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

Before the Joint Standing Committee on Appropriations and Financial Affairs

Department of Health and Human Services Finances

February 12, 2014

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

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

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

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

The Department projects to use a total of $17.32 million in DSH funds in SFY ‘14.
• RPC used $2.3 million between the beginning of the fiscal year, July 1, and decertification in September
• From September 2, through December 31 of 2013, RPC drew and utilized $6.35 million in federal DSH funds
• From January 1, 2014 through the end of the fiscal year, the Department projects RPC will utilize an additional $8.69 million in DSH funds

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

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

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

**DSH Funding Related to Census Mix**

**AFA REFERENCE #: F-A-7240 FY15 DSH $(2,296,811) GF $2,296,811**

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

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

**Initiatives to Address Certification**

**Contracted Psychiatrist**

**AFA REFERENCE #: F-A-7235 FY14**

This initiative adds a psychiatrist at the Riverview Psychiatric Center through the existing Dartmouth Healthcare contract to assist with the increased forensic population and the higher acuity levels of those forensic clients. This Doctor would be assigned to a specific unit and would be needed to testify in court. The additional clinical capacity is required to ensure the health and safety of the patients.
Increasing regulatory requirements related to the roles and responsibilities of the Clinical Director diminish the capacity to take on the increased caseload, as well as fulfilling the responsibilities of the Clinical Director. The increase in forensics requires a high level of clinical expertise and leadership to provide consistent multi-disciplinary care to facilitate thorough and safe patient evaluation, treatment and discharge planning. The psychiatrists’ role as the primary provider has resulted in patient health and safety as quality care needs to be provided according to evidence-based practice. Stability of the highly acute patients is achieved more quickly because the psychiatrists are unifying members of the treatment team ensuring that treatment plans are followed.

**Contracted Nurses**

**AFA REFERENCE #: F-A-7236**

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

**Dartmouth Consulting Contract**

**AFA REFERENCE #: F-A-7222**

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

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

**Dartmouth Consulting Contract**

**AFA REFERENCE #: F-A-7216**

This request provides funding to contract for a Director of Psychology. The previous two directors had very short tenures (the most recent barely 6 months). Exit interviews with the hospital Medical Director indicate that the salary of the state position was not competitive within the community. A management review confirmed that the salary structure for the Director was not commensurate with the level of complexity and responsibility. Additionally when we advertised the most recent vacancy we received only one applicant found to be unsuitable for the state line Psychologist IV. To continue to provide quality services, we need the position filled. The most viable solution is to identify and recruit suitable candidates through a contract.
MOU with the Department of Public Safety  
AFA REFERENCE #: F-A-7221

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

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

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

Interpreter Services  
AFA REFERENCE #: F-A-7239

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

Legal Contract  
AFA REFERENCE #: F-A-7238

There is no current statute that allows hospitals to medicate clients who are not criminally responsible (NCR) against their will, unless they pose a danger to themselves or others and then the timeframe is limited to seventy-two hours. This restriction contributes to a protracted length of hospitalization. There is a provision in the rights of recipients that allows for an administrative mediation hearing. Clients have the right to legal representation as part of this hearing process. After consultation with the State of Maine’s Attorney General’s Office,
Riverview was advised to negotiate a contract with Pine Tree Legal to provide Riverview clients assistance in medication hearings. This request is for 100% General Funds on an ongoing basis.

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

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

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

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

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

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

Specialized Training
AFA REFERENCE #: F-A-7223

This initiative would provide the necessary funds to provide staff of Riverview Psychiatric Center with the opportunity to gain, develop, and renew skills, knowledge and abilities to provide state of the art consumer-centered inpatient psychiatric care to patients/clients with
serious mental illness for compliance with constitutional, statutory, and regulatory standards. In addition this initiative will allow for Riverview Psychiatric Center to conduct staff training and education that includes existing clinical staff and expert trainers which focuses on issues and topics of special needs and interest such as: working with clients who have especially challenging or complex needs, reducing seclusion and restraint practices, understanding the nature of mental illness, the impact of trauma and evidence-based practices.

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

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

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

These GF requests are based on projected total expenditures of $2.54 billion in SFY ’14 and $2.57 billion in SFY ’15 a total spending increase in all funds of less than $222 million from SFY ’13 to ’14 and approximately $27 million from “14 to ’15. This reflects a projected .8% increase in spending over ’13 and 1.07% increase from ’14 to ’15. National health care spending is projected to increase on average of 5.7% and Medicaid is projected to increase on average of 7%. Had Maine experienced a similar growth trend we would be requesting significantly more to support the budget.

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

Even with those challenges in managing a healthcare entitlement program, we have seen significant success. The Department projects that we will realize more than $22 million in state general fund savings in SFY ’14 and more than $38 million in projected savings (reduced spending against the projected increase) in SFY ’15. Many of these initiatives reflect that
incredible work and commitment of staff throughout the Department to advance our efforts to improve the health status of MaineCare members through improved coordination of care delivery, reduction of inappropriate utilization of health care services and increased focus on high cost utilizers. We have seen significant results from the work that occurred through our care management efforts in the Office of MaineCare services in working with high utilizers of emergency department services in collaboration with hospitals and other community providers – again focused on a patient-centered approach to evaluating opportunities to reduce personal barriers to primary care and improved care coordination. Since the inception of the program we have managed more than 1700 members. We had one member with 141 ED visits in 12 months. We are now turning our attentions to high utilizers of inpatient services again with the focus on a patient-centered approach to better understand what is driving avoidable hospital admissions and the opportunity to build on the establishment of our health homes and community care teams.

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

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

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

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

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

Accountable Communities will result in such improvements as:

- reductions in inpatient readmissions
- less non-emergent Emergency Department use
• more effective use of Electronic Medical Records and real-time data through Maine’s Health Information Exchange,
• increased investment in care management for members with chronic conditions, and
• more emphasis on preventive care.

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

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

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

Thank you for your time. I am happy to answer any questions.
DHHS MaineCare Expenditures*
Year Over Year Growth

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<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
<th>2014 Forecast</th>
<th>2015 Forecast</th>
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<td>ARRA</td>
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<td>General Fund</td>
<td>$754</td>
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<td>$772</td>
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*Does not include DSH, Hospital Settlement Payments, or CDC & OCFS Seed Accounts

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%
# MAINECARE REVIEW FOR SFY 2014/2015

## CYCLE DATA

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<th>ACTUALS - SFY TO DATE AS OF - 12/13/2013</th>
<th>SFY 2014 PROJECTION (ADJUSTED FORECAST)</th>
<th>SFY 2015 PROJECTION (ADJUSTED FORECAST)</th>
<th>SFY 2013 RESULTS</th>
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## NON-CYCLE DATA

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## Authorized Budgets

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## Year Over Year All Funds MaineCare Increase

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<tr>
<td>2015</td>
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