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MEMORANDUM

TO: Joint Standing Committee on Health and Human Services and
Joint Standing Committee on Appropriations and Financial Affairs
FROM: Maine Department of Health and Human Services
DATE: February 28, 2025
RE: Responses to Questions re: DHHS Biennial Budget Initiatives

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Hospitals

1. *Hospital professional fees: please provide the historical context of the increased costs leading to the 170 percent of Medicare - how does that track historically in the last few years? (Rep. Zager)*

Visibility into drivers of professional cost growth: hospital cost reports submitted to CMS and to the State do not contain detailed information about costs for professional services. In addition, because MaineCare reimburses a combination of both claims and cost settlement for professional services, it is challenging to pull data to analyze in a coherent manner, with aligned dates of services and members served. As a result, The Department does not have a lot of visibility into what is driving the price increases to cost settlement payments.

Hospital growth and practice consolidation: It is documented that hospital consolidation has been growing nationally and in Maine, and is associated with increased costs of care. There are several reasons for the consolidation and for the reduction in independent practice ownership. One of the financial incentives that contributes to this consolidation and increase in costs to payers is the higher reimbursement hospital-based professional services receive as compared to independent practices. As discussed previously, this is the case for MaineCare, where hospital-based practices receive additional cost settlement payments in addition to standard fee schedule payments. The State of Maine does not have a database that enables a straightforward tabulation of practice acquisition or reclassification or transfer of status from independent to hospital based. MaineCare claims and provider enrollment data each, however, show a significant growth in the number of hospital professional service locations, which include the hospitals themselves as well as provider based departments, and other sites. Claims data specific to Acute Care Hospitals shows an increase of 146 locations from 2021 through 2023, or by over 58 percent. Provider enrollment data for all hospitals showed an increase of 368 professional locations between January 2022 and January 2025, a 47 percent increase.

2. *Can you provide a big picture explanation of how rate setting works for hospitals? (Rep. Ducharme)*

Please see the slides submitted with this memo which describes hospital reimbursement at a high-level.

3. *What is the total tax increase to hospitals in this budget? (Rep. Fredette)*

This budget does not propose a hospital tax increase. The change included in the biennial budget to annualize the hospital tax is a technical accounting adjustment and does not reflect any increase in the hospital tax above current law.

Federal law requires that healthcare provider taxes be broad-based. As such, all providers of a taxed service (with limited exceptions, such as public providers) must pay the tax—so hospitals providing ambulance services and/or issuing prescriptions from pharmacies would be subject to the Department's proposed assessments for these services:

- Emergency ambulance services provided by hospitals would be taxed under the proposal for the ambulance services assessment. The Department will work with entities, such as hospitals, to ensure that providers do not pay a "double tax" or duplication of the hospital tax on hospital-affiliated ambulance services.
- Hospitals would be taxed for outpatient prescriptions issued from hospital-based pharmacies.

We do not yet have an estimate of the impact of the pharmacy and ambulance assessments on hospitals. As a reminder, MaineCare will reinvest a portion of the new revenues into higher reimbursement for ambulance service providers and increased dispensing fees for pharmacies to more than offset, in aggregate, the cost of the assessments.

The overall impact to hospitals of the proposed health information technology hospital bed assessment is capped at $1,800,000 per year. While the $408 per bed assessment is new, it replaces current hospital participant fees paid to the state-designated health information exchange, HealthInfoNet (HIN). For all hospitals/health systems that currently pay a participant fee to HIN, this proposal results in either no change or a cost-savings. Hospitals will pay an average of 55 percent less under this proposed structure than they do in current fees.

<u>Health Information Exchange/HealthInfoNet (HIN)</u>

4. *Part W what hospital does not participate and will they be assessed (Rep. Lemelin*)

New England Rehabilitation Hospital is the only hospital that doesn't currently participate in the health information exchange. In order to meet federal requirements that health care provider taxes be "broad-based," the assessment would need to apply to all hospitals in Maine, including New England Rehab.

5. *The $1.8M in hospital tax for HIN draws down an additional $5.4M in federal share. Where are those dollars going? (MHA, AFA requested response)*

The $1.8 million represents a cap to the total amount of revenue the proposed assessment may bring in. At the current number of hospital beds in Maine and the proposed $408 per bed assessment, the currently projected amount of revenue is $1.4 million. This revenue will be used to support the Health Information Exchange (HIE), where it will leverage an enhanced 75 percent federal match as CMS recognizes the HIE as an important part of the State's Medicaid Enterprise System.

This is similar to current state where a combination of State funding, federal Medicaid administrative funding, and provider participant fees have supported HIE operations. The difference is that the hospital assessment paid to the State will replace the participant fees that hospitals are currently paying directly to HIN. OMS has a contract with HealthInfoNet for the continued operation of the HIE that includes the state and federal dollars.

Note that the HIE will also continue to charge participant fees to non-hospital providers, as these providers are not eligible, per federal regulations, to be subject to a provider assessment.

Pharmacy Assessment

6. *On prescription assessment- will that apply only to physical pharmacies or mail orders as well? What percent of pharmacy transactions in the state are mail order? (Rep. Ducharme)*

   The Centers for Medicare & Medicaid Services requires that healthcare provider taxes be "broad based." This means that all providers of a service within a state must be subject to a tax- with an exception for public providers. The proposed pharmacy tax excludes out of state providers, but does not (and cannot) exclude mail order providers that are in-state. Maine Health Data Organization does not collect data related to mail order pharmacy status, thus we cannot provide this information at this time.

7. *Individuals testifying suggested that the federal match is not certain. Please provide additional information on that. (Rep. Gattine)*

   Through the specific provider taxes sanctioned by the Center for Medicare & Medicaid Services (CMS), states are able to collect additional revenues. When a state reinvests those dollars back into provider reimbursement, it benefits from net positive revenue by leveraging more Federal matching dollars (these Federal matching dollars become available as a result of the new, eligible revenue stream being reinvested in Medicaid reimbursement). That is what the budget proposes to do here, and we have no reason to believe that the federal match would not be provided on those increased rates. These proposed taxes are designed to meet CMS requirements of being broad-based and uniform.

Pharmacy Benefit Managers

8. *Can we tax pharmacy benefit managers (PBM) instead of pharmacies directly? (Rep. Zager)*

   MaineCare does not currently reimburse any PBMs, so we could not employ this provider tax strategy with PBMs instead of pharmacies. We are also unaware of any other state with a healthcare provider tax on stand-alone PBM services, so we are not sure whether this would be considered a permissible tax by CMS.

9. *Does MaineCare use a PBM? If so, what are the details of that contract?*

   MaineCare uses a transparent pass-through Pharmacy Benefits Administrator (PBA) which is different than a PBM in several ways, namely that there is no fee or mark-up that is retained by the PBA, MaineCare manages and receives all the financial benefits of pharmaceutical rebates, and MaineCare establishes the reimbursement amounts pharmacies receive.

   As MaineCare's current PBA, Change Healthcare Pharmacy Solutions, Inc. (CHC) serves as the administrator that screens for eligibility and adjudicates pharmacy claims for our Maine Point of Purchase System (MEPOPS). CHC provides a single sign on portal for pharmacies, provides pharmacy clinical prior authorization (PA) support, and a Pharmacy Help Desk Call Center. They provide Intensive Benefits Management (IBM) and Pharmacy Care Management Program (PCMP) for complex care management. To assist the State in financial management, CHC prepares quarterly supplemental rebate pricing files and prepares and coordinates requests for State Maximum Allowable Cost (SMAC) review. The Department pays the provider monthly payments for operating costs upon receipt of an approved invoice.

10. What mechanisms are available to control that PBM?

Again, MaineCare contracts out for a PBA, not PBM service, which inherently comes with less risk since it is a transparent payment arrangement and CHC is not accountable for managing pharmacy costs of members and cannot benefit from spread pricing, etc.

Ambulance Assessment

11. Provide a list of ambulance services that are municipal and how many are private or not for profit. (Rep. Stover)

DHHS does not have this list available at this time, we do not license these agencies and thus would look to other agencies and registrations to determine this information. We are working with Maine EMS and other state agencies to confirm a complete list of municipal providers.

12. Which ambulances are being taxed, what is federal match and how is that match to be spent? What percentage will go to back to EMS? (Rep. Blier)

The provider tax will be assessed on all non-municipal emergency ambulance services. CMS only permits healthcare provider taxes on emergency ambulance services.

Through the specific provider taxes sanctioned by CMS, states are able to collect additional revenues. When a state reinvests those dollars back into provider reimbursement, it benefits from net positive revenue by leveraging more Federal matching dollars (these Federal matching dollars become available as a result of the new, eligible revenue stream being reinvested in Medicaid reimbursement).

MaineCare will use the funding to support the increased costs of MaineCare-covered services and will reinvest a portion of the new revenue into higher reimbursement for ambulance service providers to more than offset in aggregate the cost of the assessment. You can see both the initiative that generates the new revenue and the initiative that increases reimbursement to ambulance providers on page 357 of the budget.

13. Who is being taxed?

- *Which EMS services are expected to generate the $3.6 million in tax revenue*

  The provider tax will be assessed on all non-municipal emergency ambulance services. The Department consulted with Medicaid legal experts who shared their interpretation that the state may develop defensible criteria to define public providers, including quasi-municipal providers, as exempt from the tax.
- *Critical Access Hospitals are no longer part of the hospital tax which would have exempted their ambulances. As they are hospital owned ambulances are they included in the tax proposal?*

  All non-municipal emergency ambulance services will be taxed under this proposal, which, as stated above, is a requirement of a broad-based tax per CMS.
- *Has there been any analysis of the cash flow implications of applying this tax to the entities included? Will the carrying cost of the tax cause small agencies to fail?*

  We do not yet have an estimate of the impact of the ambulance assessment on individual providers. We are working with EMS to define municipal and non-municipal providers as a first step. Federal law prohibits States from holding individual providers harmless.

MaineCare will use the funding to support the increased costs of MaineCare-covered services and will reinvest a portion of the new revenue into higher reimbursement for ambulance service providers to more than offset in aggregate the cost of the assessment. You can see both the initiative that generates the new revenue and the initiative that increases reimbursement to ambulance providers on page 357 of the budget.

14. What revenue is being taxed?

- *What revenue is taxed and why is the language different than the other hospital and healthcare provider tax language, e.g. Grants, donations, research are excluded for hospitals.*

  Revenue estimates were based on direct all payer reimbursement for ambulance services. Municipal subsidies would not be included in taxable revenue. The Department is exploring language options from other states to further refine its definition of revenue accordingly.
- *Will it also tax municipal subsidies that some services receive to help cover the cost of providing 911 emergency coverage?*

  Please see above related to what revenue will be taxed per proposed language.

15. Who will receive the federal matching funds?

- *Will only the taxed EMS providers receive the increased MaineCare reimbursement, or will these funds be distributed to all ambulance services statewide? (a system wide MaineCare rate increase)*

  Increased MaineCare rates would apply to all ambulance services, as MaineCare strives to have consistent reimbursement rates for different providers of the same service. MaineCare will follow the public process established under its rate reform statute, MRSA 22 3173-J to determine the details of its proposed investment to ambulance reimbursement.
- *If reimbursement is extended to all providers, will the services paying the tax receive adequate financial relief, or will they end up paying more in taxes than they receive in increased reimbursement?*

  Federal law prohibits the state from holding individual providers harmless who are subject to a provider tax. However, in aggregate, the budget proposes to invest more than is received in taxes. We do not have provider-level impact data at this time.
- *Will the increased reimbursement apply to all ambulance transports, including interfacility transfers, or just 911 emergency calls?*

  The reimbursement methodology would be worked out through the process outlined in rate reform statute. MaineCare strives to have a consistent methodology applied to a class of services where possible—e.g., MaineCare currently reimburses a standard percentage of Medicare for ambulance services covered by Medicare, and would plan to continue to do so.

  The impact will be an investment in rates that exceeds the cost to providers, in the aggregate, of the new assessment.

<u>Positions</u>

16. How many positions at DHHS are currently vacant? (Sen. Nangle)

As of February 18, 2025, there are 461 vacant positions of a total 3,741 positions. These numbers include full time, part time, limited period, and seasonal positions.

17. How many new positions are being proposed per office at DHHS? (Rep. Graham)

The Department is requesting positions in 8 of the 10 offices. The positions are broken down as follows:

Office	Positions Requested
OFI	48*
CDC	16
OADS	9
DLC	5
OCFS	3
OHIM	2
OBH	1
DDPC	1
Total	**85**

*These positions are requested to make the Wilton Call Center positions permanent. Approval of this initiative would not provide any additional capacity to the Department. Rejection of this proposal would significantly reduce capacity at the Department to assist constituents with questions related to their eligibility for benefits.

18. Some of these limited period positions were established or continued by financial order but there is not sense of when they were started and when they were supposed to get done. For WS if you could tell us why they were created as limited period and say why we need them? (Rep. Ducharme)

Limited period positions are generally created due to capacity needs at the Department. As discussed, the Department has fewer permanent employees today than in 2011. Limited period positions provide temporary support to administer various programs.

19. What is the current average wait time at the Wilton Call Center and for OFI call center generally? What is the cost per position for the Wilton Call Center and total cost for this initiative? (Rep. McCabe)

Calls to OFI's call center are generally answered first by the "clerical" phone queue, which is staffed by 45 CRA-II representatives based in Wilton. The pay range for a CRA-II position is $17.30 through $24.91 per hour. Some of these calls are able to be resolved at the clerical level and others require transfer to Eligibility Specialists (the "eligibility" call queue). The eligibility queue is staffed by Eligibility Specialists across the state who rotate assignments between in-person, phone, and processing activities. Approximately 60 Eligibility Specialists are assigned to the eligibility queue each day. In addition, OFI offers an Interactive Voice Response system to process some tasks without speaking to a representative and several self-service options on MyMaineConnection.gov.

In January 2025, OFI received an average of 2,000 calls per day. The average wait time (in minutes) before a staff member answered the call was six minutes for the clerical call queue and 40 minutes for the eligibility call queue.

<u>Part UU, Cost of Living Adjustments for Medicaid (MaineCare) Services</u>

20. Under part UU, is this basically saying that the COLAs are frozen for the next 2 years? So direct care workers they are not getting it now or for two years? Will the state still comply with the AAAA requirement re: 125 percent minimum wage? (Sen. Moore)

Part UU includes language to make rate adjustments, including those related to part AAAA, contingent on availability of appropriations. MaineCare Rate Reform principles and process remain

in place; when there are sufficient appropriations the Department will proceed with annual cost of living adjustments.

Part AAAA required that MaineCare adjust the labor component of rates to equal at least 125 percent of minimum wage. MaineCare took the opportunity provided by Part AAAA to conduct full rate determinations on many services, providing wholesale rate investments, including for services that already had wages above the 125 percent minimum. MaineCare has also provided COLA on rates as a whole, not just on the labor components of those rates. The Department had recommended inclusion of language in Part AAAA to require that direct care workers receive from providers at least 125 percent of minimum wage. This language was not accepted, and the Department does not have data on the extent to which these rate increases have translated directly to direct care worker salary increases and COLAs.

21. *The DHHS budget memo estimates $132 million in savings from suspending MaineCare rate COLAs in 2026-7, but how much of that is associated with 22 MRSA §7402, the requirement to reimburse essential support work at no less than 125 percent of state minimum wage, adjusted annually on January 1? Could you also share any data used to calculate that figure? (Rep. Zager)*

To clarify, a suspension of the COLAs during the biennium results in an estimated $132 million in avoided cost increases, rather than savings. $84M of the $132M estimate is associated with COLAs for Sections of Policy subject to the 125 percent of minimum wage requirement. This amount reflects the combined amount needed in FY26-27 to provide cost of living adjustments in alignment with actual and projected State of Maine minimum wage increases on 1/1/25, 1/1/26, and 1/1/27.

The following MaineCare Sections of Policy are subject to the requirement that MaineCare reimbursement includes "An amount equal to at least 125% of the minimum wage … for the labor portion of the reimbursement rate."

- Section 2: Adult Family Care Services
- Section 12: Consumer Directed Attendant Services
- Section 17: Community Support Services
- Section 18: Home and Community-Based Services for Adults with Brain Injury
- Section 19: Home and Community Benefits for the Elderly and Adults with Disabilities
- Section 20: Home and Community Based Services for Adults with Other Related Conditions
- Section 21: Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder
- Section 26: Day Health Services
- Section 28: Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations
- Section 29: Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder
- Section 65: Behavioral Health Services
- Section 67: Nursing Facility Services
- Section 92: Behavioral Health Home Services
- Section 96: Private Duty Nursing and Personal Care Services
- Section 97: Private Non-Medical Institution Services, Appendix C

22. What is the priority process for rates impacted by Part UU? (Rep. McCabe)

The most substantive change under Part UU is that, in the case of insufficient funding, it states that criteria for prioritization include whether or not a service has already received a rate adjustment resulting from a rate determination under 3173-J, and whether or not the rate adjustment is for a service where there is evidence of member access issues.

The change to the existing process for scheduling and prioritization of rate adjustments is really the formalization and explicit inclusion of this new criteria in statute to inform the Department's prioritization of rate actions, and in particular under circumstances of insufficient funds outlined in 3173-J [note there are proposed amendments in Part UU, excerpt of a relevant amendment below]. This process includes consultation with the advisory bodies (MaineCare Advisory Committee and Technical Advisory Panel). Under this process, the Department consults with the Technical Advisory Panel (TAP) on the annual rate determination schedule and on various rate and payment model technical issues. The Department then posts the proposed rate determination schedule on its publicly accessible website and provides an opportunity for the public to review and comment on the rate determination schedule, and makes available a summary of these comments on its publicly accessible website. Throughout the year, including during formal rate schedule review, the MaineCare Advisory Committee and their rate system subcommittee provide input into issues of member access and other recommendations. The Department then takes appropriate rate system actions throughout the year which incorporate these consultations/advisements, in alignment with statutory requirements.

Excerpt of the proposed amendments to 3173-J related to the question above:

> "C. If sufficient funds are not appropriated for reimbursement adjustments in accordance with this section and there are not sufficient funds available in the MaineCare Stabilization Fund for this purpose, the department shall, proportional to any funding for reimbursement adjustments that may be available, prioritize: (1) Reimbursement adjustments resulting from any rate determinations for sections of policy or services that do not yet have reimbursement established through a rate determination under this section; (2) Rate adjustments for services where there is evidence of member access issues."

23. Does Part UU result in net reduction to payments for nursing homes compared to what they would otherwise be? (Rep. Arata)

The Nursing Facility (NF) section of Part UU reflects the statutory changes needed for MaineCare to bring NF rate setting into alignment with adjustment timelines for other services and also strikes outdated language. Following discussions with the industry, the Department is open to aligning rebasing (adjustment) timelines following the initial transition period. There are no cuts to nursing facilities proposed in this budget. The Department has used a portion of the NF reform transition fund to implement a "hold harmless" provision in the first year of reform to ensure that no facility would see a decrease from their prior rates. Please note that the budget proposal does not include funding COLAs, which impacts nursing facilities.

24. Additional information on the relationship between the recent DOJ settlement and COLAs for MaineCare rates. If changes are made, is Maine exposing itself to federal sanctions? (Rep. Ducharme) What's the specific DOJ language related to COLAs? (Rep. Gattine)

This language requires that this work is done "consistent" with state statute. If state statute is amended to address financial realities, actions consistent with those changes would remain consistent with the settlement agreement.

25. What COLAs have already been enacted and for whom (Sen. Moore)

The table below provides the list of MaineCare Sections of Policy that received a COLA during calendar year 2024. The list of services receiving a COLA will change somewhat each year, as MaineCare does not provide a COLA when implementing a new rate resulting from a rate determination or within the 12 months following the implementation of that new rate.

Section	Section Description	COLA date
2	Adult Family Care Home	1/1/24
12	Consumer Directed Attendant	1/1/24
13	Targeted Case Management	1/1/24
17	Community Support Services	1/1/24
18	HCBS for Adults with Brain Injury	1/1/24
19	HCBS for the Elderly & Adults with Disabilities	1/1/24
20	HCBS for Adults with Other Related Conditions	1/1/24
21	HCBS for Members with Intellectual Disabilities or Autism Spectrum Disorder	1/1/24
26	Day Health Services	1/1/24
28	Rehabilitative & Community Support for Children with Cognitive Impairments and Functional Limitations	1/1/24
29	Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder	1/1/24
30	Family Planning Services	7/1/24
31	Federally Qualified Health Centers	7/1/24
40	Home Health Services	7/1/24
45	Hospital (Distinct Psychiatric & SUD Units for Medically Supervised Withdrawal)	7/1/24
65	Behavioral Health	1/1/24
67	Nursing Facilities (AAAA add-on adjusted in Jan, and overall COLA in July)	1/1/24 and 7/1/24
89	MaineMOM	7/1/24
91	Health Home Services – Community Care Teams	7/1/24
92	Behavioral Health Homes	1/1/24
93	Opioid Health Homes	7/1/24
96	Private Duty Nursing & Personal Care	1/1/24
97 B&D	Private Non-Medical Institutions, Appendices B and D	7/1/24
97 C	Private Non-Medical Institutions, Appendix C (AAAA add-on adjusted in Jan, and overall COLA in July)	1/1/24 and 7/1/24
102	Rehabilitative Services	7/1/24

26. Are there any federal directives about rates that direct COLAs? (Rep. Ducharme)

There are federal requirements for annual inflationary adjustments for Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) prospective payment system (PPS) rates. All Maine FQHCs are reimbursed by MaineCare at an alternative payment model (APM) rate that is significantly higher than the PPS rate (APM was required by legislative changes implemented in 2023). Only a few RHCs are currently reimbursed according to the PPS rates – legislation in 2019 allowed RHCs to opt to rebase if that would result in new rates higher than their PPS rate.

Following implementation of Certified Community Behavioral Health Clinics (CCBHC), there will be a federal requirement to provide a COLA for those services in years where a rebasing has not occurred.

Children's Behavioral Health

27. How many children are in out of state residential treatment placements funded by MaineCare? What is the cost of these placements, including transportation (including for families)? List of facilities and their locations?

There are 69 children in an out-of-state residential treatment facility funded by MaineCare in early 2025, in the following facilities:

- American School for the Deaf, CT
- Easter Seals, NH
- Seven Hills (Crotched Mtn), NH
- Hillcrest Academy, MA
- Stetson School, MA
- Mount Prospect Academy, NH
- Sandy Pines, FL
- Millcreek, AK
- Youth Villages, TN
- Youth Villages, GA
- Lakeland, MO

The cost of out of state placements requires significant data analysis and as a result we cannot include it in this document.

Child Care Affordability Program (CCAP)

28. *How much is currently allocated for CCAP? I understand it ran out in November but that's all I know and would like more information on this, if possible (Rep. McCabe). This program is not apparently a separate item in the budget - is it part of the 26.9 million revised summary? If so, how much is CCAP? Can you give details about CCAP and how the program works? Is there currently a waitlist? If so why? How large is the waitlist? Is the program out of funds? (Sen. Ingwersen)*

Eligibility and Enrollment: Current income eligibility for CCAP is 125 percent of state median income. For context, 125 percent SMI is an annual income of $118,921.95 for a family of 3. Additional eligibility criteria and details on income thresholds is available on OCFS's website[1]. OCFS maintains a public early care and education data dashboard that includes up to date enrollment data[2]. As of January 2025, enrollment is 3,832 across the four age groups.

Funding: The Child Care Affordability Program (CCAP) is primarily funded with federal dollars, the Child Care Development Fund (CCDF) and TANF. States are required to spend approximately 70 percent of their CCDF federal block grant on child care subsidy awards. The funds

[1] https://www.maine.gov/dhhs/ocfs/support-for-families/child-care/paying-for-child-care
[2] https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/early-childhood-education

run on the federal fiscal year and can carry over and be spent over a two-year period. The block grant award is about $33 million for Maine this federal fiscal year.

Program:

- Families apply to the Child Care Affordability Program (CCAP) for their children: infants, toddlers, preschoolers, and elementary school age children.
- CCAP Financial Resource Specialists review applications and determine eligibility
- Once authorized for CCAP, families choose a child care provider approved by CCAP
- Licensed child care programs and license-exempt child care sign CCAP provider agreements to be an approved provider
- Families enroll children in a child care program.
- The child care program is paid biweekly by OCFS for a portion of the child's cost of care.
- The parent is responsible for their parent fee, determined on a sliding fee scale based on household income.

Impact of New Federal Rules

- CCAP currently pays child care providers in a reimbursement payment structure based on the attendance of children. The payments are at the market rate or the rate the provider charges, whichever is lower. Families in Maine do not pay more than 10 percent of their household income for the full child care costs of any and all of their children enrolled in CCAP.
- This spring, OCFS will roll out the Baxter Child Care Management System and will pay child care providers prospectively (at the start of two weeks of care instead of after two weeks of care), at the state child care rate, based on the enrollment of children. Family copays will not exceed 7 percent of household income for those at or below 85 percent State Median Income (SMI) and will not exceed 10 percent of household income for those between 85 to 125 percent SMI.

Waitlist: Given rising costs and federal changes, the waitlist was established at the end of 2024 to manage the program within available federal funds through the end of the calendar year 2025.

- There are 471 children on the waitlist (as of 2/19/25)*
- 301 children are from families at or below 85 percent SMI
- 170 children are from families between 85-125 percent SMI

29. *To date there has been $ 2,366,094 expended to support 85-125 percent population. Why has DHHS only spent $2.36 of the $10.2 million for the expansion, but are putting qualifying families on a waitlist? What is happening with that money? (Sen. Rotundo) Why did the CCAP program fill up so quickly after it got off to a slow start? (Rep. McCabe)*

Based on the current population of families between 85-125 percent of State Median Income (SMI) in the Child Care Affordability Program (CCAP), DHHS is projecting to spend $5 million from the general fund for this population in SFY2025. CCAP is implemented as one program, with one set of Rules. DHHS reached a cap in available federal funds for the population of families below 85 percent SMI in late 2024 and needed to start a waitlist. When DHHS awards CCAP to an eligible family, the Department needs to be prepared to pay that cost for the next 12 months. DHHS and OCFS budget CCAP a year or two out to make sure we can afford to fund all current families in the program.

The wait list was established at the end of 2024 to manage the program within available funds through the end of the calendar year 2025. OCFS is working to implementing new federal requirements in 2025, which come with a substantial projected annual increase without new federal funding. OCFS needed to start a waitlist to make sure to meet the increased costs that will be incurred in 2025. When CCAP starts a waitlist, it is for all children in the program and Maine's CCAP Rules prioritize families below 85 percent SMI, children with special needs, and families experiencing homelessness to come off the waitlist first. It would be outside CCAP Rule to take families over 85 percent SMI off the waitlist before families below 85 percent SMI. DHHS submitted a language change in the supplemental budget to allow CCAP to utilize state funds for all children enrolled to be able to bring more children off the waitlist and spend the full $10.2 million appropriated.

30. *How much is each tier for the wage supplements for childcare workers? (Rep. McCabe)*

The current tier levels are available below. Additional information is available on the Early Childhood Educator Workforce Salary Supplement System webpage: https://www.maine.gov/dhhs/ocfs/provider-resources/early-childhood-educator-workforce-salary-supplement-program

Level	ECE Workforce Registry Levels (MRTQ PDN)	Monthly Supplement Amount
Tier 1	Level 1, Level 2, Level 3, Level 4	$240
Tier 2	Level 5, Level 6	$360
Tier 3	Level 7, Level 8	$540

31. *Child Care Wage Supplement: With the program back to $15 million a year funding, will it still be tiered? If so, how many fewer child care professionals will be able to access the program? Will it be a flat $200 per month, or will it be less if more folks can access it? (Sen. Ingwersen)*

The program will remain tiered, as this is a requirement in statute. It will not be a flat rate. All eligible workers will still be able to access the program and the tiers will be adjusted to ensure the program remains within the appropriation. The second tier provides a salary supplement that is at least 50 percent greater than the first tier, and the third tier is at least 50 percent greater than the second tier.

With the current number of staff in the program and the proposed $15 million budget, OCFS would adjust the tier payment amounts based on the number of child care staff at each level in the child care registry. At the current levels of enrollment at the three tiers, these new tiers are currently estimated to be approximately $120, $180, and $270 per month starting in July 2025. This number is subject to significant change should child care workers move between tiers or additional providers enroll in the program.

32. *Child Care Employment Award: with this program gone in the budget, will workers be able to access the CCAP? (Sen. Ingwersen)*

Yes, for most of the child care workforce. Family child care providers cannot access CCAP for their own children. The child care employment award is currently available to a family child care provider for their own child.

CCAP requires both parents to be working, in job training, or in school during the hours that their children attend a licensed child care. The child care employment award has had more flexibility and is focused on categorical eligibility for the child care workforce, even if they don't meet all of the CCAP requirements.

Any parent eligible at the recently enhanced eligibility of up to 125 percent of state median income will still be able to apply for CCAP scholarships. The elimination of the employment award will mean they will be required to pay the CCAP parent fee required at their income level.

Medicare Savings Program

33. How many people signed up for the Medicare Saving Program in 2024? Please provide month by month numbers for all of calendar year 2024 (Rep. Shagoury).

Below are two representations of the same data. This shows enrollment in Medicare Savings Programs, which include three potential coverage groups: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individuals (QI). Additional information about each of these programs is available online at Medicare.gov[3].

Month (2024)	QMB	SLMB	QI	Total
January	63,765	8,124	3,822	**75,711**
February	64,065	8,128	3,882	**76,075**
March	64,465	8,068	3,888	**76,421**
April	64,657	8,064	3,911	**76,632**
May	64,755	8,070	3,917	**76,742**
June	64,922	8,084	3,939	**76,945**
July	75,484	0	962	**76,446**
August	75,913	0	1,572	**77,485**
September	76,533	0	2,075	**78,608**
October	89,500	0	2,719	**92,219**
November	89,775	0	3,314	**93,089**
December	90,111	0	3,776	**93,887**

Notes:

- In January 2024, OFI eliminated the asset test for QMB, SLMB, and QI.
- In July 2024, OFI expanded FPLs for QMB and QI. This expansion absorbed the SLMB program and those members were moved to QMB automatically.
- In October 2024, OFI completed a Federally required automatic enrollment project for SSI recipients into QMB (they did not have to apply). Most of these SSI recipients were already receiving these benefits but not officially under QMB program.

Lead Poisoning Prevention Program

34. What does the childhood lead poisoning prevention program fund? Why are the 8 positions proposed to be continued and made permanent (C-A-1311) in the Childhood Lead Poisoning Prevention Program still needed? When were they established and what was the initial end date? Why created as Limited period and why continued? Is there an estimate of the number of properties with lead paint? (Rep. Ducharme).

The Childhood Lead Poisoning Prevention Program funds a number of activities including ongoing measures to prevent children's exposure to lead including education, resources, and materials for families, landlords, community and worker outreach programming, employer and occupational settings, a public awareness campaign, research to assess of the current uses of lead and the availability, effectiveness, and affordability to lead-free alternatives, and the implementation of the lead-safe housing registry.

As the Childhood Lead Poisoning Prevention Program continues to make progress on the legislative mandate that increases the blood lead testing of 1- and 2-year-olds (i.e., the universal testing mandate of 2019), we continue to identify about 260 lead poisoned children annually. The 8

[3] https://www.medicare.gov/basics/costs/help/medicare-savings-programs

positions were established over time, 5 were initially created in 2015, with an original end date of June 2017, and 3 were created in 2019, with an original end date of June 2021.

Presently, each Environmental Specialist III (ESIII) is managing an average caseload of approximately 100 dwelling units that are in various stages of inspections, orders to abate identified lead hazards, and tracking compliance with orders to abate and eventual clearance testing. At this time, we do not foresee any lessening in the caseload and have a continued need for the 8 ESIII positions for the foreseeable future.

The positions were initially created as limited period because the Childhood Lead Poisoning Prevention Program had anticipated there would be a decrease, over time, in new cases of lead poisoned children. Unfortunately, this has yet to occur. Further, the Program has continued to struggle with staff turnover. Making these positions permanent will provide the necessary stability for recruiting and retaining staff.

The Department has estimated there are approximately 61,000 rental units in Maine that were built before 1950 and may contain lead paint.

Victims of Crime Act (VOCA) Funding

35. *How much VOCA funding is needed to make up for the reduction in funding from Congress? If the shortfall is $6 million, why is $3 million proposed? (Rep. Stover).*

As discussed with the Committee on Tuesday 2/26, the budget included significant hard choices, and generally the state is not in the financial position to fully backfill lost federal funding. The budget is required to be balanced, and the initiative in the proposed budget is what the State determined was possible in this fiscal climate.

General Assistance

36. *What is the estimated shortfall for General Assistance Reimbursement to Municipalities in FY26 and FY27 if Part S (from the supplemental) is not enacted? (Rep. Arata)*

Part S was designed to bring GA costs to current baseline ($10.4 million) vs projected GF costs for SFY25 of approximately $20 million. If Part S, or a similar provision, is not enacted, the estimated shortfall for GA will be $10 million per year or $20 million for the FY26-27 biennium.

37. *What types of facilities will be considered temporary housing and emergency shelters, and therefore exempt from the General Assistance housing assistance limitation language proposed in the Governor's Supplemental, Part S?*

GA rules define housing assistance as "Payments made by, or on behalf of an individual, for rent or mortgage." Facilities that offer housing on a temporary basis and usually that don't charge a standard "rent" will be considered temporary housing and not subject to the time limit proposed in Part S (supplemental). Examples of these facilities, which would not be subject to the time limit, include homeless shelters (both municipal and non-profit/private) and recovery residences. In addition, individuals would be eligible for rental assistance beyond the limit proposed in Part S if the applicant has a severe and persistent mental or physical condition warranting such an extension or has an application for assistance pending with the federal Social Security Administration.

Fund for a Healthy Maine

38. Fund for a Healthy Maine (FHM): A) Why did the Dept. propose to remove programs from FHM-funding, rather than add other sources of funds (e.g. GF revenue from Tobacco Excise Tax) to the FHM to cover the gap? B) Of the suite of current FHM funded programs, why were certain programs vs. others selected to shift to GF funding? Why is Tobacco Prevention and Treatment in particular moved out?

The budget proposes to fund public health activities previously funded through FHM with General Fund to address a shortfall in the FHM beginning in SFY2027. When considering how to address the shortfall, the Department and Administration assessed that the public health activities have become relatively permanent fixtures of state programming and the reliability offered by the General Fund led to the determination that it was appropriate to move these programs to the general fund.

Bridging Rental Assistance Program (BRAP)

39. Can you bring a chart of fair market rents (Rep. Javner)

The BRAP program uses the FMRs as published by HUD, which can be found here: https://www.huduser.gov/portal/datasets/fmr.html. Here is the Maine summary:

Final FY2025 Maine Fair Market Rent (FMR) Metropolitan Area Summary					
Metropolitan Area Name	**Efficiency**	**1 BR**	**2 BR**	**3 BR**	**4 BR**
Bangor Maine HUD Metro	$1,034	$1,114	$1,424	$1,825	$1,890
Cumberland County, ME (part) HUD Metro	$1,197	$1,330	$1,745	$2,191	$2,667
Lewiston-Auburn, ME MSA	$898	$994	$1,268	$1,663	$1,845
Penobscot County, ME (part) HUD Metro	$839	$880	$1,155	$1,455	$1,723
Portland, ME HUD Metro	$1,379	$1,563	$2,011	$2,464	$2,763
Sagadahoc County, ME HUD Metro	$1,037	$1,168	$1,435	$2,011	$2,410
York County, ME (part) HUD Metro	$1,162	$1,312	$1,616	$2,134	$2,351
York-Kittery-South Berwick, ME HUD Metro	$1,352	$1,528	$1,971	$2,552	$3,310

40. Who administers the BRAP program?

DHHS administers the program through a contract with a provider, Shalom House.

41. How many people are currently on the waitlist?

As of 2/24/25, the cumulative waitlist total (since it began February 2024) is 148. A portion of these individuals may have self-resolved or found alternate resources. Total served in February is reported by Shalom House as 944.

42. What would be required to clear the waitlist? What is needed to meet the full need?

It is difficult to measure the full need for this program. At the time when the budget was developed, we estimated that we would need an additional $1.9 million to continue to house the existing 834 individuals in the program, although that level of support would have still required a partial waitlist. Based on rent increases since then, the need is now $2.5 million. To clear the current waitlist, the program would need $1.5 million annually in funding in addition to the $2.5 million, although that still would not represent the current need since vouchers go unused and demand will continue to grow.

43. How has demand grown over the years?

Maine Housing's Housing Outlook Report 2025[4] provides helpful information on the growth in demand for housing in recent years. There are two major factors:

44. Growth in unhoused population has increased demand for housing assistance resources.
45. Limited supply of housing assistance resources.

Additionally, the federally funded, state administered Continuum of Care housing program was oversubscribed and frozen to new applicants between April 2023 and September 2024. This resulted in an unforeseen spillover effect to the BRAP program. Housing Authorities have also restricted their resources recently.

Mobile Crisis Services

46. Mobile Crisis response data (Rep. McCabe)

In FY 2024, mobile crisis teams reported 13,930 encounters:

- 85 percent of mobile crisis referrals were responded to in 60 minutes or less
- 93 percent of mobile crisis responses were resolved in 3 hours
- 99 percent of responses did not result in involuntary psychiatric hospitalization

[4] https://mainehousing.org/docs/default-source/policy-research/research-reports/outlook-reports/2025-housing-outlook-report.pdf