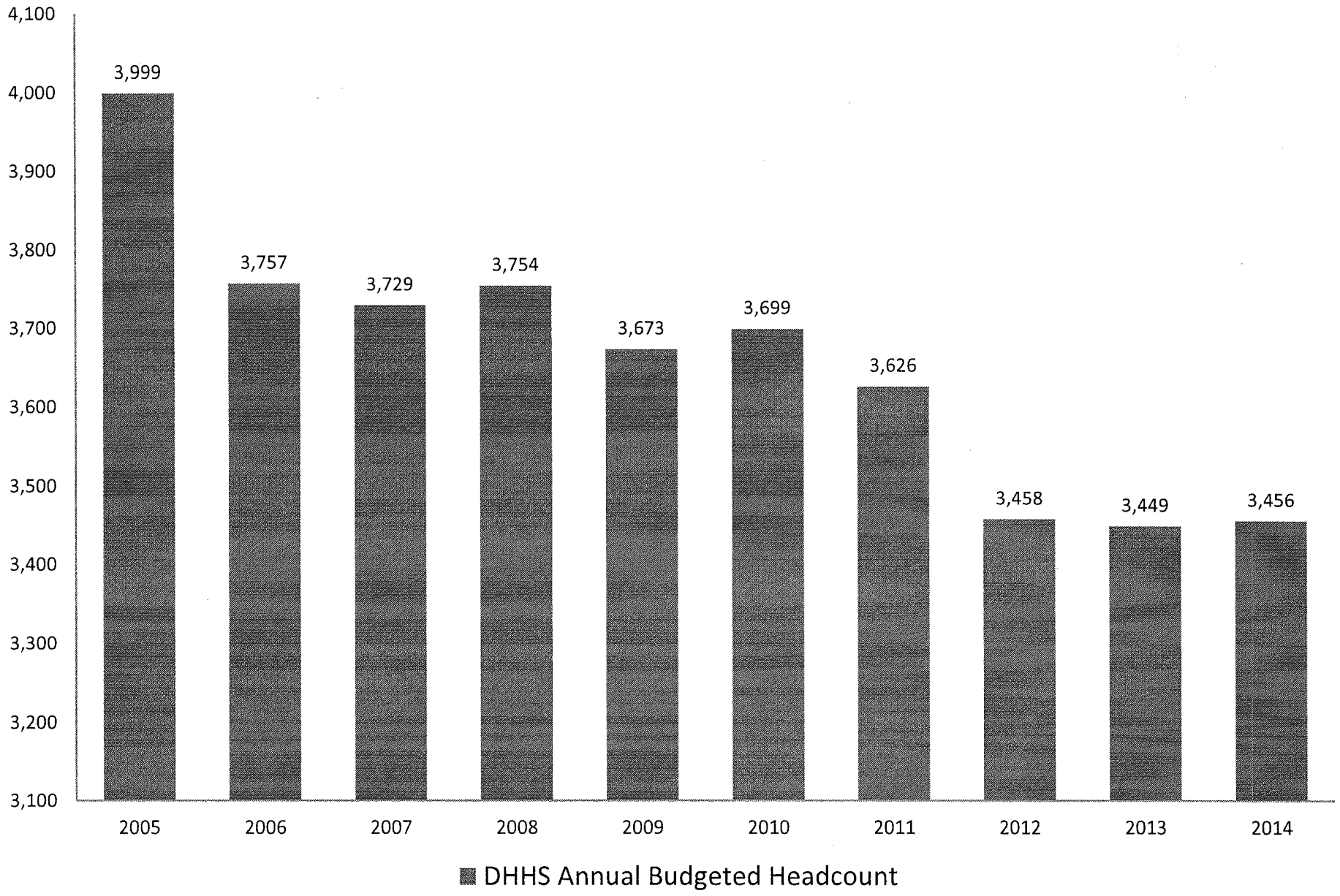
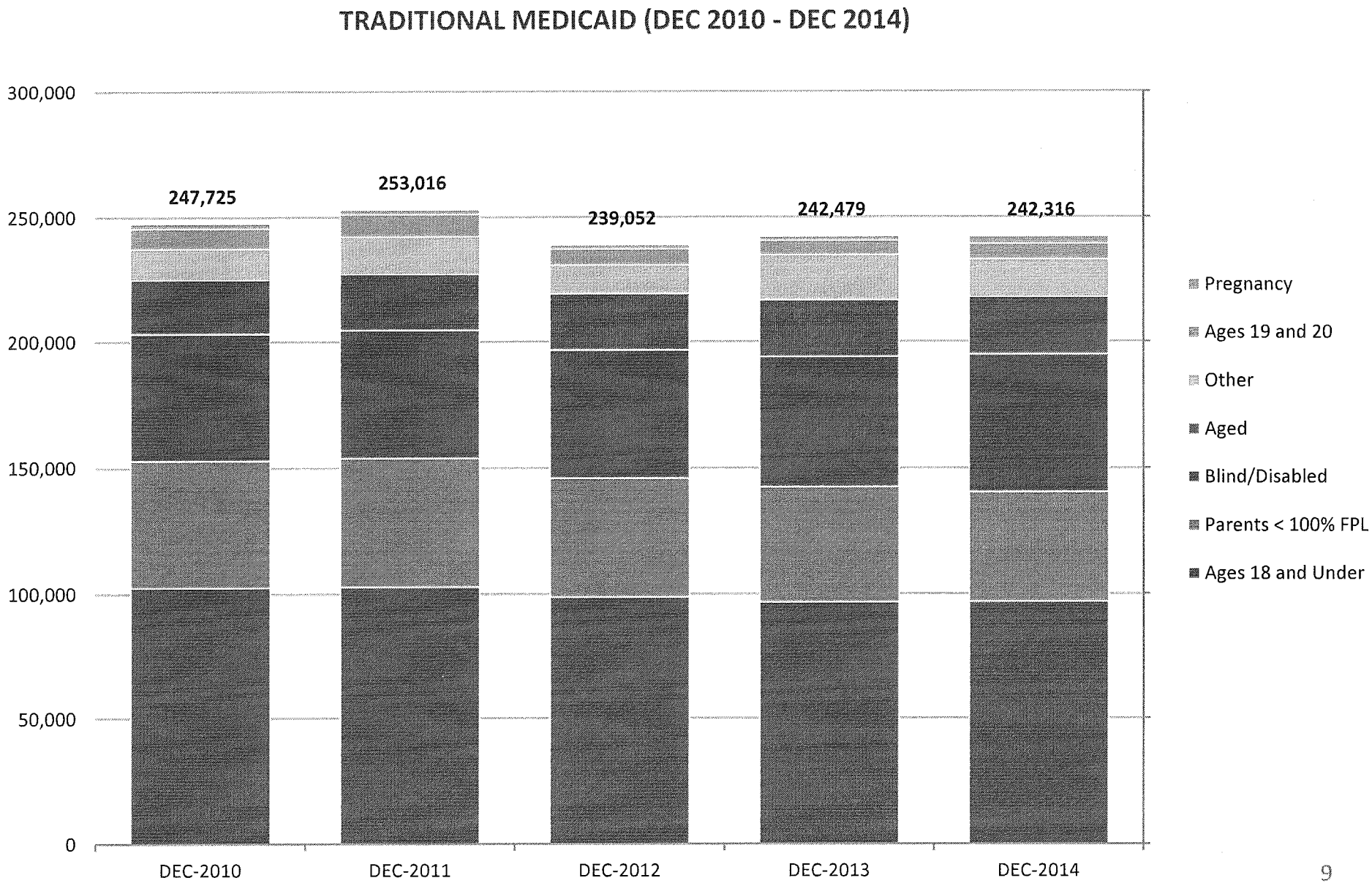
- DDPC (Dorothea Dix Psychiatric Center)
- DLRS (Division of Licensing and Regulatory Services)
- OADS (Office of Aging and Disability Services)
- OCFS (Office of Child and Family Services)
- OFI (Office for Family Independence)
- OMS (Office of MaineCare Services)
- RPC (Riverview Psychiatric Center)
- SAMHS (Substance Abuse and Mental Health Services)
- All other positions

Note: Position numbers include, Legislative headcount, Limited Period and Seasonal/Intermittent positions.

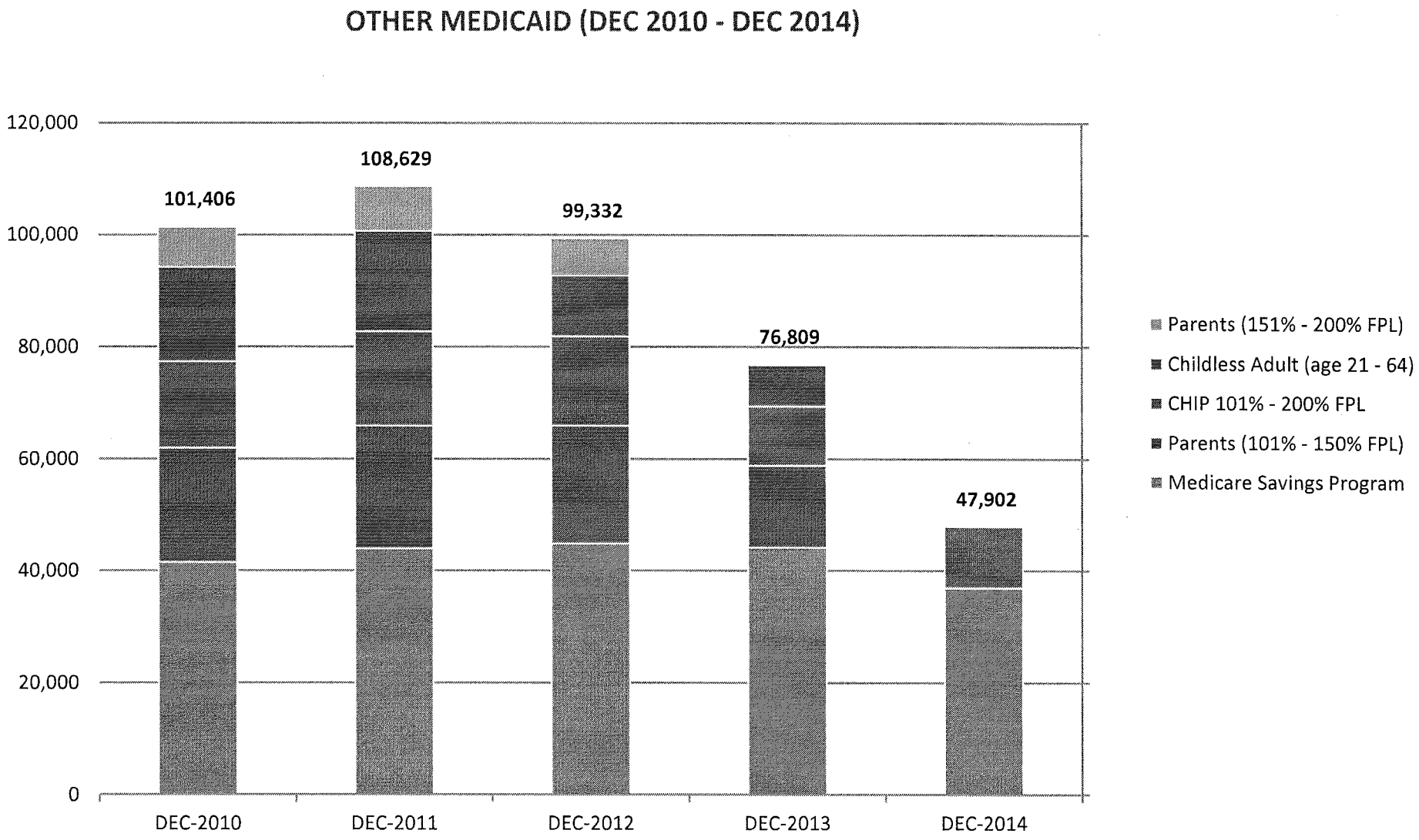
DHHS Staffing: Historical Trends



MaineCare: Historical Caseload by Eligibility Group



MaineCare: Historical Caseload by Eligibility Group



MaineCare: Enrollment and Expenditures

Maine's Medicaid expenditures:

$1.44 billion in 2002
$2.48 billion in 2014

Medicaid enrollment:

220,876 in December 2002
290,218 in December 2014

Maine's State obligation:

$494 million in 2002
$1.016 billion in 2014

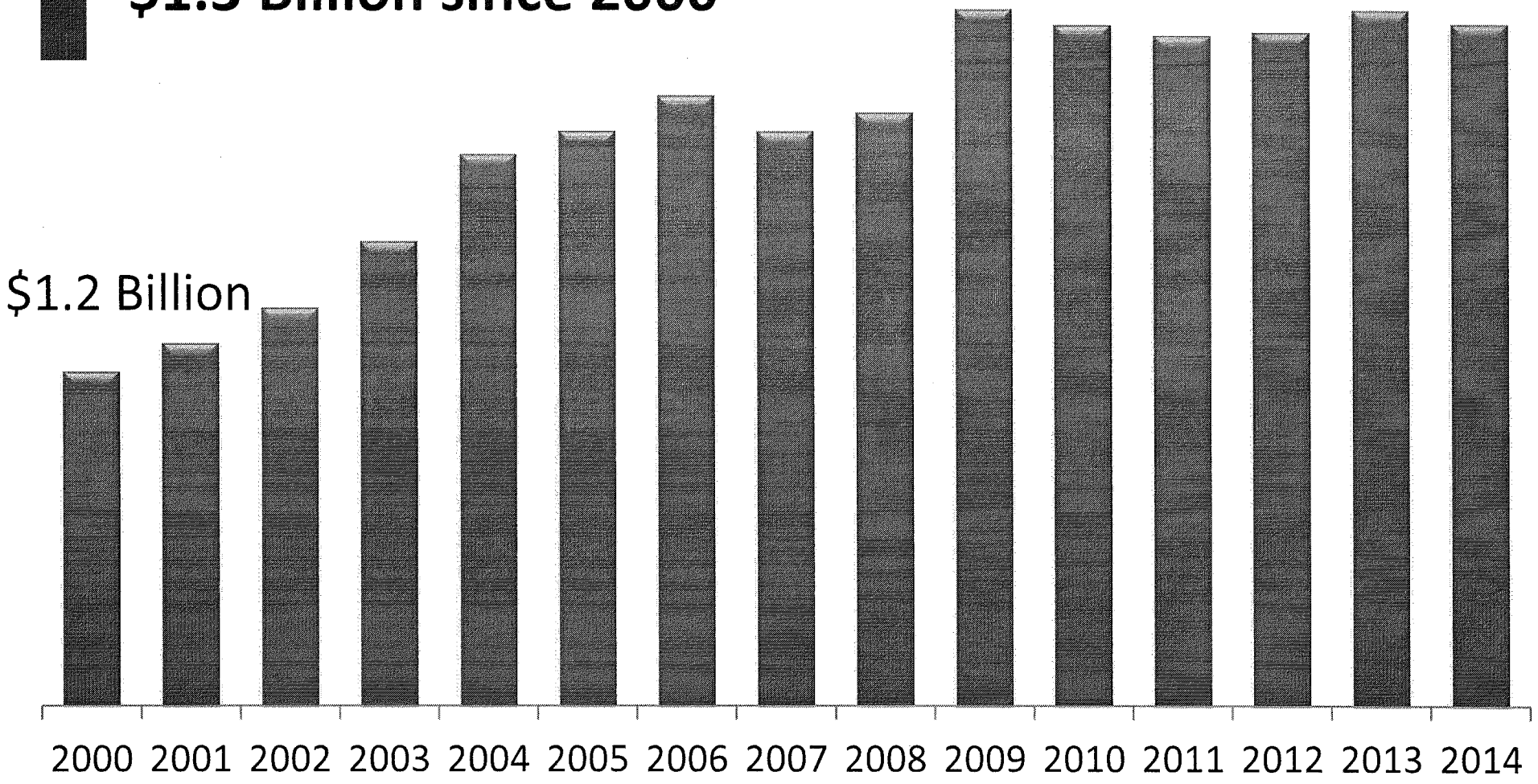
- The federal match rate rapidly declined from nearly 74.73% in 2010 to 61.88% in 2014.

Between 10/1/08 and 12/31/10, Maine received more than $600M in enhanced federal funding.

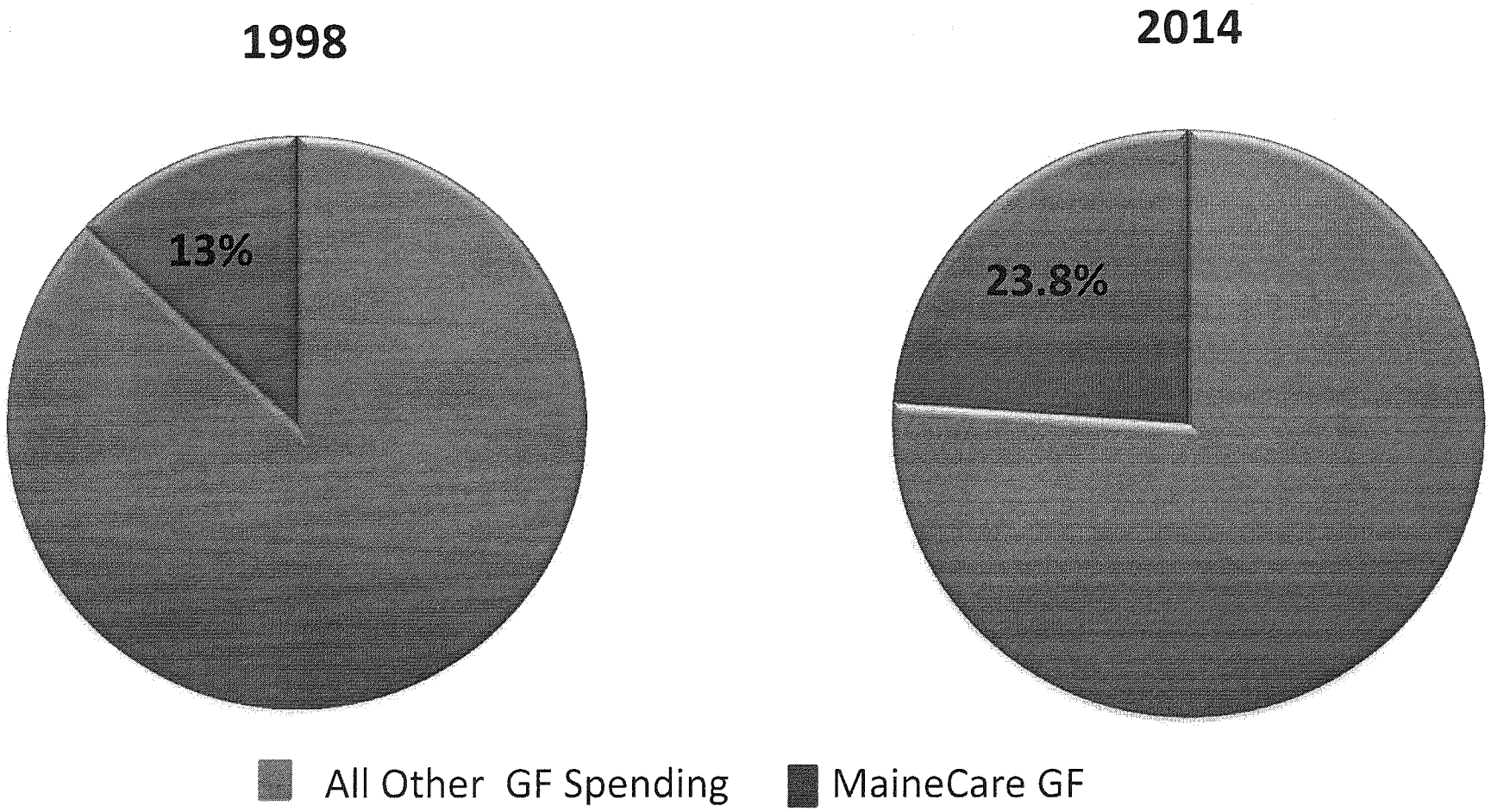
MaineCare: Historical Budget Growth

Total program cost

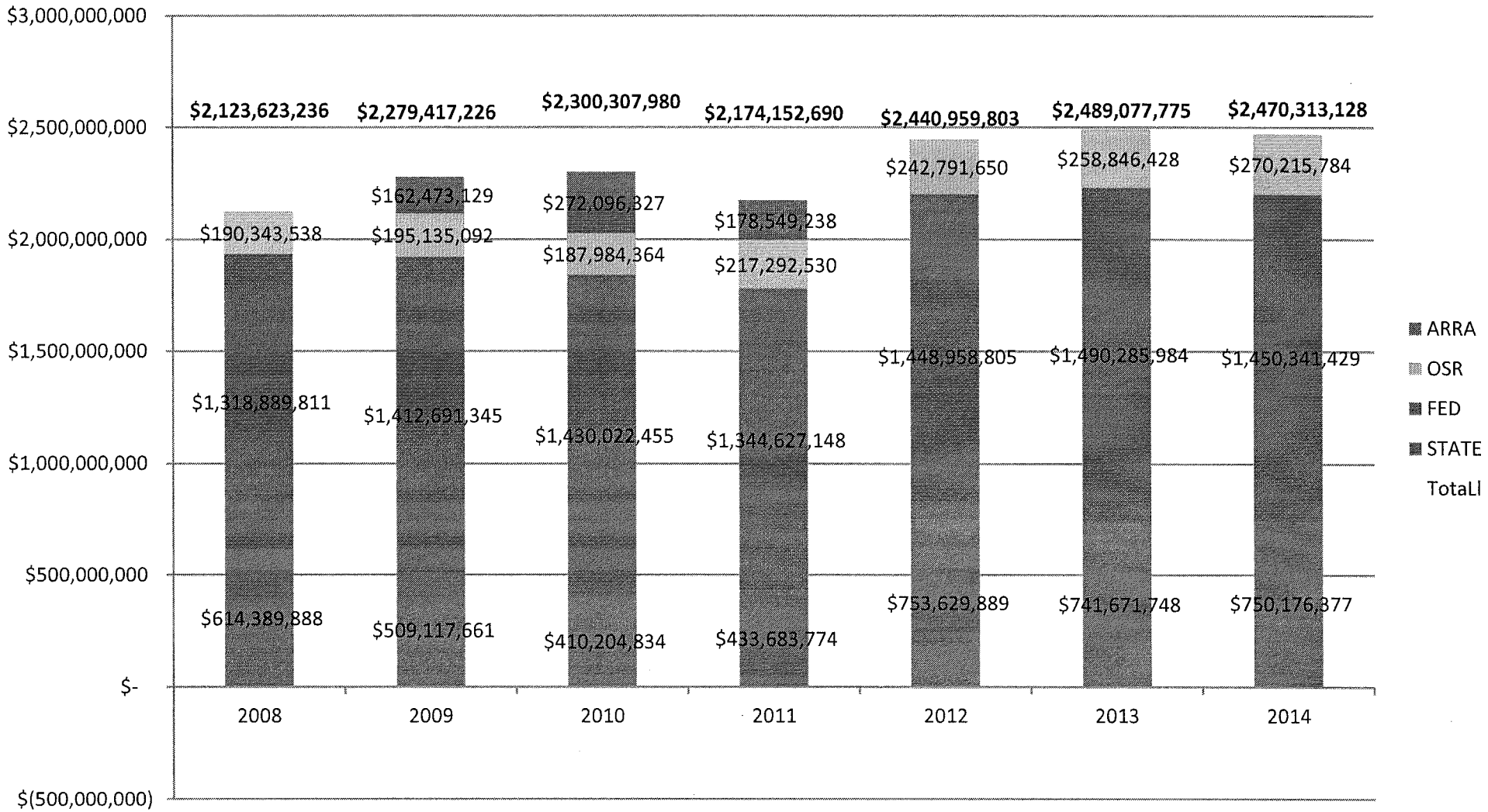
$1.3 Billion since 2000



MaineCare: As a Percent of General Fund

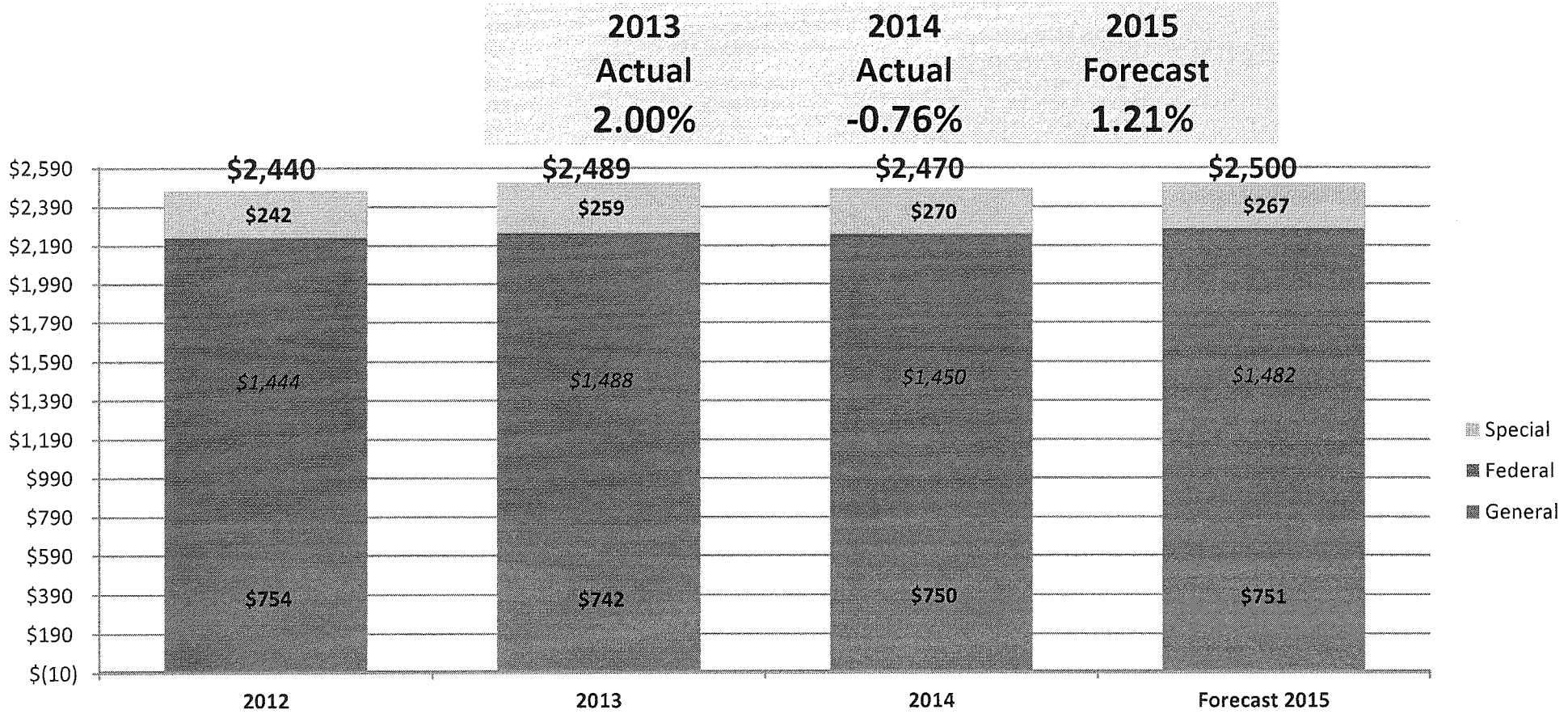


MaineCare: Source of Funds SFYs



DHHS MaineCare Expenditures (Millions)*

Year Over Year Growth



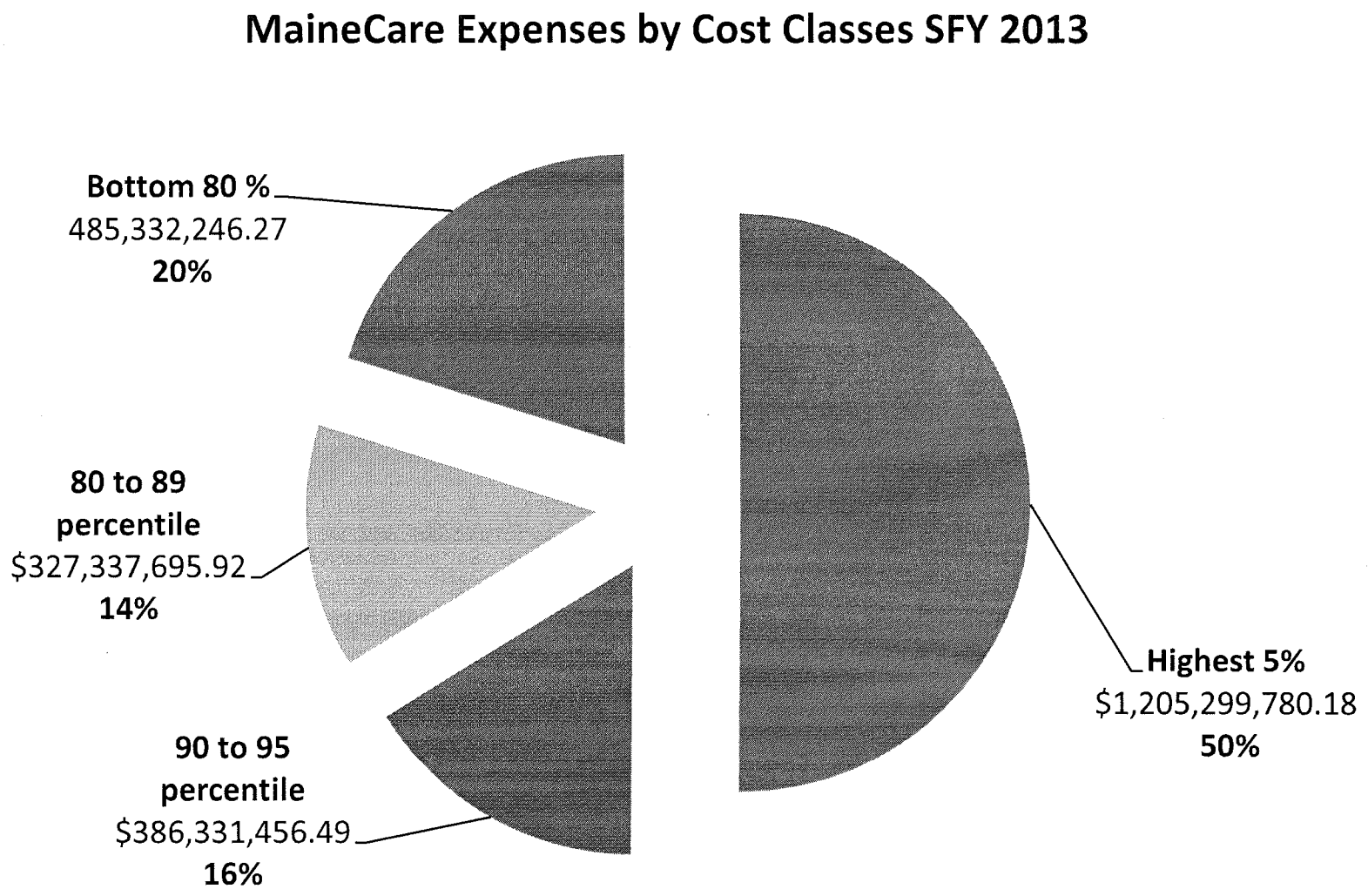
Average National Healthcare Growth: **4%**

Projected Average Growth In the Next 10 Years: **5.8%**

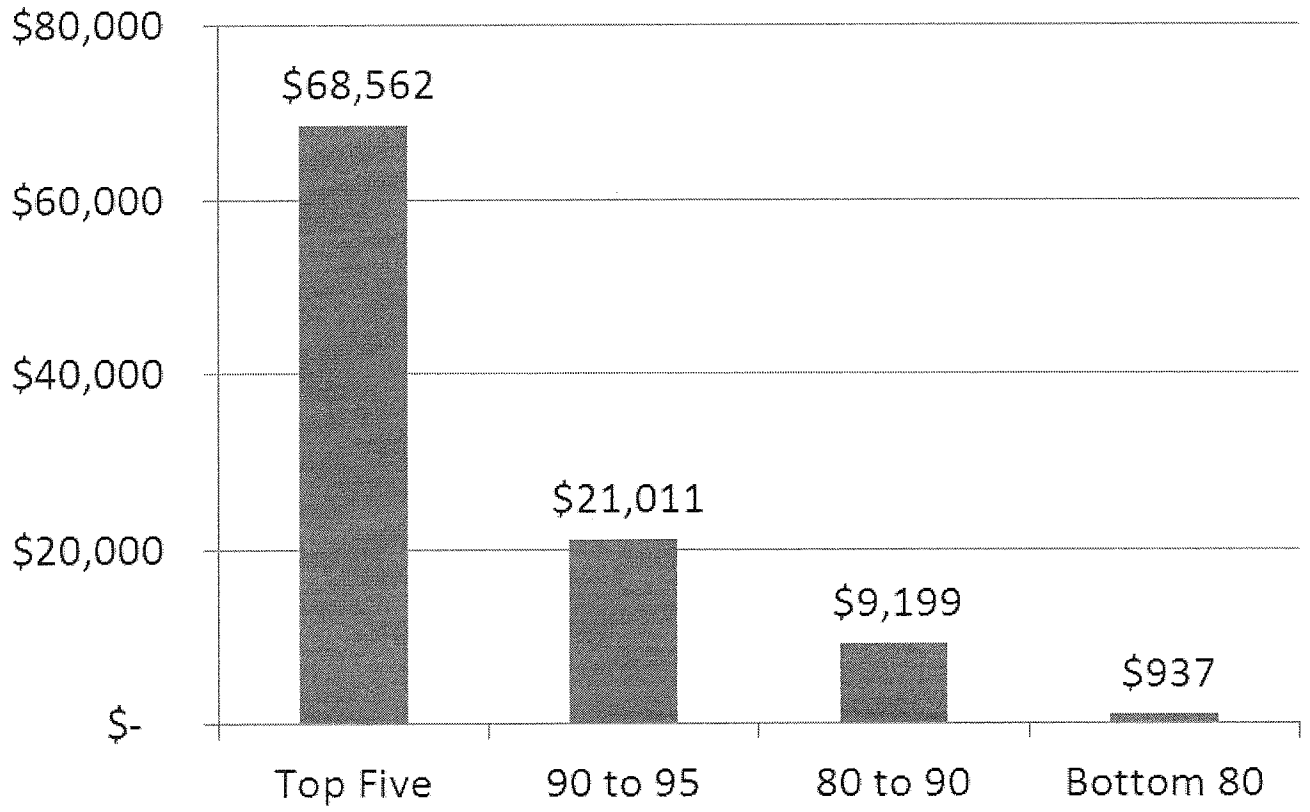
Projected Average National Medicaid Growth In the Next 10 Years: **8.1%**

* Hospital Settlement of $490,200,000 removed from SFY 2014
* Actual results may change as a result of as-of activity

MaineCare: **20** percent of Members Account for **80** Percent of the Costs



MaineCare: High-Cost Utilizers (cost per member)



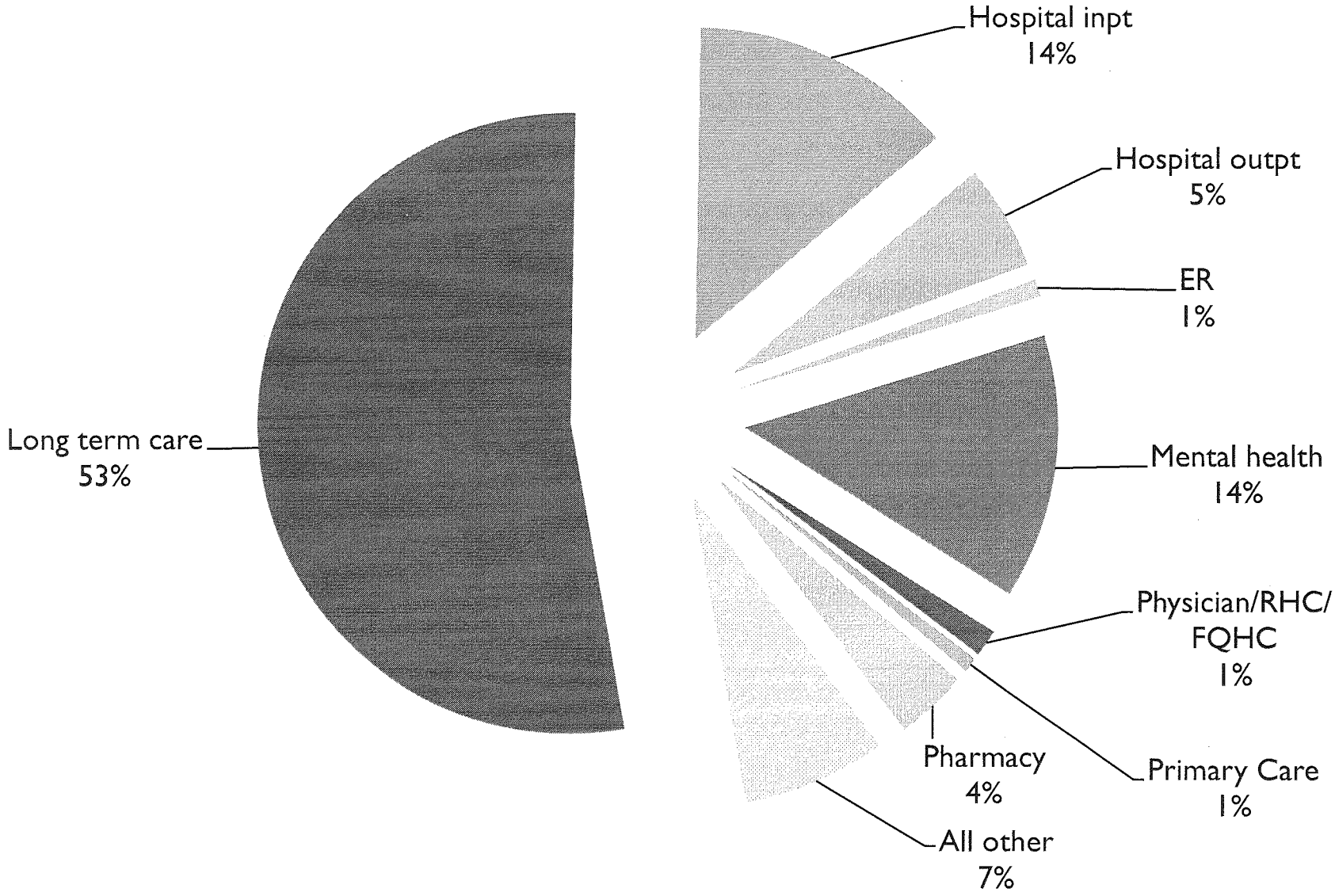
Cost PMPM	Top 5	90 to 95%	80 To 90%	Bottom 80%
	$5,713	$1,750	$766	$78

MaineCare: Top Clinical Conditions by Total Payment

	Top 5	90 to 95	80 to 90	Bottom 80
Mental Health	$ 311,756,435	***$ 93,047,064***	***$ 65,120,364***	***$ 33,523,118***
Signs/Symptoms/Oth Cond, NEC	$ 57,116,808	$ 26,043,121	$ 24,092,254	$ 23,382,225
Neurological Disorders, NEC	***$ 350,511,170***	$ 21,940,044		
Diabetes	$ 20,784,343	$ 9,734,030		
Dementia, Primary Degenerative	$ 34,841,102			
Prevent/Admin Hlth Encounters			$ 7,473,665	$ 26,673,474
Pregnancy w/ w/out Compl			$ 22,794,381	
Infections - ENT Ex Otitis Med				$ 9,520,166
Total Number of Members	18,197	17,950	36,100	403,825

Top clinical condition for the Cost Group is in bold italic.
A blank space means that the condition is not in the Cost Group's top 5, ranked by net payments.

MaineCare: Service Utilization for Top 5 Percent of High-Cost Users = $1.2 Billion



MaineCare: People Served, Services Provided

Federal Medicaid law requires states to cover the following services:

- Inpatient hospital care
- Outpatient hospital care
- Physician services
- Nurse mid-wife and nurse practitioner services
- Federally Qualified Health Centers/Rural Health Centers
- Laboratories and x-ray services
- Nursing Facility services (age 21 and older)
- Home Health Services (including related supplies and equipment)
- Transportation to medically necessary services
- Early Periodic Screening Diagnosis and Treatment (<21)
- Family Planning
- Tobacco Cessation

MaineCare: People Served, Services Provided

MaineCare Optional Services Include:

- Prescription Drugs
- Chiropractors
- Podiatrists
- Diagnostic Services and Screening
- Preventative services
- Rehabilitative services
- Clinic services
- Dental services (limited for adults)
- Dentures
- Physical and occupational therapy
- Speech, language and hearing services
- Prosthetic devices, including eyeglasses
- Inpatient psychiatric care for people under 21 and over 65 (adults 21-64 not covered by Medicaid)
- ICF/IID
- Case management services
- Private Duty Nursing
- Personal care services
- Hospice care
- Home and community based services (habilitation)
- Primary care case management services
- Respiratory care (for ventilator-dependent)
- Eye care

MaineCare: Waiver Services

Waiver:

Allows for greater state flexibility under federal law

Primary requirement:

Federal government will pay no more than it would if no waiver existed.

MaineCare: Current Waiver Services

- Disabled & Elderly Waiver
- Intellectual Disability or Autistic Disorder (Adult waiver & children's waiver)
- Home & Community Based Services for persons with physical disabilities
- HIV
- Transportation Services

DHHS Waitlists: As of October 2014

State-Funded Programs	Waitlist (As of Oct. 2014)	Average PP Annual Cost (State Funds only)	Annual State Cost to Fund	
Consumer-directed Home Based Care	319	$18,900	$6,029,100	
Home Based Care	132	$8,856	$1,168,992	
Homemaker (Independent Support Services)	820	$1,428	$1,170,960	
Annual State-Funded Program Needs Totals	1,271		$8,369,052**	
MaineCare Programs	Waitlist	Average PP Annual Cost (State & federal Funds)	Annual State Cost to Fund	Annual State & Federal Cost to Fund
Section 19, Elderly and Adults w/ Disabilities Waiver	0	$52,092	$0	$0
Section 20, Other Related Conditions Waiver	0	$201,000	$0	$0
Section 21, Home and Community Based Services Comprehensive Waiver	1006	$101,000	$39,067,507	$101,606,000
Section 29, Home and Community Based Waiver Support Waiver	485	$22,000	$4,102,615	$10,670,000
Section 22, Physically Disabled Waiver	71	$27,719	$756,715	$1,968,049
Brain Injury Residential Services	52	$95,695	$1,913,326	$4,976,140
Annual Maine Care Totals (State Funds only)	1,614		$45,840,163	
Total State Funding Needed			$54,209,215**	
Total State & Federal				$119,220,189

MaineCare: VBP – *Why the Change?*

Our system is designed to reward volume instead of quality and efficiency. This does not always ensure that MaineCare members receive the right services for their needs at the right time, or in the most appropriate setting. This has created a cost problem. In our current system:

- 20% of MaineCare members incur 87% of cost

- This 20% often have more than one long-term condition, such as:
  - **COPD**
  - **Diabetes**
  - **Mental Illness**
  - **Heart Disease**
  - **Substance Abuse**

The only way to make positive change is to create a system that focuses on patient-centered, quality and efficient care delivery.

MaineCare: VBP – *What we want to accomplish.*

By implementing our various VBP initiatives, the Department anticipates the following results:

- A holistic approach to healthcare delivery by addressing a person's physical and mental health needs as one
- A more coordinated and collaborative healthcare delivery system
- A reduction in over-utilization of unnecessary, costly services and an increase in appropriately timed interventions aimed to improve long-term health outcomes
- Short- and long-term cost containment
- Providers are accountable for the outcomes of the services they provide

Maine's Emergency Department Collaborative: Reducing Inappropriate Use, Improving Outcomes

Program Goals

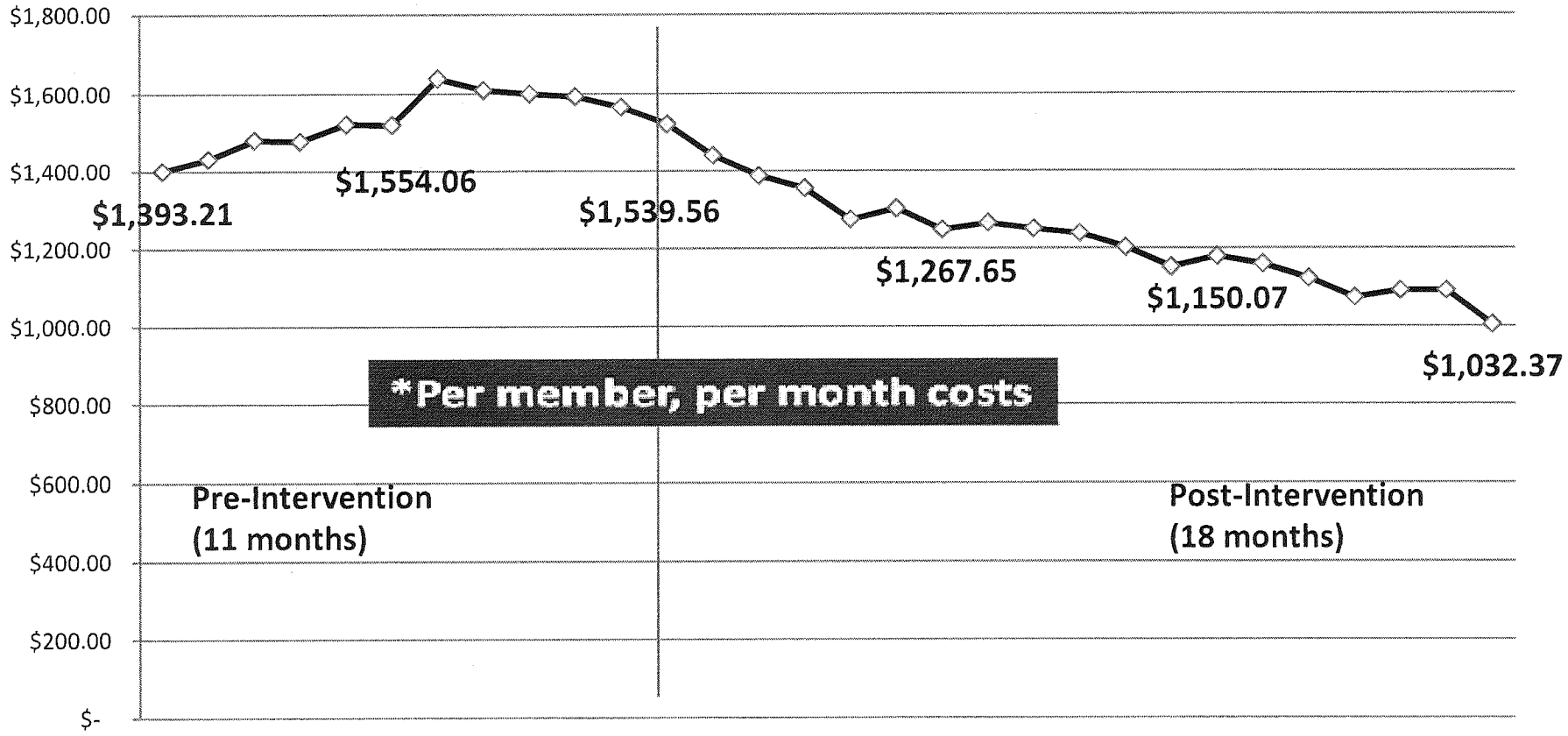
- Reduce avoidable ED use and improve health outcomes for high needs, high utilizers of the ED through statewide care management efforts
- Use care management resources in the community wherever possible
- Identify and fill the gaps where no care management capacity exists
- Increase availability of ED for true emergency situations
- Achieve savings in order to reinvest in primary care and other Department priorities

MaineCare: ED Care Collaborative

Successes

- Presently, 36 hospitals are involved in this program
- Average number of ED visits pre-intervention: 13 in 11 months
- Average number of ED visits post-intervention: 6 in 12 months
- Members managed: 1,078 current, 2,114 since program inception
- Nearly $9.9M has been saved since 2010 and patient outcomes have improved

MaineCare: ED Care Collaborative



The above graph represents outcomes for the 1,078 members that have received 18 months of intervention. Per member, per month costs represent outcomes at a specific point in the intervention process: 11 months pre-intervention, 6 months pre-intervention, start point, 6 months post-intervention, 12 months post-intervention and 18 months post-intervention. This graph does not represent costs at a specific point in time (i.e. August, 2014). This graph includes MaineCare incurred claims data as of August 31, 2014.

- **Members managed: 1,078 this population (2,114 total since program inception)**
- **Savings realized: $9.9 million ($3.7 million in State Funds) total since program inception**

MaineCare: Stage A Health Homes

Background

Health Homes Stage A was implemented in 2013 and targets individuals who have two or more chronic conditions, or are diagnosed with one and are at risk of another.

- Includes 170 primary care practices, 10 Community Care Teams
- There are over 50,000 MaineCare members enrolled in the Stage A Health Homes initiatives

MaineCare: Stage B Health Homes

Background

Health Homes Stage B was implemented in April 2014 and targets individuals with Serious and Persistent Mental Illness (SPMI) and children with Serious Emotional Disturbance (SED).

- Currently, there are 25 organizations, with over 70 locations around the state, engaged in this effort
- Initial enrollment of approximately 2,000 MaineCare members

People with SPMI often encounter a system that is siloed, not welcoming, and not designed to meet their needs. As a result:

- Their health care is fragmented, not integrated
- They do not have a medical home, but instead may receive care through multiple primary care practices / behavioral health agencies
- They do not have access to the support needed to successfully manage their own care and stay healthy

MaineCare: Stage B Health Homes

People with mental illness shoulder a disproportionate burden in getting the care they need to stay healthy.

- Adults with a diagnosis of SPMI typically have shorter lifespans and higher rates of chronic disease than people without these disorders.

- Adults with SPMI die on average 25 years sooner than their counterparts without a diagnoses of SPMI.

- Children with SED use more physical health care services than Medicaid-enrolled children, in general.

MaineCare: Stage B Health Homes

Features of Stage B Health Homes include:

- The integration of mental and physical health care, so that a single, person-centered plan of care identifies and drives all needs.

- Peer supports, so that individuals and families can have access to information and advocacy to help them manage their own care.

- A data-driven and outcomes-based approach, to better identify what is working and what needs improvement.

MaineCare: Accountable Communities (AC)

Accountable Communities will result in such improvement as:

- Reduction in inpatient readmissions
- Less non-emergent ED use
- More effective use of Electronic Medical Records and real-time data through Maine's Health Information Exchange
- Increased investment in care management for members with chronic conditions
- More emphasis on preventive care

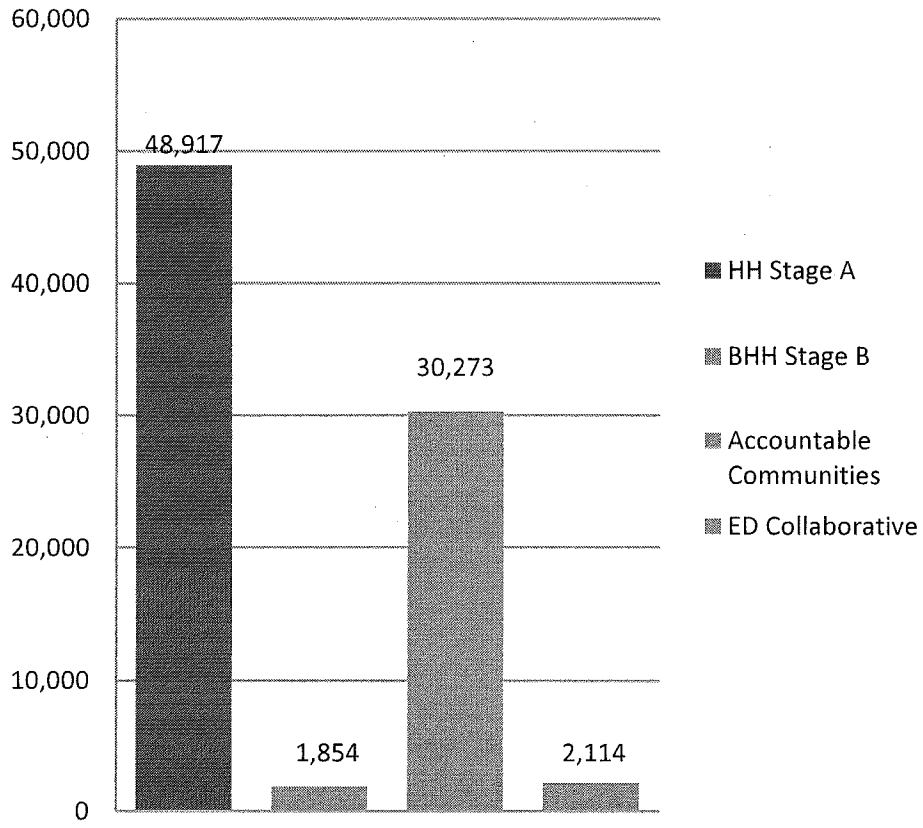
MaineCare: Accountable Communities Incentivizing Quality Care and Cost Reduction

Enrolled provider organizations engaged in Accountable Communities can share in savings that come with care coordination if quality benchmarks are met.

Current participants are:

- **Eastern Maine Health**
- **MaineHealth**
- **MaineGeneral Medical Center**
- **Penobscot Community Health Center**

Number of MaineCare Members in Health Homes, Accountable Communities and the ED Collaborative



MaineCare: Accountable Communities (AC)

Shared Savings model

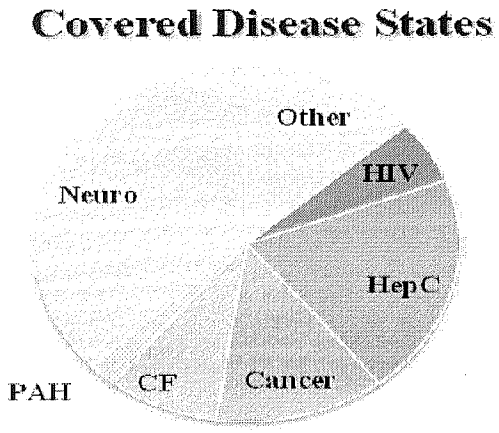
- ACs can choose between Model I (shared savings only) and Model II (shared saving and shared losses).
- All 4 ACs have chosen Model I, but can change to Model II in subsequent years.
- Under Model I, the AC can share in a maximum of 50% of savings, depending on how it does on a number of quality measures.
- Under Model II the AC can share in a maximum of 60% of savings and also be at risk of 5% of losses in year 2 and 10% of losses in year 3, all depending on how it does on a number of quality measures.

In both models, there are no shared savings or loss payment made unless savings or losses exceed: (a) 2.5% of Benchmark TCOC for ACs with 1,000 – 4,999 members, or (b) 2.0% of Benchmark TCOC for ACs with 5,000+
members

MaineCare: Pharmacy Management

Outcomes Since beginning in SY14:

- Cost avoidance = $1,735,622 (combined state and federal) as of June 30, 2014. Another $1.1M is estimated for SFY 15.
- 711 members enrolled (i.e. contacted and counseled) Note: 11% of members were enrolled for poor adherence thus reducing waste of medications.
- 94 drugs are currently part of the Pharmacy Management Program.



MaineCare: Pain Management

New Policy Highlights

- **Acute Pain Management (pain that is expected to last less than 8 weeks)**
  - Up to 15 days of opioids per year without Prior Authorization (PA).
  - For each two weeks beyond the first 15 days, a face-to-face visit between member and provider must occur and a PA must be submitted and approved.
  - A maximum of three refills (plus the original 15 days) may be allowed for management of acute pain.
  - Post-operative pain management only requires one 60-day PA request, not a new request every two weeks.
- **Chronic Pain Management (pain has or is expected to last longer than 8 weeks)**
  - Prior to starting the next prescription for opioids, the member must engage in an evidenced-based treatment service, including, but not limited to, Physical Therapy, Cognitive Behavioral Therapy, Osteopathic Manipulative Treatment, etc.
  - For patients with a diagnosis of neck pain, back pain, headache or Fibromyalgia, a second opinion from another provider must concur that for this patient, opioids are an appropriate next step in his/her care as all other options have either been tried or are deemed inappropriate.

MaineCare: Pain Management

Results after first year (comparing 2012 to 2013)

- 10,000 fewer MaineCare members received a prescription for opioid medications
- 69,634 fewer prescriptions were filled for MaineCare members
- 5,896,106 fewer opioid pills were dispensed to MaineCare members
- $1,322,075 less spent on opioid medications in CY 2013 compared to CY 2012
- Nearly the entire cost reduction can be attributed to the reduction in high dose, chronic use members

For the first six months of 2014, as compared compared to 2012, there is a nearly 50% decrease in the number of opioid pills dispensed to MaineCare members!

MaineCare: Radiology Management

Background

- The Radiology Utilization Management program was implemented in February 2014. It includes Prior Authorizations for CT & PET scans for clinical appropriateness, identifying duplication of radiology requests, etc.

- January – July 2014 Estimated Cost Savings:

CT Scans, YTD:	**$2,311,823**
PET Scans, YTD:	**$72,543**
Total YTD:	**$2,384,366**

MaineCare: Radiology Management

CT Scans - Summary

Time Period	Review Category	Annual Total Number of Services	Monthly Average Number of Services	Monthly Average Services per 1000 Members	Average Monthly Expenditures for Service
Baseline	CT/CTA	28,018	2,335	13.64	$1,196,652
YTD 2014	CT/CTA	12,475	1,782	12.43	$866,391

PET Scans - Summary

Time Period	Review Category	Annual Total Number of Services	Monthly Average Number of Services	Monthly Average Services per 1000 Members	Average Monthly Expenditures for Service
Baseline	PET	489	41	0.24	$36,222
YTD 2014	PET	220	31	0.22	$25,858

MaineCare: Maine State Innovation Model Grant (SIM)

What is SIM?

- Supports Value-Based Purchasing efforts through a focus on payment reform, delivery system reform, data analytics, Health Information Technology (HIT), and consumer engagement

- Seeks to bolster work currently underway in our state to reduce healthcare costs, strengthen clinical quality, and improve patient experience

SIM Goals

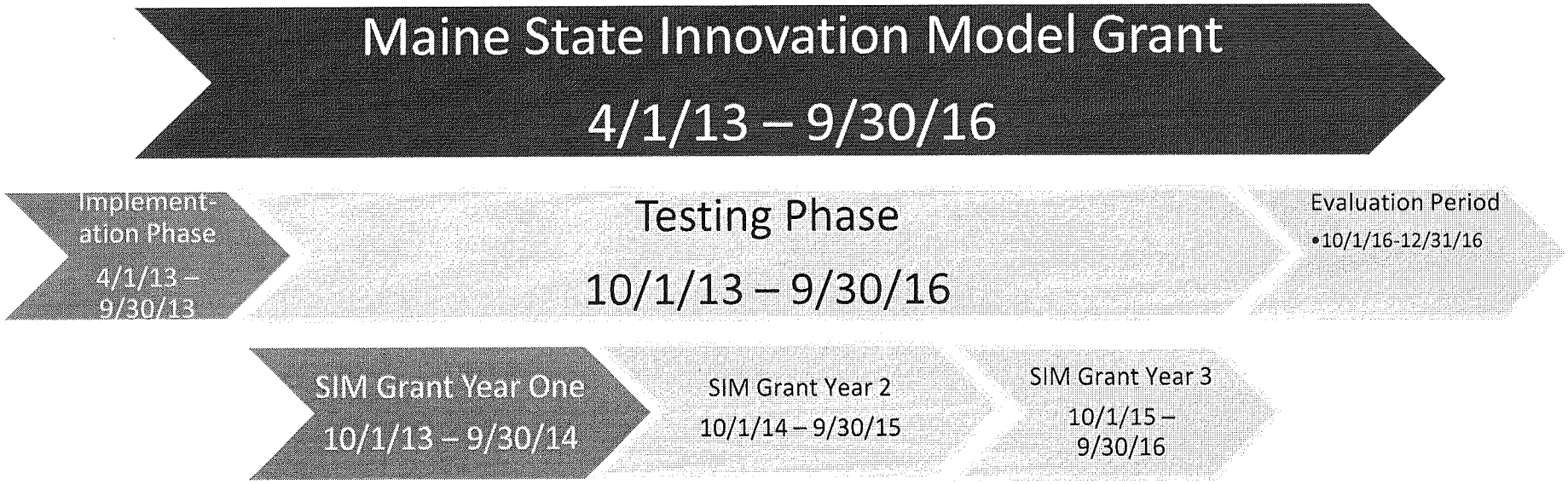
- Reduce the total cost of care per member per year to the national average

- Improve population health in at least 4 disease categories (diabetes, mental health, obesity, tobacco)

- Improve patient experience scores for targeted practices by 2% from baseline

- Increase the number of practices reporting patient experience from 50% to 80%

MaineCare: SIM Timeline



MaineCare: Maine State Innovation Model (SIM) Initiative

Our Mission	The Maine SIM initiative, through a collaborative process, will promote the alignment and acceleration of statewide innovations designed to improve health and health care and reduce health care costs for the people of Maine
Our Vision	Working together to promote innovations which transform health care and make Maine the healthiest state in the nation
Our Strategy	We will achieve this vision by leading and aligning efforts to transform health care delivery and payment using the following primary innovations:

	Strengthen Primary Care	Integrate Physical & Behavioral Health Care	Develop New Workforce Models	Develop New Payment Models	Centralize Data & Analysis	Engage People & Communities
Primary Innovations	•Expand access to Patient Centered Medical Home (PCMH) / Health Home (HH) models •Provide quality improvement support, recognition & rewards to PCMH/HH practices •Provide leadership development opportunities for providers	•Provide learning collaborative & technical assistance to help BH organizations move to Health Homes model, and to improve integration of physical and BH •Provide resources & assistance to BH providers for health information technology and interoperability •Develop BH quality measures	•Develop Community Health Worker pilot in 5 communities •Develop Diabetes Prevention Program •Provide training for PCMH/HH practices to improve care for persons with developmental disabilities •Support efforts to Align Long Term Care with PCMH/HH models •Support the Improvement of care transitions	•Support development of Accountable Community Organizations (ACOs) •Offer ACOs peer-to-peer learning •Develop common quality measures • Engage employers, payers, and consumers •Develop value-based insurance & benefit design	•Support development & use of common quality & cost measures •Support the development of standard cost & quality reporting	•Engage patients and families as active participants in their care •Conduct consumer engagement campaign, with special focus on MaineCare members •Promote Shared Decision Making, tools including Choosing Wisely •Measure & publicly report patient experience

Goals by 2017	The total cost of care per member per month in Maine will fall to the national average Maine will improve the health of its population in at least four categories of disease prevalence (ie diabetes, mental health, obesity, etc) Maine will improve targeted practice patient experience scores by 2% from baseline for practices that participated in the 2012 survey Maine will increase from 50% to 66% the number of practices reporting on patient experience of care

MaineCare: SIM Strategic Pillar Objectives

Pillar 1 - Strengthen Primary Care- transition from a single provider engagement to a team based approach in which the patient is a fully engaged and equal partner on the team

- Learning Collaboratives for Health Homes to guide the practice transition from old delivery model to Health Home model
- Health Information Exchange with push out reports allowing these new teams to have real time information on care access by patients
- Data Analytics(claims & clinical) used to inform providers of their care pattern and the subsequent outcomes
- Education about reports and their proper use and interpretation

MaineCare: SIM Strategic Pillar Objectives

Pillar 2 - Integrate Physical and Behavioral Health - bring together both worlds of medical care and address the patient with a holistic view of their well-being not just each individual diagnosis

- Behavioral Health Home Organizations to be recognized and funded for a new model of delivery
- Bring the value of electronic health records to the Behavioral Health community
- Connect BHHO to the Statewide Health Information Exchange
- Learning Collaboratives for BHHO to guide the practice transformation from old delivery model to new integrated model

MaineCare: SIM Strategic Pillar Objectives

Pillar 3 - Develop New Payment Models - Match funding to new model of team and integrated care delivery as well as fund for outcomes

- Establish a new model of payment for a new model of care delivery through Accountable Care Community and Health Homes/BHHO
- Develop Value Based Insurance Design for payers
- Inform practices of their status through practice reports on cost and quality

Pillar 4 - Develop New Workforce Models - with a new work environment new skills and adaptation to current skills will be necessary

- Leadership Development
- Community Health Workers will be utilized as part of the team
- Curriculum for new member of integrated team between physical health and behavioral health care teams

MaineCare: SIM Strategic Pillar Objectives

Pillar 5 - Centralize Data and Analysis - Establish a single standard for what data to use when, how to best analyze that data and turn it into actionable information then disseminate that information so that it can drive health care towards better outcomes

- Public reporting on quality and cost
- Development of a 'dashboard' for providers and payers to monitor trends and results of transformation efforts
- Use of data/analytics/information to drive decision-making in a way that all would agree

MaineCare: SIM Strategic Pillar Objectives

Pillar 6 - Engage People and Communities - Establish and expectation, plan and programs for use of community resources and social supports to ensure best health outcomes

- Implement National Diabetes Prevention Program
- Community Health Worker Program
- Educate consumers on what to expect from this new model of care
- Provide patients with direct access to their own health information