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

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January 24, 2012

To: Senator Richard Rosen, Senate Chair
Representative Patrick Flood, House Chair,
Members of the Joint Standing Committee on Appropriations and Financial Affairs

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

Re: DHHS response to questions from the January 12th and 13th Work Sessions.

We are working on responses to other questions asked at the above work sessions and also from January 18th.

January 12, 2012 Work Session

1. Rep Flood: Is there overlap between savings in Childless Adult and other eligibility categories elimination and the elimination of optional services?

   Response: When the Department was calculating the savings numbers for the optional services, we eliminated the optional eligibility groups in the proposal therefore, eliminating any double counting of savings.

Dirigo

2. Rep. Winsor for DHHS: How many parents under 100% poverty level are currently enrolled?

   Response: 46,170

Childless Adult Waiver

3. Rep. Keschl: If we didn't have this program, what percentage of the total population would be uninsured and what is the percentage with this program?

   Response: The Bureau of Insurance would be better suited to answer this question.

4. Rep. Rotundo: What will be the impact on hospitals of the elimination of the waiver in increased charity care?

   Response: We cannot determine at this time what additional costs will be imposed on hospitals. There will likely be some impact to the hospitals, but the Maine Hospital Association would be better equipped to provide an in depth response.

5. Rep. Webster: How many people who applied as a non-cat were then found to be qualified for coverage in other categories?

   Response: Since implementation of the Childless Adult Waiver, approximately 30,000 non categorical individuals, have moved to other categories of coverage under MaineCare. These categories include, Families with Children, Pregnant, and SSI related.

6. Rep. Flood: Please provide the guidelines for determining a disability.

   Response: Any impairment could potentially be disabling, if it imposed enough of a functional limitation. Many factors play in to the decision, the claimants age, education, past work experience, as well as the impairment or combination of impairments. Some conditions are more straightforward to assess; certain types of cancer, cognitive disability, paralysis, blindness, but these cases cannot be processed on diagnosis alone. Even with these impairments, significant supporting material is needed.

   The Social Security disability determination process takes about 100 days from the time the claimant goes to the SSA field office to the time they get a decision. If the individual appeals a decision, the first level of appeal would take an additional 70 days or so. The next level past that would take about an additional year. The next level after that can take an additional several months.

7. Rep. Webster: What are the timelines between application and determination of eligibility for various categories of Medicaid coverage?

   Response: All applications must be determined within 45 days from the date of application. Generally an application is decided within 2-4weeks from the date of application. If the individual is applying for MaineCare based on disability the process can take up to 45 days and in some instances longer if we are waiting for medical information.

8. Can we receive an update on efforts to identify veterans on MaineCare and to coordinate services with the VA?

   Response: The Office for Family Independence is currently in the process of updating our eligibility system to capture if someone has a military record. Currently OFI identifies Veterans based on their VA income source. The Department is currently reviewing the Washington State Veterans project to determine how best to locate and identify potential Veterans.

<u>Targeted Case Management</u>

9. Sen Katz: Can we get a summary of TCM as provided in other states?

   Response: See **Attachment A**

10. Rep. Rotundo: Requested confirmation/clarification of answer to Question #7 posed on January 3rd. There are some who believe that the same level of care cannot be provided under the waiver.

    Response: The department spoke with advocates as requested and they believe that TCM is a necessary service for the members on the waiver wait list.

11. Rep Flood: Is the savings noted net of additional costs as services shift to other accounts?

    Response: These are not direct care services. Since it is care coordination, it will not be picked up elsewhere.

Adult Family Care

12. Rep Rotundo: Who will provide services to those currently in Adult Family Care settings?

    Response: The Department is still working on alternatives to those services as they work on alternatives to PNMI services.

13. Sen. Rosen: How many individuals are served? The number (88) given in the fact sheets seems low.

    Response: Please refer to the updated fact sheet.

14. Sen. Katz: Given the small number of people receiving this service – what are the demographics? Is it essentially the same level of need as PNMI? What are the demographics?

    Response: Please refer to updated fact sheet.

Consumer Directed Attendant Services

15. Rep. Rotundo: How many people receiving services are able to work because of them? How will services be provided (if at all) and would there be any increased costs in other programs?

    Response: Please refer to the updated fact sheets.

16. Sen. Rosen: Were the Alpha-One service providers included in collective bargaining additions?

    Response: We are not aware of any state collective bargaining negotiations related to the services provided through DHHS with these providers.

January 13, 2012 Work Session

Inpatient Rate Reduction

17. Sen. Katz: In looking at total inpatient spending, there was a marked decrease in total spending. What is the explanation? *Hospital Association believes that one of the explanations is unpaid debt.*

Response: There have been a variety of savings initiatives like limits on services and reductions of rates that have impacted the hospitals in recent years. The decrease in dollars for SFY 11 is due in part to the implementation of MIHMS and the zero pay of claims that began in March of 2011 due to hospitals spending being above budget.

Hospital Inpatient Limit (5/year)

18. Sen Katz: What is the number of people who were over the limit in the last year?

Response: There were a total of 174 who had more than 5 inpatient admissions in a year. The numbers are broken out by 31 members under the age of 20 and 143 over age 21.

19. Rep. Webster: What types of procedures would be eliminated.

Response: This initiative proposes to eliminate reimbursement for inpatient services after 5 visits. It will not eliminate services or procedures.

Hospital Reimbursements

20. What type of services are provided in an out patient setting?

Response: All medically necessary service is covered. A few examples of services would be: lab, imaging, PT, OT, drugs and biological, asthma self-management services, diabetes education and follow-up service.

21. Were other initiatives that affect IP reimbursement included in reduction?

Response: No

22. What happens when a member reaches 5 admissions?

Response: This is a reduction in hospital reimbursement, not a limit on the service to members therefore, the members may receive the service but the hospitals will not get Medicaid reimbursement

23. Sen. Rosen: In General is there a greater opportunity for savings if some of the ideas would be expanded through initiatives or statutory changes?

Response: The Department feels as though they have done an exhaustive search for those initiatives which would generate greater savings to contribute to the shortfall request. Between 13.7M in Administrative Savings in SFY12, and another 11M in SFY13

as well as those initiatives yet to be voted on that were accepted by the Streamlining Task Force, there are no additional initiatives at this time.

24. Rep. Rotundo: How will people buy DME with no one to explain how to use them or what would be appropriate.

Response: Individuals requiring equipment or supplies that require fittings or manual intervention will still be allowed to go to a DME supplier. The items in which we are proposing would be purchased through mail order include routine, bulk supplies such as; wound, ostomy, incontinence and some diabetic supplies (test strips, syringes, lancets).

Cc: Joint Standing Committee on Health and Human Services
Governor Paul R. LePage
Dan Billings, Chief Counsel, Governor's Office
Kathleen Newman, Deputy Chief of Staff, Governor's Office
Katrin Teel, Senior Health Policy Advisor, Governor's Office
Peter Rogers, Director of Communications, Governor's Office
Sawin Millett, Commissioner, Department of Administrative and Financial Services (DAFS)
Dawna Lopatosky, State Budget Officer, DAFS
Shirrin Blaisdell, Deputy State Budget Officer, DAFS

Some Facts about TCM in other States

Under section 1905(a)(19) of the Social Security Act (SSA), states are given the option to cover case management and targeted case management in their Medicaid programs. Under Section 1915(g)(2), case management is defined as "services which will assist individuals eligible under the plan [Medicaid plan] in gaining access to needed medical, social, educational, and other services."

Total Medicaid expenditures for all States for TCM increased by 107% in the period from 1999 to 2005. (In comparison the total Medicaid expenditures increased 86%)

- Almost all states cover some TCM benefits. In 2009 only Delaware did not cover TCM.
- In 2005 Maine had the third highest per beneficiary expenditure ($2,752) in the nation. Highest was in Massachusetts ($5,778) and lowest was Ohio ($116).
- In 2005 most states spent between $500 and $1,500 per beneficiary for TCM services.

Medicaid Targeted Case Management Expenditures, Beneficiaries, and Expenditures Per Beneficiary FY2005

State	Expenditures	Beneficiaries	$ Per Beneficiary
Alabama	$47,079,039	28,436	$1,656
Alaska	$7,395,511	4,310	$1,716
Arizona	0	0	—
Arkansas	$15,688,320	45,430	$345
California	$535,768,383	418,922	$1,279
Colorado	0	0	—
Connecticut	$26,461,108	17,592	$1,504
Delaware	0	0	—
District of Columbia	0	0	—
Florida	$123,073,255	85,794	$1,435
Georgia	$128,704,852	117,526	$1,095
Hawaii	$872,458	1,463	$596
Idaho	$11,844,337	10,636	$1,114
Illinois	$222,685,899	820,976	$271
Indiana	$13,143,144	13,793	$953
Iowa	$22,827,509	10,942	$2,086
Kansas	$74,943,822	21,140	$3,545
Kentucky	$22,077,584	15,233	$1,449
Louisiana	$21,983,190	14,080	$1,561
Maine	$96,493,716	35,068	$2,752
Maryland	$5,601,164	16,129	$347
Massachusetts	$221,258,249	38,294	$5,778

State	Expenditures	Beneficiaries	$ Per Beneficiary
Michigan	$19,726,427	52,251	$378
Minnesota	$224,214,087	101,823	$2,202
Mississippi	$39,345,391	44,926	$876
Missouri	$60,530,941	39,387	$1,537
Montana	$3,314,715	4,679	$708
Nebraska	$19,974,036	NA	NA
Nevada	$21,913,738	13,911	$1,575
New Hampshire	0	0	—
New Jersey	$6,669,245	5,456	$1,222
New Mexico	$12,875,580	11,150	$1,155
New York	$210,161,965	103,755	$2,026
North Carolina	$186,068,397	143,440	$1,297
North Dakota	$4,063,820	4,565	$890
Ohio	$1,270,746	10,913	$116
Oklahoma	$47,414,174	38,959	$1,217
Oregon	$67,604,053	42,664	$1,585
Pennsylvania	$57,964,007	69,275	$837
Rhode Island	$8,052,616	9,266	$869
South Carolina	$70,833,597	50,941	$1,391
South Dakota	0	0	—
Tennessee	0	0	—
Texas	$184,761,615	211,513	$874
Utah	$16,810,410	7,699	$2,183
Vermont	$7,644,346	6,436	$1,188
Virginia	$1,677,454	4,023	$417
Washington	$3,606,705	4,129	$874
West Virginia	$3,875,936	8,643	$448
Wisconsin	$22,136,862	36,077	$614
Wyoming	$1,637,081	2,382	$687
United States	$2,902,049,484	2,744,027	$1,058

Source: All Medicaid expenditure data discussed in this report include both federal and state expenditures, as well as expenditures for Medicaid-expansions under the State Children's Health Insurance Program (M-SCHIP). Medicaid Statistical Information System (MSIS), FY2005, downloaded January 24, 2008. FY2004 data were used for Maine as an estimate of FY2005 data.