Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

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Health and Human Services Committee Work Session

Tuesday, January 19, 2010

- General Assistance
- Children's Mental Health
- Other Children's Services
- Additional Medicaid Reduction
- Other Questions
    - Use of Antipsychotic Medication for children.
    - Differences between Children's Behavioral Health prior authorization functions and APS Health Care's continued stay reviews for residential treatment services.
    - What percent of children for whom residential treatment is requested is approved?

Questions from Legislative Committees of Appropriations and Financial Services and Health and Human Services

Part YY-General Assistance

The history of the General Assistance Program and Reimbursement formula to the municipalities.

General Assistance Legislative History

Prior to 1968, Maine was administering the General Assistance Program based on the Elizabethan Poor Law which established the community obligation for pauper relief.

In 1968, Title 22 of the Maine Health and Welfare Law Section 4462 provided "persons chargeable shall not be set up and bid off at auction either for support or service; but towns at their annual meeting, under a warrant for the purpose, may contract for the support of their poor for a term not exceeding 5 years." The State of Maine paid for applicants with no settlement and the State had no supervisory authority over the municipalities. In 1967, the State of Maine provided $705,674 for this purpose.

In 1974, the General Assistance Program was enacted (P.L. 1973, Chapter 470, Chapter 473). Municipalities were required to adopt written rules for the program regarding need and the amount of assistance that could be given.

In 1977, the definitions of "eligibility", "General Assistance Program" and "overseers" were added to the law. Municipalities were required to adopt an ordinance that set the standard of eligibility. Municipalities were "allowed" to adopt a workfare program.

In 1989, Chapter 833 was enacted which increased the level of state reimbursement to municipalities to at least 50% of their net General Assistance costs and for municipalities that met a threshold of .0003 percent of their property tax base on General Assistance costs, they would receive 90% after the threshold was met.

Between 1987 and 1991, General Assistance Program policy changes included:

Limiting the legal liability for financial support to parents of minor children and spouses;
Permitting municipalities to enter into agreements with homeless shelters to determine presumptive eligibility for General Assistance;
Permitting municipalities, under certain conditions, to pro-rate lump sum income and deem it available to GA recipients for a period of time; and
Permitting municipalities to verify any information necessary to determine eligibility provided the applicant knew of and consented to the third party contact.

In 1991, Chapter 591 (the 1992-1993 budget bill) changed the General Assistance program as follows:

Recipient must spend their income on basic necessities;
Municipalities must review household expenditures made by non-initial applicants for the 30 day period prior to application and consider income not spent on basic necessities as available;
Municipalities are allowed to establish use-of-income guidelines for recipients, which to a certain extent could require recipients to spend their income on specific basic necessities, such as rent or utilities;
Municipalities are allowed to limit emergency assistance grants when the household created the emergency by not spending income toward basic necessities;
Added "discharge from employment due to misconduct" to the list of work-related violations which could lead to disqualification; and
Municipalities are allowed to place non-foreclosing liens on property when capital improvement are paid for with General Assistance funds, just as municipalities are allowed to place a lien when a mortgage payment is made.

In December 1991, Chapter 622 was signed into law which established the following:
Eligibility standard for the General Assistance Program referred to as the "overall maximum level of assistance";
Establishing a lien process for Workers' Compensation lump sum benefits;
Extended the disqualification time from 60 to 90 days for those not abiding to some of the rules;
Clarifying the lump sum rules; and
Restricting the municipal obligation to pay rent to relatives or roommates of recipients.

In 1992, the SSI Interim Assistance Reimbursement Program was established for the General Assistance program. The Department of Health & Human Services contracts with the Social Security to administer the SSI Interim Assistance Reimbursement Program. For individuals who have applied for Social Security disability, during the determination period, General Assistance can assist the individual with "basic needs". If the individual is determined eligible for SS disability, the retroactive payment is sent to the Department. The Department contacts the municipality(ies) and recoups the assistance given by both the Department and the municipality(ies).

In 1993, additional changes to General Assistance Program occurred in Chapter 410. These changes were:

Amending the reimbursement formula to increase the municipalities' obligation levels and reduce the State's overall level;
Re-defined an "initial" applicant as someone who has never applied to General Assistance in Maine;
Lengthened the disqualification time from program violations from 90 to 120 days;
Established municipal authority to actually retain the issuance of non-emergency assistance until workfare assignments were completed:
Expanded parental liability for support for applicants under the age of 25;
Tightened up the lump sum pro-rating process;
Created the financial responsibility for siblings to provide burial for each other; and
A Series of less substantial changes that tightened up the program.

Since 1993, there have been clarifications of General Assistance Program policies, with no major legislative changes.

<u>What has been the General Assistance reimbursement history?</u>

Year	Total Expenditure	State Share	State Percentage
1992	$18,502,695		
1993	$12,574,379		
1994	$ 9,986,777		
1995	$ 8,589,779		
1996	$ 7,881,308		
1997	$ 7,660,403		
1998	$ 7,419,248		
1999	$ 6,742,289	$ 4,548,565	67%
2000	$ 6,190,512	$ 4,136,729	67%
2001	$ 6,778,990	$ 3,378,014	50%
2002	$ 6,543,721	$ 3,887,988	59%
2003	$ 7,696,772	$ 4,881,033	63%
2004	$ 8,643,358	$ 5,472,101	63%
2005	$ 8,623,840	$ 5,433,019	63%
2006	$ 9,220,280	$ 5,578,591	61%
2007	$ 9,820,954	$ 6,068,228	62%
2008	$11,493,872	$ 7,172,210	62%
2009	$13,754,166	$ 8,741,915	64%
2010**	$ 6,543,712	$ 3,634,682	56%

What are the General Assistance services the municipalities receive reimbursement for?
What are the General Assistance expenditures by type of service?

STATE OF MAINE
GENERAL ASSISTANCE EXPENDITURES
STATE FISCAL YEAR 2008 VS. STATE FISCAL YEAR 2009
(JULY 2007-JUNE 2008 vs. JULY 2008-JUNE 2009)

Expenditures	2008	2009	Difference
Housing	$6,340,270	$8,035,934	$1,695,664
Emergency Housing	$1,660,319	$1,914,567	$254,248
Heating	$929,394	$913,414	-$15,980
Electric	$384,554	$468,564	$84,010
Propane	$36,185	$19,173	-$17,012
Food	$973,431	$1,249,431	$276,000
Prescriptions	$111,809	$237,740	$125,931
Medical	$12,915	$7,865	-$5,050
Dental	$5,360	$80	-$5,280
Burial	$179,224	$237,082	$57,858
Diapers/Baby Sup	$35,180	$54,171	$18,991
HH Personal	$304,430	$368,774	$64,344
Other Needs	$255,945	$96,116	-$159,829
Total	$11,229,016	$13,602,911	$2,373,895

What discretion do the municipalities have in determination of benefits and services?

The General Assistance Program have operational requirement that each municipality must adhere to. The major ones are as follows:

Each municipality must have an ordinance which is compliance with state law;
Each municipality must have contact information available to applicants 24 hours a day;
Each municipality must allow applicants to complete a written application;
Each municipality must adhere to General Assistance maximums unless an emergency is determined; and
Each municipality must determine the General Assistance benefits based on "basic need".

The General Assistance Program does provide municipalities discretion in determining such items as:
The components of "basic need" for a specific circumstance;
Circumstances which are considered an emergency;
If General Assistance funds are used to pay for homeless shelters;
Types of agreements and providers for General Assistance services; and
Methods of meeting the "basic needs".

What are the "rules" regarding people "relocating" between towns?

The General Assistance Program does allow municipalities to "charge" another municipality for General Assistance expenditures under specific circumstances.

Q&A for Budget Supplemental
Office of Child and Family Services

Children's Mental Health:

HHS-66 Reduces funding for PNMIs to reflect the savings associated with the creation of a children's waiver.

Q: What basis do we think doing a waiver will save $1 million?

A: Our waiver will allow for home based and residential/small group settings. We know that with the flexibility that the waiver funding affords that we will be able to provide supports which will allow some children with developmental disabilities to remain with their parents and other children will be able to return to their families. With this flexible use of federal dollars we will also be able to bring back some number of children with developmental disabilities from their out of state placements. Children's Behavioral Health Services will work with the Federal Center for Medicaid Services and Office of MaineCare Services to implement a new section of MaineCare policy to serve children. This new section would set forth eligibility criteria, covered services, and prior authorization and utilization review procedures to ensure that the service is appropriate and is for the right amount, scope and duration. It is anticipated that there would be approximately 40 children across Children's Behavioral Health and Child Welfare Services that would be served in the waiver program at a state expenditure of approximately $29,720 per child/per year. These children would otherwise be receiving services in a facility such as a Private Non-Medical Institution at an annual state expenditure of $59,097. This initiative would generate a savings of $29,377 per child/ per year or up to $979,560 in general fund expenditures for 40 children after being adjusted for the PNMI tax.

Q: When will the waiver be in place?

A: Our plan is to have it in place July 1, 2010.

Q: What are the details of the waiver plan?

A:

1. Services that are being considered for the children's waiver at this time are:
   - Habilitation Services (personal supports in family home or out of home placement)
   - Respite
   - Environmental Adaptations
   - Consultative services (therapeutic recreation, OT, PT, Speech) as needed
   - Extensions of any existing MaineCare services if needed: i.e. personal care, private duty nursing, etc)
2. We have been given a work schedule by MaineCare to begin weekly work sessions on January 14, 2010 and run for 6 weeks.
3. OMS and OCFS will be working to develop policy and rules to support the waiver.
4. The waiver application template provided by the Federal government is in the process of being completed.

Q&A for Budget Supplemental
Office of Child and Family Services

HHS-8 Limited Mental Health Outpatient Therapy to 18 visits per year.

Q: Please explain the Limited Mental Health Outpatient Therapy to 18 visits per year.
A: Outpatient Services is considered a core service in the children's mental health system of care. Approximately 13,000 children and youth access this service component annually. Outpatient services are preventative in nature and can be individual, group or family focused. These counseling services are oriented to addressing mental health symptoms and promoting emotional and behavioral stability. Typically, a child participates in 10-12 counseling sessions and good outcomes related to improvement in functionality and stability is noted. These services often prevent the child from entry into more restrictive and expensive services such as crisis services, intensive in-home treatment services, residential treatment services and inpatient psychiatric services.

The proposed budget initiative is looking at the duration of care for the cohort of children that are above 18 sessions. We are proposing a tighter utilization review through APS HealthCare for approximately 3,000 children that have exceeded the average number of counseling sessions. It is important for us to take a closer look in these cases to see why improved functionality and other outcomes have not been achieved and if the child needs something different or more intense in order to improve and stabilize. This approach will not change the number or availability of community providers.

We will be revising the MaineCare rule to clarify criteria which will be used for the new utilization review standards. Continued stay criteria will include a review of the presenting problem clinical interventions implemented or utilized, and improvements in the child's overall functionality.

Q: Is there evidence that duration of treatment is correlated with outcomes?
A: The evidence related to the impact of duration of care on the provision of and outcomes in children's mental health services are well documented. In Maine, we have several evidenced-based practices that are available to children and families through two community-based components; Outpatient Counseling Services (OP) and Home & Community Treatment Services (HCT).

Evidenced-based practice (EBP) is the integration of the best available research evidence in the context of the client characteristics, culture and preference. The growing need for high-quality children's mental health services has increased the demand for treatments that are proven to produce better outcomes.

Here are examples of evidenced-based practices and the typical duration (number of therapy sessions).

<u>Outpatient Services</u>

1. Trauma Focused-Cognitive Behavioral Therapy -16 sessions
2. Cognitive Behavioral Therapy for Depression, Anxiety & OCD – 12 to 16 sessions
3. Anger Control- 10 sessions
4. Incredible Years- 18-22 sessions
5. Parent child Interactions Therapy- 10-16 sessions

<u>Home & Community Behavioral Health Treatment Services</u>

1. Multi-Systemic Therapy- typically 4 months / 17 sessions
2. Functional Family Therapy- 8-12 weeks

The need for more then 18 treatment sessions will be reviewed on a case-by-case basis by APS HealthCare clinicians.

Q&A for Budget Supplemental
Office of Child and Family Services

Q: A statement was made that Outpatient Services are not readily available and the wait can be 6-9 months.

A: Services are available in a timely fashion. Below is a random polling of community service providers.

Region 1:

- Community Counseling Center (District 2) average wait 2 weeks
- Counseling Services Inc. (Districts 1&2) average wait 1-3 weeks depending on location
- Spurwink (School-based outpatient Districts 1&2) all Spurwink's outpatient at present for children is school-based, and children are contacted within 48 hours
- Tri-County MHS (Bridgton, District 2) wait time is immediately to 1 week
- Saco River Health Services (rural area of District 1) no wait at this time
- Possibilities Counseling (District 2) 1 week wait time
- Sweetser (Districts 1&2) wait time is immediate to 3 weeks

Region 2:

- Oxford County Mental Health, who covers Oxford County, (No wait list),
- Midcoast Mental Health, which covers Knox, Northern Lincoln, and Waldo County, 1-2 weeks,
- Care and Comfort, which covers Franklin, Kennebec, Oxford, Somerset and Waldo counties, serves children within one week of the referral,
- Tri-County Mental Health, which covers Androscoggin, Oxford, Northern Oxford, Northern Cumberland, Franklin Counties, the wait time is none up to 1 month in the Rumford area,
- Kennebec Behavioral Health, which covers Franklin, Kennebec, Somerset, Knox and Waldo County, the wait is from 1 week in the Augusta area, 2 weeks in the Waterville area and up to a month in the Skowhegan and Winthrop area.

Region 3:

- Aroostook Mental Health (AMHC):
  Aroostook County within 1 week to 10days
  Washington County 3 to 4weeks and struggling to find a clinician
- Northeast Occupational Exchange (NOE):
  They do a 2 step process. Step one is an intake within 24 to 48 hours.
  Step 2 they try to serve within 48hours.
  Roughly within 1 week to 10days
- Community Care (Care Development):
  Individuals must come into the Bangor office to receive services. They strive for less than 10days
- Life by Design:
  Caribou office is between 2 days and 1 week
  Houlton Office is also between 2 days and 1 week
  Presque Isle office is between 3-4 weeks.
- Community Health and Counseling (CHCS):
  Aroostook County is almost immediately
  Penobscot Count is within 1 to 2 days
  Piscataquis County is less than 10days
  Hancock & Washington County is 2 to 3 weeks
  Variables are age of child and time of day client is available.

Other Children's Services:
HHS-95-96 Reduces funding for contracted services for a variety of community supports.

Q: What funds remain in State Purchased Social Services?
A: Please see Attached Documents for Funding Histories for each service area, with the exception of the Maine Children's Trust Funding History which is at the bottom of this section.

SFPSS

Provider/Services Curtailed by OCFS	Total GF	Curtailment FY10	* Proposed Reductions FY11 (* SEE ATTACHED DOCUMENTS)
Domestic Violence	1,699,566	0	42,129
Victim Advocacy	45,376.00	0	37,907
Family Planning	581,599	89,879	281,599
Shaw House	34,000	10,852	34,000
Crossroads	23,416.07	7,474	23,416
Maine Children's Trust	130,949.00	41,795	130,949
TOTAL		**150,000**	**550,000**

Services not curtailed by OCFS	
Transportation	631,328
Spurwink forensic clinic	45,949
Maine General Medical Center (PREP)	82,000
AFFM	46,843
Child Care Slots	1,046,715
Sexual Assault	698,811
Florence House	556,376

Q: Victim Advocates loses all of their State Purchased Social Services funding. Do they receive any other funding?
A: The District Attorney's Offices receive $338,000 in federal funding and $166,000 in ARRA funds which are dedicated to victim advocates.

Q: Will cuts to Family Planning from State Purchased Social Services result in providers not having match for federal funds?
A: (Melissa Read has contacted CDC and awaiting response).

Q: Will eliminating funds for Maine Children's Trust result in no dollars being available for prevention services (CAN Councils)
A: The Councils will still receive funding from the Children's Trust Fund tax check off (approximately $20,000/year) as well as up to $8,000 per Council from federal Community Based Child Abuse Prevention based on competitive grant applications. The State receives $200,000 in total from Community Based Child Abuse Prevention for child abuse prevention activities some of which is dedicated to specific statewide prevention initiatives.

Q: How will mandatory training be done if Child Abuse and Neglect Councils no longer perform that function?
A: Currently, Mandated Reporter Training is provided by Department of Health and Human Services Staff and Child Abuse Neglect Council Staff. The curriculum currently used was jointly developed by the CAN Councils and DHHS. The training is made available on site to mandated reporter groups who request

it. Requests can be made to any of the CAN Councils, District DHHS Offices, or the Central Intake Unit in Augusta.

There is also a Web based version of the training available at www.maine.gov/dhhs/ocfs/cps for individual use which can be taken all at once or in parts. The web based training program is interactive and covers all of the same areas as on site training. Reviews of the web based training submitted by users have been very favorable.

In a recent twelve month period there were 70 mandated reporter trainings in Maine. As we have 8 districts that would mean each district would do around 9 per year. This is very manageable and would also support increase networking between child protection and mandated reporters. Groups have ranged in size from 5 to 100. The most common group size is about 15. On site training programs vary in length from one to three hours depending on the content requested. DHHS District Casework and Supervisory staff can access the standard curriculum electronically and has the capacity to work with their local partnerships at meeting the needs of reporting professionals.

Q: What is the funding history for the State Purchased Social Services providers where reductions in funding are proposed?

A:

Maine Children's Trust Funding History:

For FY08 (and a few years prior because it was pretty much stable, flat-funded), we had state allocated funds of $261,698 for 16 contracts

FY09: funds were cut to $130,849 for 16 contracts

FY10: consolidated 16 contracts to one by contracting with the Maine Children's Trust as fiscal agent for CAN councils. Began FY10 with $130,849 but because of curtailment, that amount is now $89,054.

*Other funding histories are in attachments.

Funding Histories for State Purchased Social Services

Shaw House Funding History

SHAW HOUSE **HOMELESS YOUTH/OUTREACH**	**FY08** CS3-08-012	**FY09** CBH-09-4106	**FY10** CFS-10-4106
STATE FUNDING 0228	34,000	34,000	34,000
STATE FUNDING 0923	110,000	110,000	110,000
STATE FUNDING (CBH)	42,500	42,500	42,500
FEDERAL FUNDING (CBH)	36,500	36,500	36,500
TOTAL FUNDING	**223,000**	**223,000**	**223,000**

Victim Advocacy Funding History

	Victim Advocacy FY08			**Victim Advocacy FY09**			**Victim Advocacy FY10**		
	SPSS	VOCA	TOTAL FY08	SPSS	VOCA	TOTAL FY09	SPSS	VOCA	TOTAL FY10
Aroostook County DA	5,474	46,638	52,112	6,842	58,298	65,140	5,474	46,638	52,112
Androscoggin County DA	-	29,988	29,988	16,875	20,610	37,485	-	29,988	29,988
Hancock County DA	5,522	24,030	29,552	6,902	30,038	36,940	5,522	24,030	29,552
Kennebec County DA	5,243	41,157	46,400	6,554	51,446	58,000	5,243	41,157	46,400
Knox County DA	5,152	40,391	45,543	6,440	50,489	56,929	5,152	40,391	45,543
Penobscot County DA	5,541	53,052	58,593	6,926	66,315	73,241	5,541	53,052	58,593
Piscataquis County DA	5,559	8,536	14,095	6,949	10,670	17,619	5,559	8,536	14,095
Portland Police Department	800	32,294	33,094	1,000	40,368	41,368	800	32,294	33,094
Washington County DA	5,356	24,768	30,124	5,356	24,768	30,124	5,356	24,768	30,124
York County DA	5,361	25,961	31,322	6,701	32,181	39,152	5,361	25,961	31,322
TOTALS	**44,008**	**326,815**	**370,823**	**70,545**	**385,183**	**455,998**	**44,008**	**326,815**	**370,823**

Family Planning Funding History

	SFY 01*	**SFY 02***	**SFY 03**	**SFY 04**	**SFY 05**	**SFY 06**	**SFY 07**	**SFY 08**	**SFY 09**
Federal Funds - SSBG	273,406	273,406	273,406	273,406	273,406	525,552	525,552	525,552	110,274
010 10A 2000									
010 10A 2030	211,502	211,502	202,695	202,695	202,695	214,593	225,322	225,322	225,322
010 10A 2031									
010 10A 2020									
010 10A 3659 - MCHBG state match	323,262	323,262	285,843	285,843	285,843	285,843	285,843	285,843	285,843
010 10A 5517									
010 10A 8851 - SSBG state Match	548,386	548,386	525,552	525,552	525,552	273,406	273,406	205,055	-
State General Funds	1,083,150	1,083,150	982,370	1,014,090	1,014,090	773,842	784,571	716,220	511,165
Fund for a Healthy Maine	400,000	400,000	400,000	400,000	400,000	399,223	410,062	468,962	468,962
Total	**1,756,556**	**1,756,556**	**1,655,776**	**1,687,496**	**1,687,496**	**1,698,617**	**1,720,185**	**1,710,734**	**1,090,401**

All amounts are annualized.
*includes $25,000 funding earmarked for the Maine Council on Adolescent Health

Crossroads for Women Funding History

	SFY 06	**SFY 07**	**SFY 08**	**SFY 09**
OSA General Fund - 010	324,600	292,900	290,026	296,351
OCFS General Fund - 010	23,000	23,000	22,999	23,140
Medicaid General Fund - 010	454,012	423,249	230,760	241,565
Fund for Healthy Maine - 014	128,000	159,700	382,954	361,717
OSA Fund for Health Maine - 014	305,013	629,408	570,724	400,495
Federal Fund - 013	1,247,454	1,730,634	1,096,457	1,059,913
Block Grant Fund - 015	594,600	594,600	386,534	428,237
Total	**3,076,679**	**3,853,491**	**2,980,453**	**2,811,418**

SFY2006 - 2009 based on expenditures.
SFY2010 based on existing contracts

HHS-57 Reduces funding by streamlining adoptive family recruitment using technology.

Q: Will eliminating Specialized Recruitment result in fewer children receiving adoptions?
A: Last year the Legislature eliminated funding for home studies done by International Adoption Services, with those home studies being assigned to DHHS staff. By eliminating the hand-off to International Adoption, the time to completion of those home studies was reduced by 50%. Similarly, ending the hand-off for recruitment activities will streamline the process and reduce the time to adoption. Families will no longer have to deal with two separate agencies to apply to become foster or adoptive families. We have no reason to believe that adoptions will diminish as a result of this action.

Q: Do other states use web sites for recruitment?
A: Numbers of other states do have listing of children on their web sites and also use AdoptUSKids. 11,000 children listed on AdoptUSKids have been adopted in the past six years. In Maine, we have 242 children listed on AdoptUSKids. Also, the Maine web site is very family friendly and leads people asking the question, "How do I go about learning about adopting a child?" to straight forward links and process. We will also work to fulfill any gaps in the work previously done by International Adoption Services with DHHS staff and we are initiating a process to work with the faith based community to partner in finding adoptive homes for children in care.

How to find website listed children in Maine's Foster Care system that are available for Adoption.

1. Go to www.maine,gov. In the upper Right Corner where it says **search Maine.gov**. -----Enter ---**Adoption** and click the **Go** box.
2. On the next screen **double click on** one of the first two options.
   Adoption – Maine Department of Health and Human Services
   OR
   Adoption – Child Welfare Maine DHHS: OCFS
   Both bring you to the same screen/page.
3. On the next screen double click M**aine's Waiting Children**
   A POP-UP will advise you that you leaving DHHS on the maine.gov site---CLICK OK.
4. You are now on the AdoptUsKids.org website
5. Now Click **Browse to view the Maine Children listed there**.
   You can also click **Search** for other options and to locate a possible match based on the criteria you enter.

Additional Medicaid Reduction:
HHS-7,8,9,18,19,20,76,82 10% Rate Reduction (excl hospitals, pharmacy, physicians & dental)

Q: What will be the impact of the 10% Medicaid cut to children's services?
A: We have compared the 10% rate reduction to rates with other states. With a 10% reduction:

Service	Maine Current	Maine with 10% reduction	New England Median	Deloitte Cost Based Proxy
TCM	21.52	19.37	18.62	N/A
65 Outpatient Therapy	21.00	18.90	19.98	19.01
65 Medication Management	(By report-not standard) Deloitte median estimate: 63.75	57.38	53.18	43.94

Residential Treatment comparison is:

	Cost per child per year	10% Reduction
CT	$102,000	
NH	$80,176	
ME	$160,373	$144,336
RI	$83,950	
VT	$109,500	

Q: What cut will Treatment Foster Care parents receive as a result of the 10% across the board reduction to MaineCare?
A: There would be an approximate 6% reduction to the reimbursement for Treatment Foster Parents.

Q: Providers have stated that if room and board rates were standardized, that total reimbursements would be equitable?
A: A standardized room and board rate would result in all providers having the same rates; however, providers who currently have a room and board rate higher than the average will lose money by standardizing. Providers who currently have room and board rates lower than the average, will gain money.

Weighted average with room and board -$**50.50** using beds at each rate. Please note this is an estimate-to get the precise number of beds at each rate with all the consolidations and closings that have happened would take more time.

MaineCare Benefits Manual Section 97 Appendix D - Children's PNMI

Provider Name	Location	Approved PNMI Costs (Cap)	Approved Census	**Rate w/tax**	Room & Board Costs	**Room & Board Rate**	# Beds (estimate)	Weighted Average
NFI North Incorporated	Stetson	965,612	2,440	448.31	17,324	7.10	8.00	57
NFI North Incorporated	Sidney	1,034,161	2,304	480.21	20,713	8.99	8.00	72
NFI North Incorporated	Beacon	999,332	2,304	464.22	25,482	11.06	8.00	88
PORT RESOURCES INC	Port Resources-Ding	1,949,455	3,659	569.99	44,457	12.15	12.00	146
NFI North Incorporated	Bridge Crossing	889,262	3,388	281.69	42,184	12.45	12.00	149
NFI North Incorporated	Oliver Place	404,798	1,728	254.25	22,827	13.21	6.00	79
NFI North Incorporated	Summit	414,891	1,728	260.73	30,422	17.60	6.00	106
NFI North Incorporated	Dirigo	551,440	1,723	343.64	36,757	18.23	7.00	128
Charlotte White Center	Expanding Horizons	1,838,369	2,482	791.92	45,756	18.43	8.00	147
SISTERS OF CHARITY HLTH SYS	Genesis/Renaissanc	1,322,447	4,198	338.23	87,612	20.87	14.00	292
Northern Lighthouse	The Northern Lighthc	555,209	1,951	304.83	18,027	22.69	6.00	136
SPURWINK CORPORATION	Sanford, Staff Secur	3,507,355	6,066	618.54	136,375	22.75	20.00	455
SPURWINK CORPORATION	Special Projects, RT	13,288,819	33,526	425.86	1,150,649	31.86	130.00	4142
SWEETSER	Staff Intensive	5,239,689	15,586	361.89	521,980	33.49	19.00	636
Community Health and Counseling Services	Stillwater	470,123	1,152	441.25	43,224	37.52	12.00	450
Connection For Kids	Connections For kids	1,506,430	3,723	434.76	155,453	41.75	6.00	251
WASHINGTON CTY PSYCHOTHERAPY	Washington Cnty Ps	3,339,779	7,200	498.79	317,232	44.06	6.00	264
YOUTH ALTERNATIVES INC	Heritage House	426,182	1,728	268.60	94,020	54.41	36.00	1959
Community Health and Counseling Services	Ellsworth Falls, Beec	1,918,852	5,585	370.52	308,311	55.21	6.00	331
SWEETSER	Community Residen	613,003	1,862	356.08	124,949	67.10	24.00	1610
YOUTH ALTERNATIVES INC	Girls Transitional	428,089	1,728	269.99	119,647	69.24	6.00	415
YOUTH ALTERNATIVES INC	Edgewood	525,989	1,728	330.60	127,025	73.51	15.00	1103
SWEETSER	Family Focus	3,282,947	7,203	492.64	529,829	73.56	6.00	441
CATHOLIC CHARITIES MAINE	Christopher Home	554,859	1,532	401.48	120,584	78.71	7.00	551
SWEETSER	Family Focus	1,954,041	4,616	457.41	364,557	78.99	6.00	474
YOUTH ALTERNATIVES INC	STEPS/Bass/Perry's	1,450,659	5,585	283.13	474,113	84.90	16.00	1358
YOUTH ALTERNATIVES INC	Reardon	492,576	2,016	267.55	171,380	85.01	6.00	510
UCP of Maine	Ft. James	492,323	1,355	394.44	116,584	86.04	16.00	1377
KidsPeace National Centers of New England	Residential	3,170,038	9,487	364.00	283,300	91.50	28.00	2562
Aroostook Mental Health Services, Inc.	Grand Isle	600,413	1,728	377.96	162,374	93.99	12.00	1128
KidsPeace National Centers of New England	ASD Residential	2,034,561	3,659	602.67	367,546	100.44	16.00	1607
Harbor Schools of Maine, Inc.	Rockport 1	792,130	2,304	374.89	236,667	102.72	8.00	822
BECKET ACADEMY INC	Belgrade	708,340	3,219	244.04	309,734	120.28	8.00	962
Harbor Schools of Maine, Inc.	Rockport II	750,901	2,304	357.35	286,226	124.23	8.00	994
Harbor Schools of Maine, Inc.	Winterport	721,608	2,304	344.62	312,837	135.78	8.00	1086
BECKET ACADEMY INC	Norridgewock	741,106	2,575	320.40	565,220	175.57	8.00	1405
Saint Andre Home Incorporated	ST ANDRE HOME II	1,929,911	5185/10081	401.49	230,093	5.49	19.00	104
MAPS	Stepping Stones	4,917,640	6,099	864.68	151,751	12.00	20.00	240
			average	394.37	**average**	**56.39**	567.00	28,638.59
			median	367.26	**median**	**49.24**		
							weighted average	**50.508977**

Saint Andre Home Incorporated
MAPS

Other Questions:

Q: A Concern was raised about the use of Antipsychotic Medications for Children:
A:

- Approximately 3% of MaineCare youth are currently being prescribed antipsychotics; this rate is similar to other states in the country.
- Antipsychotic medications have significant side effects, including weight gain, an increase in the risk of diabetes and an increase in cholesterol levels.
- It is very important to make sure that youth are only prescribed antipsychotics when the benefit outweighs the risk.
- 20% of youth in Child Welfare custody are being prescribed antipsychotic medication. OCFS has developed a broad group of stakeholders to study this issue and to make sure that youth in state custody get the best care possible, and receive antipsychotics only when it is medically appropriate.

Q: What are the differences between Children's Behavioral Health Prior Authorization functions and APS Health Care's Continued Stay Reviews for Residential Treatment Services?
A: Children's Behavioral Health Services (CBHS) does the prior authorization (PA) functions for the Intensive Temporary Residential Treatment (ITRT) service. Prior Authorization is a review process that assures the child and family receive the most clinically appropriate, effective treatment in the least restrictive environment This includes:

- Discussions/Planning with the youth's community team (including the family/caregiver);
- Reviewing application and clinical documentation;
- Authorizing or denying residential treatment based on the clinical needs of each individual child;
- Recommendations for appropriate mental health treatment in the community if residential treatment is not required;
- Entry of a prior authorization into the APS computer system on the day of admission into the residential program. This includes documenting the medical necessity for this level of care for the youth and initiates a prior authorization number for the provider for billing purposes.

❖ APS HealthCare is responsible for the Continued Stay Reviews. This entails APS Healthcare staff reviewing any requests that the residential treatment provider submits requesting that the child stay in the program beyond the initial approved dates. APS Healthcare reviews these requests and determines whether or not the child continues to meet medical necessity for residential treatment as specified in MaineCare Rule. The 1st continued stay request from the provider is not due until 30 days after the child has been admitted to the program, and only if the provider feels the child needs continued treatment.

❖ Once a child is admitted to a residential treatment program, CBHS works closely with the community and residential providers to expedite the child's return to his/her home and community as soon is safely and clinically possible, mitigating any untoward side effects of a restrictive environment and detachment from home and community.

Q: For what percent of children for whom residential treatment is requested is it approved?
A:

- 279 applications for children's residential treatment were reviewed in this six month time period
- 236 applications (85%) received for residential treatment were authorized in this six month time period
- 43 applications (15%) received for residential treatment were denied in this six month time period
- Out of the 43 denied:
  - 32 youth (74 %) were referred to and received community based professional and/or natural supports and have NOT required a higher level of care since denial

(i.e. hospitalized, admitted to a crisis unit or reapplied and authorized for residential treatment)

- Of the 43 denials, only 11 youth (26%) received a higher level of service at some point in time after the initial denial (higher level of service includes admission to a crisis unit, hospital or residential treatment)
  - 4 of the 43 denials (9%)were later authorized for residential treatment after a subsequent review
- 2 were appealed by the guardian - 1 denial was overturned and 1 is still awaiting hearing

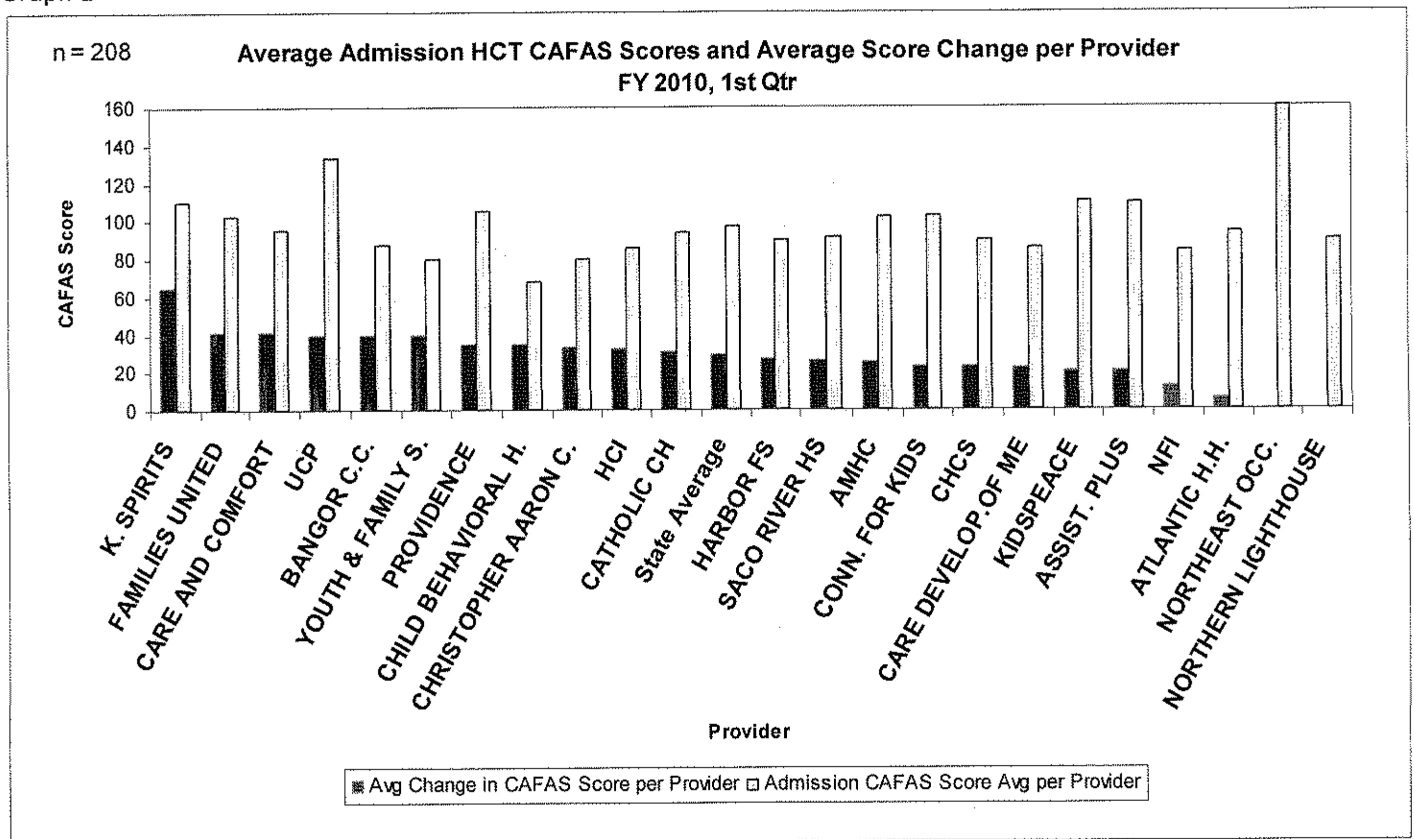
APS Healthcare

Maine Children's Home & Community Based Treatment Service (HCT)
Treatment Outcome Report- Measured by Change in CAFAS Score
FY 2010, 1st Qtr (July – Sept, 2009)

- The symptoms and functioning of children treated in the HCT service improved.
- This improvement was measured by a change in CAFAS score from admission to discharge.
- This improvement is statistically significant (p=0.0001). The average score improvement statewide is 29 points.
- The larger the change in score, the greater the improvement.
- Graph 1 displays the average admission CAFAS score alongside the average CAFAS point improvement for each provider.
- Admission scores average 97, with a range of 68-160. Higher admission scores indicate children with greater treatment needs. A score of 100 or more means that a youth typically needs intensive services.

The Child & Adolescent Functional Assessment Scale or CAFAS (Hodges, 1997) is designed to measure the degree of functional challenges in children and adolescents with emotional, behavioral, and/or substance abuse challenges. This report uses the overall Youth Score in the analysis.

Graph 1

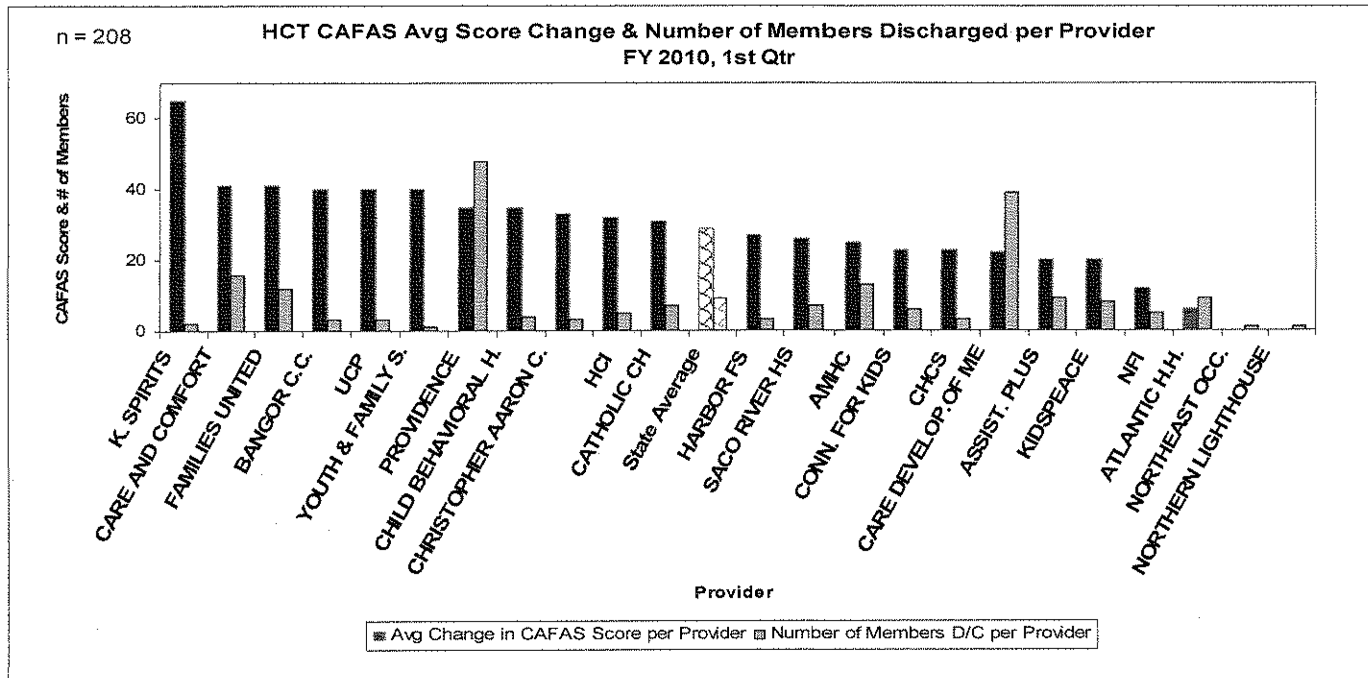


* Graph includes only members who have both an admission and discharge CAFAS, and excludes a total score of 0.

** The following agencies did not submit both admission and discharge CAFAS scores for members discharged in this quarter: Becket Family of Services; Choices; Kennebec Behavioral Health; Resources for Resolving Violence; Spurwink School; Tri-County Mental Health Services.

- Graph 2 displays the average CAFAS point improvement per provider, along with a bar that shows the number of members discharged by the provider in this quarter.

Graph2



The graph includes only members who have both an admission and discharge CAFAS, and excludes a total score of 0.

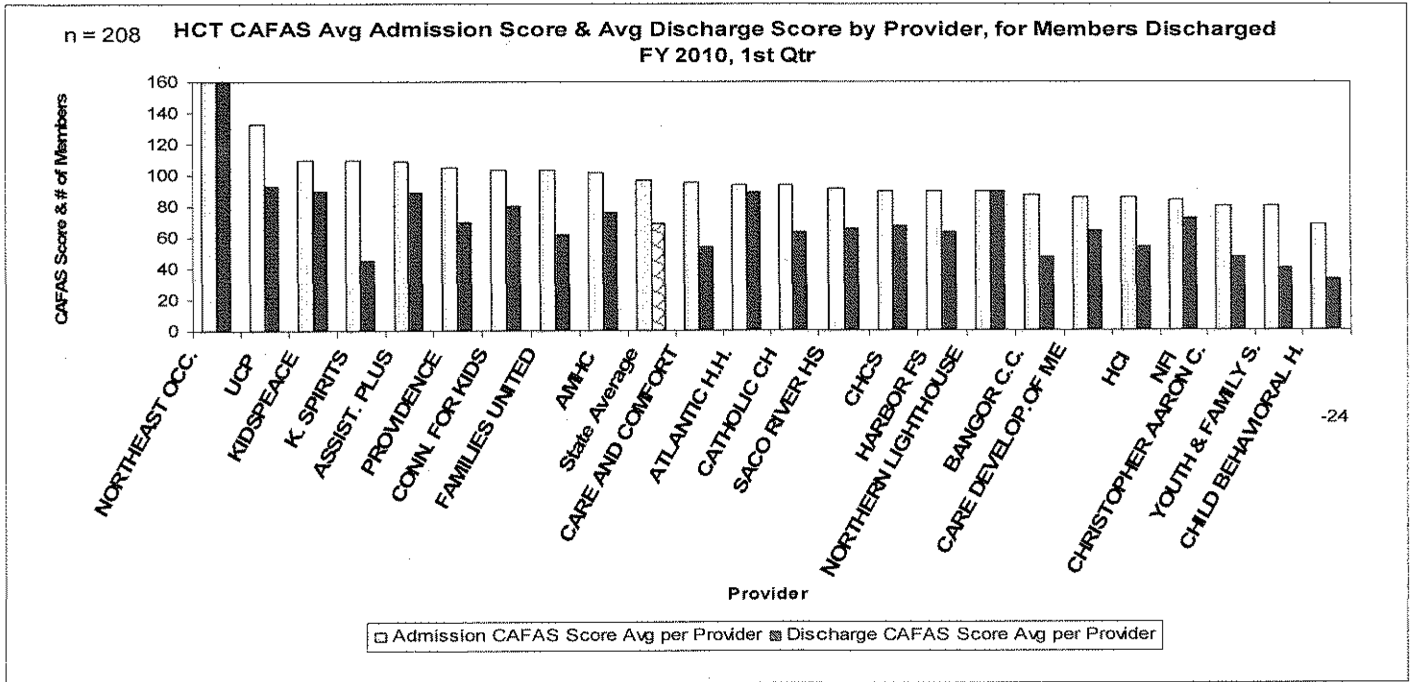
Report Statistics for the 1st Quarter, FY 2010:	
Total # members served, unduplicated	1899
Total Census of Members authorized for HCT Services on last day of the quarter	1192
Total # members admitted, unduplicated	819
Total # members discharged, unduplicated	671
Members with an admission and discharge CAFAS	208
Average Length of Stay	130 days
Average Age of CAFAS tested population	10.30 y/o
Average Length of Stay of CAFAS tested population	224 days
ALOS Range CAFAS tested population	91-590 days
# Males CAFAS tested population	137
# Females CAFAS tested population	71
Average Admission Score	97.16
Average Discharge Score	68.61
Average Point Change Statewide	29 points
Paired, Two-Tail, T-Test	<0.0001 score changes considered extremely statistically significant

Report Criteria:

HCT Program; Must have both Admission and Discharge CAFAS Scores; Must be in HCT program > 30 days; admission and discharge total scores of 0 are excluded; Average Point Change Score from admission to discharge score assessed for each consumer; Discharged from HCT service during FY 2010, 1st qtr; Positive point change indicates improvement; negative indicates decline.

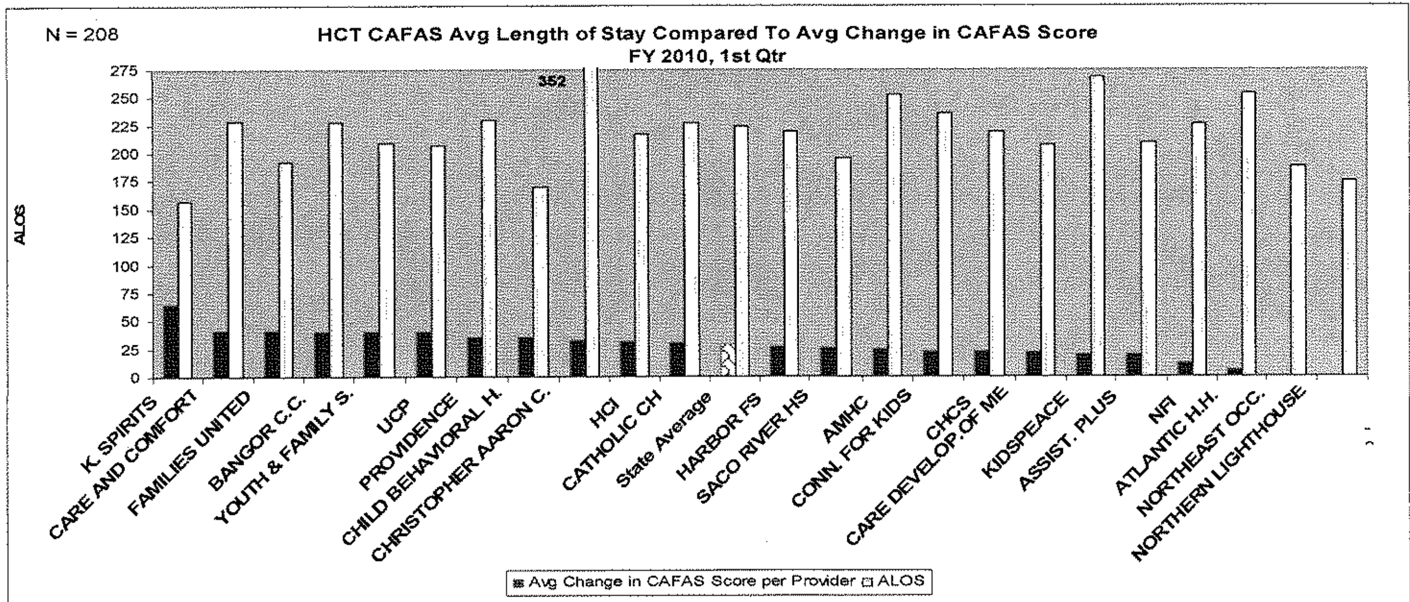
- Graph 3 displays the average CAFAS admission score per provider along side a bar displaying the average discharge score per provider.

Graph 3



- Graph 4 compares the average length of stay (ALOS) per provider with a bar that indicates the average change in CAFAS score per provider.

Graph 4



Note: All changes in CAFAS score indicate a decrease in score from admission score to discharge score. There was no change in the scores of two of the Providers, Northeast Occ and Northern Lighthouse.

APS Healthcare

Department of Health and Human Services

Children's Behavioral Health PNMI (Residential Treatment) Services Discharge Outcome Report April–June 2009

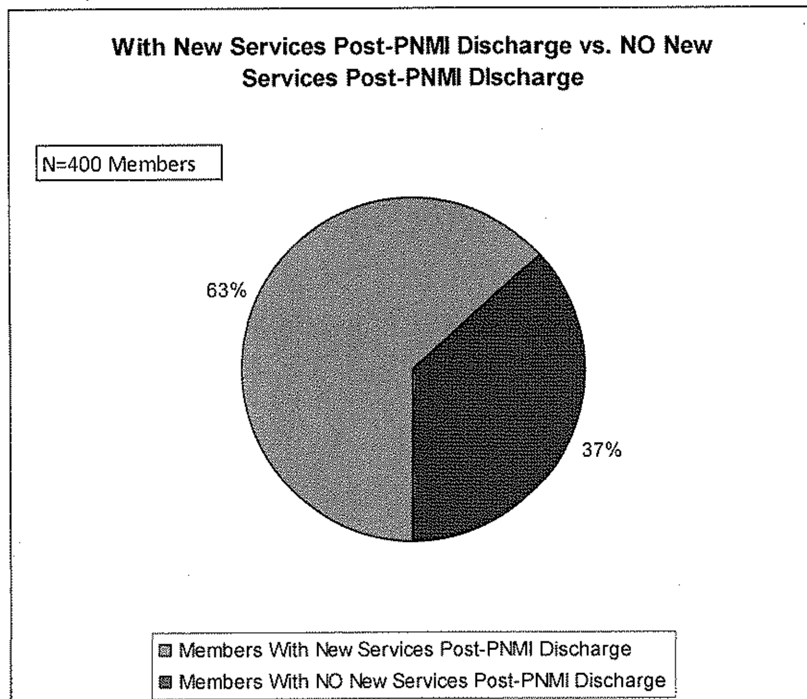
A key way to understand mental health service outcomes of MaineCare members is to measure what new services the member needs after he or she are discharged from a particular service. This report focuses on child members discharged from Children's Behavioral Health PNMI (Residential Treatment) Services in the period April 2009 to June 2009 (4/1/09-6/30/09). The report shows the number and type of services authorized for these members in the 90-days following their discharge from PNMI services.

37% of Members Discharged Were Not Authorized for New Services within 90-Days

- 37% (146 of 400) of members discharged from Child PNMI services were not authorized for any new mental health services within 90-days following discharge from PNMI services (see Graph 1).

- 53% (254 of 400) of members discharged from Child PNMI services were authorized for new mental health services within 90-days following discharge from PNMI services (see Graph 1).

Graph 1



In reporting services authorized for members post-PNMI services discharge, only newly authorized services are included. Previously authorized services that are continued post-PNMI services discharge (such as an existing authorization for outpatient services) are not included. Only newly authorized services are reported in order to quantify new service needs of members following PNMI services discharge.

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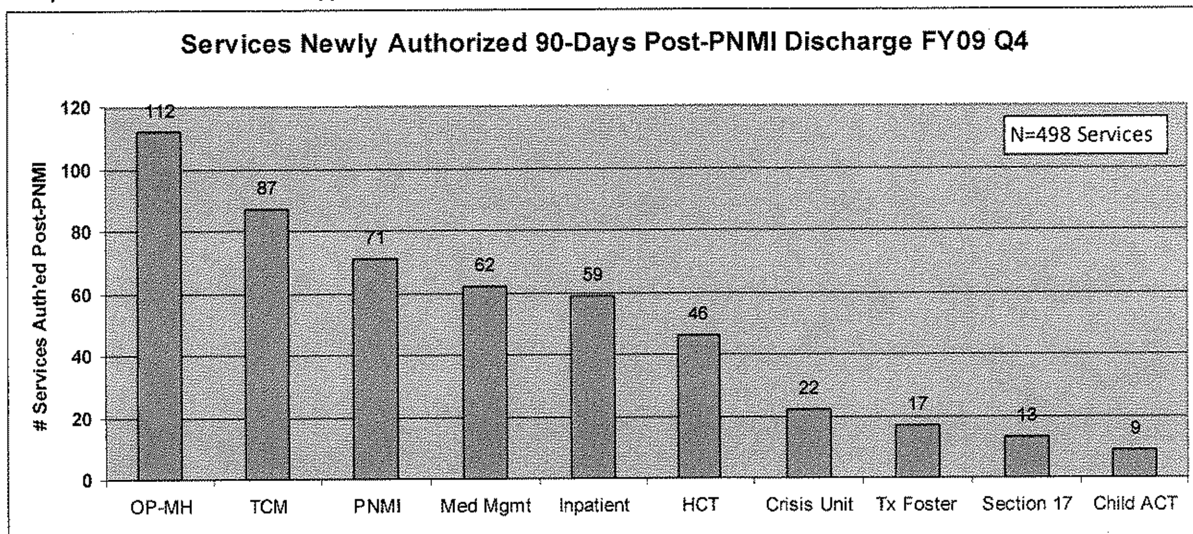
53% of Those with Services Were Authorized for Outpatient/Med Mgmt & TCM
The 254 members authorized for services 90-days post-PNMI services discharge were authorized for a total of 498 services or 1.96 services per member (See Graph 2).

- 35% (175 of 498) of newly authorized services consisted of outpatient & med mgmt
- 18% (87 of 498) of newly authorized services consisted of Targeted Case Management
- 16% (81 of 498) of newly authorized services consisted of hospital & crisis unit services
- 14% (71 of 498) of newly authorized services consisted of PNMI services
- 9% (46 of 498) of newly authorized services consisted of HCT services

Graph 2: The number and types of services authorized within 90-days of discharge from Child PNMI



Summary
This report serves as a baseline measurement of service-based outcomes for members discharged from PNMI services. Quarterly trends will shed light on improvements or declines in consumer outcomes. This data should also be viewed in light of service availability and existing wait lists to access services. Access to services will influence the number and type of services accessed by members following discharge from PNMI services.