OAMHS Briefs
July 2010
Prepared for CCSM

Managed Care Initiative

The Maine Department of Health and Human Services is planning a major initiative that will change the MaineCare program and its relationship to members, providers and other stakeholders. The initiative will move MaineCare away from its traditional role of approving and paying for individual services, toward a role of holding contractors accountable for the delivery of high-quality health services to members.

The **goals** of the initiative are:

- Enhance the quality of MaineCare services; and
- Reduce the growth rate in per person spending.

The Department aims to achieve these goals by forging a new partnership with members, providers and health plans. Collectively, all stakeholders must share incentives to improve the quality and reduce the growth rate of the MaineCare program. **Objectives** of this new approach are:

- Align the incentives of members, providers, contractors and MaineCare; and
- Measure and reward quality.

BACKGROUND

In 2009 the Maine Legislature charged DHHS with studying the feasibility of risk-based contracting in the MaineCare program. The Department reported its findings to the Legislature during the 2010 Session and recommended the development of a substantial risk-based Medicaid managed care program with a strong emphasis on quality. [1]

The Legislature accepted the report and directed the Department to create a stakeholder advisory group as part of its planning. (The Department had recommended a strong stakeholder engagement process in its feasibility report.)

Following a one-year planning phase (2010-2011), the Department plans to enroll most MaineCare members into risk-based contracting arrangements over a three-year period.

More information about the MaineCare Managed Care Project may be found at http://maine.gov/dhhs/oms/mgd_care/mgd_care_index.html

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[1] *Feasibility of Risk-based Contracting in the MaineCare Program*. Report from the Maine Department of Health and Human Services to the Maine Legislature's Joint Standing Committee on Health and Human Services. (April 1, 2010).

Recovery for ME

Recovery for ME:

Wellness…Growing…Living!

Defining…Measuring…Improving!

The Webinar series for Recovery for ME are held on the 3rd Tuesday of the month at 11:00. The discussion will start at 11:05. Please call in or connect a few minutes before. Call in/ connection information may be found at http://www.maine.gov/dhhs/mh/recovery and is also included in this email. This will be an opportunity for discussion about each domain. Feedback given through the webinar discussion or mailed or emailed to OAMHS will be used to revise the Connecticut practice guidelines to create Maine's own practice guidelines for recovery-oriented care. Please remember:

- Print a copy of Domain 3 to have for the discussion (available at http://www.maine.gov/dhhs/mh/recovery/defining.shtml)
- Be as specific as possible in your feedback. For example, refer to a specific portion of the text when commenting.
- Our revisions of the document rely on your input.
- This is a collaborative discussion. This answers to discussion questions as well as any questions posed during the webinar come from all of us.

You may also provide feedback via email to: OAMHS.DHHS@maine.gov
Please note in your email which domain you are commenting on. Emails and feedback will not receive individual responses. All feedback will be considered as the practice guidelines are edited. We encourage you to discuss the domains and questions with others in peer groups, in provider groups, at agencies, whenever you can find another interested party. We are contracting with the CCSM to develop and implement a process for gathering additional input from consumers.
A summary of the feedback on Domain 2 to date has been posted on the website.

May 2010 APS Reports
The May 2010 APS Healthcare reports are attached for your review and feedback.

COSII Report
The Quarterly COSII Report is attached. Please contact Claudia Bepko with any questions or feedback.

SAMHSA ADS Center Training Teleconference

Mental Health for Military Families:

The Path to Resilience and Recovery

August 3, 2010

The nightmares of war don't always end when our loved ones return home. . . . Sometimes the deadliest wounds are the ones you cannot see, and we cannot afford to let the unseen wounds go untreated.

U.S. President Barack Obama (2009)

What systems-level and policy changes need to be implemented to increase U.S. service members' and their families' access to the mental health services, supports, and treatment they need? What resilience-building, self-care, or preventive measures, on an individual or systems level, should be considered and implemented prior to deployment to reduce the frequency and/or severity of mental health problems during and after combat? What solutions might increase the likelihood of successful community reintegration upon a service member's return home?

SAMHSA ADS Center invites you to a free training teleconference entitled "Mental Health for Military Families: The Path to Resilience and Recovery." This training teleconference will help current and past recipients of mental health services, U.S. service members and their families, U.S. Department of Veterans Affairs health providers, veteran advocacy organizations, family and peer support personnel within the U.S. Department of Defense and branches of the military (including the reserves), and the general public explore the questions above.

Date and Time

Tuesday, August 3, 2010
3:00 p.m.–4:30 p.m., Eastern Time (ET)

Presenters

- Tom Berger, Ph.D.
  Vietnam Veterans of America (VVA)
- Sheri Hall
  Military Spouse
- Steve Robinson
  Gulf War Veteran and Advocate

Register Today!
To learn more and to register, please visit the following page: http://promoteacceptance.samhsa.gov/teleconferences/default.aspx.
We encourage you to share this invitation with interested friends and colleagues.

Please note: Registration will close at 5:00 p.m., ET, on Thursday, July 29, 2010.

Questions?

This training teleconference will include a question-and-answer session. We invite you to submit questions at any time before or during the teleconference. To submit questions before the teleconference, please e-mail promoteacceptance@samhsa.hhs.gov. Speakers will answer as many questions as possible during the question-and-answer session, but we cannot guarantee that your question will be answered during the teleconference. We will provide each

presenter's contact information so that you may contact him or her directly for a response or additional information.

Please note: You may submit anonymous questions. If you provide your name and organization when submitting a question, we may use it during the call.

Training Sponsor

This teleconference is sponsored by SAMHSA ADS Center, a project of the Center for Mental Health Services (CMHS). CMHS is a center within the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Please explore the SAMHSA ADS Center Web site for more information: http://www.promoteacceptance.samhsa.gov.

Fact Sheet: The Affordable Care Act's New Patient Bill of Rights

A major goal of the Affordable Care Act – the health insurance reform legislation President Obama signed into law on March 23 – is to put American consumers back in charge of their health coverage and care. Insurance companies often leave patients without coverage when they need it the most, causing them to put off needed care, compromising their health and driving up the cost of care when they get it. Too often, insurance companies put insurance company bureaucrats between you and your doctor. The Affordable Care Act cracks down on the some of the most egregious practices of the insurance industry while providing the stability and the flexibility that families and businesses need to make the choices that work best for them.

Today, the Departments of Health and Human Services (HHS), Labor, and Treasury issued regulations to implement a new Patient's Bill of Rights under the Affordable Care Act – which will help children (and eventually all Americans) with pre-existing conditions gain coverage and keep it, protect all Americans' choice of doctors and end lifetime limits on the care consumers may receive. These new protections apply to nearly all health insurance plans.[1]

How These New Rules Will Help You

- **Stop insurance companies from limiting the care you need.** For most plans starting on or after September 23, these rules stop insurance companies from imposing pre-existing condition exclusions on your children; prohibit insurers from rescinding or taking away your coverage based on an unintentional mistake on an application; ban insurers from setting lifetime limits on your coverage; and restrict their use of annual limits on coverage.
- **Remove insurance company barriers between you and your doctor.** For plans starting on or after September 23, these rules ensure that you can choose the primary care doctor or pediatrician you want from your plan's provider network, and that you can see an OB-GYN without needing a referral. Insurance companies

will not be able to require you to get prior approval before seeking emergency care at a hospital outside your plan's network. These protections apply to health plans that are not grandfathered.

Builds On Other Affordable Care Act Policies

These new protections complement other parts of the Affordable Care Act including:

- **Reviewing Insurers' Premium Increases.** HHS recently offered States $51 million in grant funding to strengthen review of insurance premiums. Annual premium hikes can put insurance out of reach of many working families and small employers. These grants are a down-payment that enable States to act now on reviewing, disclosing, and preventing unreasonable rate hikes. Already, a number of States, including California, New York, Maine, Pennsylvania and others are moving forward to improve their oversight and require more transparency of insurance companies' requests to raise rates.

- **Getting the Most from Your Premium Dollars.** Beginning in January, the Affordable Care Act requires individual and small group insurers to spend at least 80% and large group insurers to spend at least 85% of your premium dollars on direct medical care and efforts to improve the quality of care you receive – and rebate you the difference if they fall short. This will limit spending on overhead and salaries and bonuses paid to insurance company executives and provide new transparency into how your dollars are spent. Insurers will be required to publicly disclose their rates on a new national consumer website – HealthCare.gov.

- **Keeping Young Adults Covered.** Starting September 23, children under 26 will be allowed to stay on their parent's family policy, or be added to it. Group health plans that are grandfathered plans can limit this option to adult children that don't have another offer of employment-based coverage. Many insurance companies and employers have agreed to implement this program early, to avoid a gap in coverage for new college graduates and other young adults.

- **Providing Affordable Coverage to Americans without Insurance due to Pre-existing Conditions:** Starting July 1, Americans locked out of the insurance market because of a pre-existing condition can begin enrolling in the Pre-existing Condition Insurance Plan (PCIP). This program offers insurance without medical underwriting to people who have been unable to get it because of a preexisting condition. It ends in 2014, when the ban on insurers refusing to cover adults with pre-existing conditions goes into effect and individuals will have affordable choices through Exchanges – the same choices as members of Congress.

New Consumer Protections Starting As Early As This Fall

The new Patient's Bill of Rights regulations detail a set of protections that apply to health coverage starting on or after September 23, 2010, six months after the enactment of the Affordable Care Act. They are:

- **No Pre-Existing Condition Exclusions for Children Under Age 19.** Each year, thousands of children who were either born with or develop a costly medical condition are denied coverage by insurers. Research has shown that, compared to those with insurance, children who are uninsured are less likely to get critical preventive care including immunizations and well-baby checkups. That leaves them twice as likely to miss school and at much greater risk of hospitalization for avoidable conditions.

- A Texas insurance company denied coverage for a baby born with a heart defect that required surgery. Friends and neighbors rallied around the family to raise the thousands of dollars needed to pay for the surgery and put pressure on the insurer to pay for the needed treatment. A week later the insurer backed off and covered the baby.[2]

The new regulations will prohibit insurance plans from denying coverage to children based on a pre-existing condition(s). This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for a child with cancer because the child had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the family for the child because of the child's pre-existing medical condition). These protections will apply to all types of insurance except for individual policies that are "grandfathered," and will be extended to Americans of all ages starting in 2014.

- **No Arbitrary Rescissions of Insurance Coverage.** Right now, insurance companies are able to retroactively cancel your policy when you become sick, if you or your employer made an unintentional mistake on your paperwork.

  - In Los Angeles, a woman undergoing chemotherapy had her coverage cancelled by an insurer who insisted her cancer existed before she bought coverage. She faced more than $129,000 in medical bills and was forced to stop chemotherapy for several months after her insurance was rescinded.[3]

Under the regulations, insurers and plans will be prohibited from rescinding coverage – for individuals or groups of people – except in cases involving fraud or an intentional misrepresentation of material facts. Insurers and plans seeking to rescind coverage must provide at least 30 days advance notice to give people time to appeal. There are no exceptions to this policy.

- **No Lifetime Limits on Coverage.** Millions of Americans who suffer from costly medical conditions are in danger of having their health insurance coverage vanish when the costs of their treatment hit lifetime limits set by their insurers and plans. These limits can cause the loss of coverage at the very moment when patients need it most. Over 100 million Americans have health coverage that imposes such lifetime limits.

  - A teenager was diagnosed with an aggressive form of leukemia requiring chemotherapy and a stay in the intensive care unit. He reached his family's plan's $1 million lifetime limit in less than a year. His parents had to turn to the public for help when the hospital informed them it needed either $600,000 in certified insurance or a $500,000 deposit to perform the bone marrow transplant he needed.[4]

The regulation released today prohibits the use of lifetime limits in all health plans and insurance policies issued or renewed on or after September 23, 2010.

- **Restricted Annual Dollar Limits on Coverage.** Even more aggressive than lifetime limits are annual dollar limits on what an insurance company will pay for health care. Annual dollar limits are less common than lifetime limits, involving 8 percent of large employer plans, 14 percent of small employer plans, and 19 percent of individual market plans. But for people with medical costs that hit these limits, the consequences can be devastating.

- One study found that 10 percent of cancer patients reached a limit of what insurance would pay for treatment – and a quarter of families of cancer patients used up all or most of their savings on treatment.[5]

The rules will phase out the use of annual dollar limits over the next three years until 2014 when the Affordable Care Act bans them for most plans. Plans issued or renewed beginning September 23, 2010, will be allowed to set annual limits no lower than $750,000. This minimum limit will be raised to $1.25 million beginning September 23, 2011, and to $2 million beginning on September 23, 2012. These limits apply to all employer plans and all new individual market plans. For plans issued or renewed beginning January 1, 2014, all annual dollar limits on coverage of essential health benefits will be prohibited.

Employers and insurers that want to delay complying with these rules will have to win permission from the Federal government by demonstrating that their current annual limits are necessary to prevent a significant loss of coverage or increase in premiums. Limited benefit insurance plans – which are often used by employers to provide benefits to part-time workers — are examples of insurers that might seek this kind of delay. These restricted annual dollar limits apply to all insurance plans except for individual market plans that are grandfathered.

- **Protecting Your Choice of Doctors.** Being able to choose and keep your doctor is a key principle of the Affordable Care Act, and one that is highly valued by Americans. People who have a regular primary care provider are more than twice as likely to receive recommended preventive care; are less likely to be hospitalized; are more satisfied with the health care system, and have lower costs. Yet, insurance companies don't always make it easy to see the provider you choose. One survey found that three-fourths of OB-GYNs reported that patients needed to return to their primary care physicians for permission to get follow-up care.

The new rules make clear that health plan members are free to designate any available participating primary care provider as their provider. The rules allow parents to choose any available participating pediatrician to be their children's primary care provider. And, they prohibit insurers and employer plans from requiring a referral for obstetrical or gynecological (OB-GYN) care. All of these provisions will improve people's access to needed preventive and routine care, which has been shown to improve the health of those treated and avoid unnecessary health care costs. These policies apply to all individual market and group health insurance plans except those that are grandfathered.

- **Removing Insurance Company Barriers to Emergency Department Services**. Some insurers will only pay for health care provided by a limited number or network of providers – including emergency health care. Others require prior approval before receiving emergency care at hospitals outside of their networks. This could mean financial hardship if you get sick or injured when you are away from home or not near a network hospital.

The new rules make emergency services more accessible to consumers. Health plans and insurers will not be able to charge higher cost-sharing (copayments or coinsurance) for emergency services that are obtained out of a plan's network. The rules also set requirements on how health plans should reimburse out-of-network providers. This policy applies to all individual market and group health plans except those that are grandfathered.

Benefits of Consumer Protections

The new rules will bring immediate relief to many Americans and provide peace of mind to millions more who are only one illness or accident away from medical and financial chaos.

The new ban on lifetime limits would affect group premiums by 0.5% or less and individual market premiums by 0.75% or less. The restricted annual limit policy would affect group and individual markets by roughly 0.1% or less (grandfathered individual market plans are exempt). And, the prohibition of preexisting conditions exclusions for children would affect group health plans by just a few hundredths of a percent. For new plans in the individual market, this impact would be roughly 0.5% in many states. In states with community rating, (roughly twenty states), the impact could be up to 1.0%. These costs are before taking into account benefits.

In addition, the rules will achieve greater cost savings by:

- **Reducing the"hidden tax" on insured Americans:** By making sure insurance covers people who are most at risk, there will be less uncompensated care and the amount of cost shifting among those who have coverage today will be reduced by up to $1 billion in 2013.
- **Improving Americans' health:** By making sure that high-risk individuals have insurance, the rules will reduce premature deaths.[6] Insured children are less likely to experience avoidable hospital stays than uninsured children[7] and, when hospitalized, insured children are at less risk of dying.[8]
- **Protecting Americans' savings:** High medical costs contribute to some degree to about half of the more than 500,000 personal bankruptcies in the U.S. in 2007.[9] These costs borne by individuals might be assumed by insurance companies once rescissions are banned, annual limits are restricted, lifetime limits are prohibited, and most children have access to health insurance without pre-existing condition exclusions.
- **Enhancing workers' productivity:** Making sure that kids with health problems have coverage will reduce the number of days parents have to take off from work to care for family members. Parents will also be freed from "job lock," which occurs when people are afraid to take a better job because they might lose coverage for themselves or their families.[10]

From: www.Healthreform.gov

[1] Limits on pre-existing conditions and annual limits will not apply to existing "grandfathered" plans offering individual coverage. For details, see the Fact Sheet and interim final regulations released on the topic on June 14.

[2] Jarvis, Jan, "Under Fire, Blue Cross Blue Shield of Texas Offers to Cover Medical Expenses for Crowley Baby," *Houston Star-Telegram*, (March 31, 2010).

[3] Girion, Lisa "Health Net Ordered to Pay $9 million after Canceling Cancer Patient's Policy," *Los Angeles Times* (2008), available at: http://www.latimes.com/business/la-fi-insure23feb23,1,5039339.story.

[4] Murphy, Tom. "Patients struggle with lifetime health insurance benefit caps," Los Angeles Times, July 2008.

[5] See "National Survey of Households Affected by Cancer." (2006) accessed at http://www.kff.org/kaiserpolls/upload/7591.pdf

[6] See, for example, Almond, Doyle, Kowalski, Williams (2010), Doyle (2005), and Currie and Gruber (1996).

[7] Keane, Christopher et al. "The Impact of Children's Health Insurance Program by Age." *Pediatrics* 104:5 (1999), available at: http://pediatrics.aappublications.org/cgi/reprint/104/5/1051..

[8] Bernstein, Jill et al. "How Does Insurance Coverage Improve Health Outcomes?" *Mathematica Policy Research* (2010), available: http://www.mathematica-mpr.com/publications/PDFs/Health/Reformhealthcare_IB1.pdf
[9] David Himmelstein et al, 2009.
[10] Gruber, J. and B. Madrian. "Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature." (2001).

NCSTAC to Hold Webinar on Strategic Planning on July 16

Alexandria, VA--The National Consumer Supporter Technical Assistance Center (NCSTAC), supported by SAMHSA/CMHS, will hold another in its series of management webinars for consumer run organizations. Consumer leader and consultant Steve Harrington will explain Effective Strategic Planning in a LiveMeeting Webinar on Friday, July 16, 2010, from 2:30 to 4:00 p.m. EST.

What is strategic planning? Why is it especially important during tough economic times? How can strategic planning be performed with a tight budget? How can peer-run organizations use strategic planning to survive and thrive? This webinar will answer these questions and more. Effective strategic planning can bring new life to consumer-run organizations by exploring new funding sources, leadership development and serving peers effectively.

About the presenter: Steve Harrington is president of the National Association of Peer Specialists and serves on the boards of other mental health organizations. He owns Recover Resources, a consulting firm. Steve has performed strategic planning for Fortune 500 companies, state and local governments and mental health organizations.

This is a repeat of the Effective Strategic Planning webinar presented on May 7. A number of attendees had a hard time getting in because of technical difficulties. Participation is open to all consumer-run organizations.

Receive an invitation by e-mail
To receive instructions for attending the webinar, send an e-mail to consumerta@nmha.org.
You will receive an invitation with a link to the online meeting and a toll-free number. If more than 1 person will be participating from your site, please let us know how many you expect. Participants will be able to ask questions during the webinar.

Or, follow these directions
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6. Note: you can join webinar up to 30 minutes before the start time.

Questions? Call 1-866-439-9465. Find us on Facebook or at www.nctstac.org. Feel free to forward this e-mail. Thank you.
703-838-7538

Statement from Secretary Sebelius on Proposed CMS Rule to Expand Medicare Preventive Services and Expand Access to Primary Care

Today, the Centers for Medicare & Medicaid Services (CMS) took another important step to help improve the health status of Medicare beneficiaries. The proposed regulation will implement the new preventive health benefits created under the Affordable Care Act for the seniors and persons with disabilities who rely on Medicare for their health care coverage.

The new rule proposes to make two significant improvements to preventive care benefits under Medicare: Beginning January 1, 2011, Medicare will cover annual wellness visits so that doctors and patients can develop a personalized prevention plan that takes a comprehensive approach to improving the patient's health. Also beginning January 1, 2011, Medicare beneficiaries will no longer have to pay any out-of-pocket costs for most preventive services – including that annual wellness visit.

To help make sure that Medicare beneficiaries have access to primary care doctors, the rule would also boost payments for primary care services. The proposed regulation would also increase access to services by creating payment incentives for general surgeons as well as expand access to other types of health care providers.

Improving access to preventive services and primary care is a top priority for HHS. The proposed rule is just one part of a broader effort we are making to improve the health status of Medicare beneficiaries – and all Americans. We recently announced the allocation of $500 million from the Prevention and Public Health Fund – created by the Affordable Care Act – to invest in the training and development of primary care professionals as well as preventive care activities and public health infrastructure.

With these new benefits under Medicare, and investments in our health care system, the Affordable Care Act is continuing the Obama Administration's historic work to promote wellness and reduce chronic disease.

APS Healthcare

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
John E. Baldacci, Governor Brenda M. Harvey, Commissioner

APS Healthcare Maine Report
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APS Healthcare

APS Healthcare-Maine: Dashboard Report Adult Mental Health Fiscal Year 2010

Demographics, Utilization and Access Measures: Active Authorization Census on the Last Day of Each Month	Apr	May	Jun	
Total # MaineCare Eligible Members	276,251	276,251		
Total # Members Age 18+ Authorized Adult Mental Health Services	24,377	24,796		
Ages 18-20	1,304	1,337		
21-64	22,134	22,509		
65-74	659	667		
Over 75 Years Old	280	283		
Total # Members Age 18+ Authorized Mental Health Services- Male	9,170	8,946		
Total # Members Age 18+ Authorized Mental Health Services- Female	15,783	15,850		
Total # Members Age 18+ Authorized Mental Health Services- Caucasian	21,314	21,119		
Total # Members Age 18+ Authorized Mental Health Services- African-American	309	315		
Total # Members Age 18+ Authorized Mental Health Services- Native American	382	387		
Total # Members Age 18+ Authorized Mental Health Services- Other Race	2,948	2,975		
Total # Adult Members Authorized CSI & PNMI Services (SMI Proxy)	11,864	11,671		
Total # Adult Members Authorized MH Services who were screened for co-occurring SA/MH disorders	1,466	1,390		
Demographics, Utilization and Access Measures: The following Indicators are totalled for each month and are NOT Cumulative	**Apr**	**May**	**Jun**	
Total # Adult Members Authorized Psychiatric Inpatient Services (New Admissions)*	153	181		
Total # of Discharges from Psychiatric Inpatient Units*	126	151		
Average Length Of Stay (in days) for In-Patient Psychiatric Discharged*	7	7		
Total # of Discharges from Psychiatric Inpatient Units Readmitted within 30 days*	19	22		
Total # Members Age 18+ Authorized Individual Outpatient Services (New Admissions)	1,345	1,330		
Total # Members Age 18+ Authorized Group Outpatient Services (New Admissions)	217	206		
Total # Members Age 18+ Authorized Medication Management Services (New Admissions)	521	495		
Total # Members Authorized to Receive Residential Services (PNMI) (New Admissions)	30	29		
Total # of Discharges from Residential Services (PNMI)	38	28		
Average Length Of Stay (ALOS) (in days) for Residential Services (PNMI) discharged	189	266		
Total # Members Age 18+ Authorized Crisis Unit Services (New Admissions)	214	216		
Total # Members Age 18+ Discharged from Crisis Unit Svs in the month	197	193		
ALOS (in days) for Crisis Unit Services discharged in the month, Age 18+	5	3		
Total # Adult Members who are Authorized to Receive Community Support/Integration Services (New Admissions)	484	483		
Total # Adult Members who are Discharged from Community Support/Integration Services	350	356		
ALOS (in days) for Community Support/Integration Services Discharged in the month	297	314		
Utilization, Access, and Continuity of Care Measures - End of Each Quarter Fiscal Year (1Qtr=Jul,Aug,Sep; 2Qtr=Oct,Nov,Dec; 3Qtr=Jan,Feb,Mar; 4Qtr=Apr,May,June)				
Total % of non-hospitalized adult members assigned Community Support/Integration Services within 7 working days of application of services (Quarterly)				
Total % of non-hospitalized adult members assigned Community Support/Integration Services within 3 working days of application of services (Quarterly)				
Total % of adult members who apply for and are assigned CI Services while an inpatient in a psychiatric facility within 7 working days (Quarterly)				
Total % of adult members who apply for and are assigned CI Services while an inpatient in a psychiatric facility within 2 working days (Quarterly)				
* Excludes IMD and State Facilities				

Report Source: Authorization Data from APS CareConnection

APS Healthcare

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
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APS Healthcare-Maine Fiscal Year 2010 Report Dashboard

Demographics, Utilization, and Access - Monthly Cumulative Totals For Fiscal Year 2010 **From: July 1, 2009 - The End of Each Month of the Fiscal Year**	**YTD thru Apr '10**	**YTD thru May '10**
Total # MaineCare Eligible Members	276,251	276,251
Total # Members Authorized Services	62,289	64,208
Total # Members Authorized Mental Health Services (MH)	59,069	60,830
Total # Members Authorized Substance Abuse Services (SA)	6,940	7,324
Total # Members Authorized both Mental Health and Substance Abuse Services	3,720	3,946
Total # Members Authorized Mental Health Services: Caucasian	50,402	51,822
Total # Members Authorized Mental Health Services: African American	1,033	1,067
Total # Members Authorized Mental Health Services: American Indian	925	955
Total # Members Authorized Mental Health Services: Other	6,520	6,986
Total # Members Authorized Mental Health Services: Children/Adolescents age 0-17	20,804	21,387
Total # Members Authorized Mental Health Services: Adults age 18+	38,265	39,443
Total # Members Authorized Mental Health Services: Female	32,828	33,852
Total # Members Authorized Mental Health Services: Male	26,241	26,978
Total # Members Authorized Substance Abuse Services: Caucasian	5,775	6,085
Total # Members Authorized Substance Abuse Services: African American	102	108
Total # Members Authorized Substance Abuse Services: American Indian	146	153
Total # Members Authorized Substance Abuse Services: Other	917	978
Total # Members Authorized Substance Abuse Services: Children/Adolescents age 0-17	510	541
Total # Members Authorized Substance Abuse Services: Adults age 18+	6,430	6,783
Total # Members Authorized Substance Abuse Services: Female	3,286	3,456
Total # Members Authorized Substance Abuse Services: Male	3,654	3,868
Total # Members Authorized Services in an Outpatient Setting	51,655	53,275
Total # Members Authorized Services Diagnosed with a Serious Mental Illness	15,001	15,263
Total # Members Authorized Services Diagnosed with a Severe Emotional Disorder	13,346	13,558
Total # of Members Authorized Services that were screened for co-occurring disorders	14,142	14,177
Total # of Members Authorized Services that were diagnosed with a co-occurring disorder	19,310	19,405
Total # of Members Diagnosed with a co-occurring SA/MH diagnosis Authorized MH Services	16,842	16,863
Total # of Members Diagnosed with a co-occurring SA/MH diagnosis Authorized SA Services	629	632
Total # of Members Diagnosed with a co-occurring SA/MH diagnosis Authorized both SA and MH Services	1,836	1,909
Total # of Members Diagnosed with a co-occurring SA/MH diagnosis Authorized integrated SA and MH Services	404	406
Administrative ASO Measures - The following indicators are totalled for each month and are NOT cumulative	**Apr**	**May**
Total # Administrative Denials (post reconsiderations)	0	0
Total # Clinical Denials (post reconsiderations)	45	74
Total # Partial Authorizations (post reconsiderations)	176	118
Total # Administrative Denials, Clinical Denials, or Partial Authorizations Reconsidered then Resulting in Authorized or Partially Authorized Services	91	74
Denial Rate (post reconsiderations)	1.82%	1.68%
Total # Formal Complaints	0	1
Total # Formal Grievances	0	0
Total # Appeals	13	6

Report Source: Authorization Data from APS CareConnection

Total # of APS Cases Processed	19,851	17995
Total # of Services Processed	23,285	21006
Average # Services per APS Cases Processed	1.17	1.17
Total # of Services Discharged	6,527	6177
Total # Phone Calls Received	3,364	2862
Average # Calls Received per work day	153	136
Average Answer Speed in Seconds (target < 30 seconds)	8	8
Average Length of Calls in Minutes:Seconds	3:52	3:56
Total # DHHS Meetings	11	17
Total # Attendees at the DHHS Meetings	61	123
Total # Provider Meetings	14	13
Total # Attendees at the Provider Meetings	177	95
Total # Member Meetings	1	0
Total # Attendees at the Member Meetings	9	0
Administrative ASO Measures - Quarterly Contract Year (1Qtr=Dec,Jan,Feb; 2 Qtr=Mar,Apr,May; 3 Qtr=Jun,Jul,Aug; 4 Qtr=Sep,Oct,Nov)		
Contract Standard 1, Indicator 1 - Data Transfer of Eligibility Files Incorporated within 24 hours (target 95%)		100%
Contract Standard 1, Indicator 2 - Data Transfer of Provider Files Incorporated within 24 hours (target 95%)		100%
Contract Standard 1, Indicator 3 - 98% Data Transfer of Authorization data entered into MECMS (target within 3 business days of Provider notification)		99%
Contract Standard 2, Indicator 1 - Response to Service Appeals meets time frames stated in agreement (target 98%)		100%
Contract Standard 2, Indicator 2 - Appeals that reach the hearing level have accurate information provided to the Department in less than 48 hours (target 98%)		100%
Contract Standard 3 - Members contacting Member Services are satisfied with their experience (target 90%)		****
Contract Standard 4 - All required reports are completed and submitted within 30 days of the period for which the report is due (target 100%)		98%
Contract Standard 5, Indicator 1 - Telephone calls answered live within 6 rings (target 95%)		98%
Contract Standard 5, Indicator 2 - Fewer than 5% of telephone calls to APS will be abandoned (target < 5%)		1.71%
* DHHS momentum FTP experienced serveral issues which resulted in reduced timeliness of APS file transfers.		
** High Volume and Fax Difficulties		
***Communication difficulty resulted in slower response time during one week in the quarter.		

COSII Quarterly Update
April, May, June 2010

This quarter, we completed the Clinical Guidelines Resource Manual. We were busy wrapping up our Pilot Site project and applying for a no-cost grant extension. We attended the national COSIG grantee conference in Bethesda. National COSIG evaluators visited us. It has been a time of wrapping up our current projects and activities and celebrating successes, though we hope to have an extra year to accomplish more work.

GENERAL

- Met with Project Launch Steering Committee
- Met with producer of the Consumer video
- Worked on identifying and contacting consumers for participation in the Consumer Video Project
- Met several times to plan the Pilot Recognition Event
- Taught two day long sections of the Co-occurring Certificate Program at USM
- Met regularly with the Mental Health Team
- Met monthly with the Mental Health Senior Leadership Team
- Participated in bi-weekly planning calls and several consultation calls for the national COSIG Conference
- Met regularly with the OSA Treatment Team
- Hosted a two-day evaluation visit from the SAMHSA national evaluators including visits to three pilot sites
- Provided two trainings for the Department of Regulatory Services staff
- Organized and participated in Pilot Ste Review meetings
- Prepared for and attended 3 Regional Performance Improvement Partnership Meetings in May
- Participated in APS bi-weekly meetings
- Participated in Maine Reentry Committee Meetings
- Planned and facilitated Pilot Site meeting in January
- Facilitated Workforce Development, Clinical Practices and Steering Committee meetings
- Provided training for Common Ties
- Attended parts of Maine Learning Collaborative meetings
- Attended APS Data Workgroup meetings
- Met with Kristen Jiorle on ROSC
- Participated in Recovery Webinars
- Participated in OSA interviewing process
- Planned upcoming presentations for MPH and Nurses Assoc

- Met with OSA and MAAR
- Met with Cate Chichester several times for planning purposes
- Participated in planning meetings related to the Department's Health Care Reform Initiative
- Helped to plan and attended Co-occurring Institute on ROSC
- Facilitated and attended meetings of the Mid-Coast Interagency Services Collaborative
- Provided input to the Health Workforce Forum document
- Prepared all documents, agendas and minutes for Committee meetings
- Worked extensively on final revisions and editing of all clinical guidelines
- Attended Mid Coast Community Mental Health meeting
- Met with APS/HZA re: data integration issues
- Planned and facilitated Pilot Site meeting in June
- Attended 3 day national COSIG meeting
- Prepared budget and documents for non-cost extension request
- Wrote article on COSII data for the Department Newsletter

COMMUNICATIONS/PUBLIC RELATIONS

- Ongoing work with the Mid Coast Interagency Services Collaborative
- Monitored and updated DHHS COSII web site
- Wrote article on the Winter Quarterly data report for the Department Newsletter

PILOTS

- Joanne Ogden did final site visits with all seven pilot sites, and completed administration of the Maine Co-occurring Self Assessment Tool
- April Pilot Site meeting held on 4/28 and final Pilot site meeting was held on 6/16/10 with focus on Sustainability, brief presentation by Ken Minkoff and final case study reports.

TECHNICAL ASSISTANCE/TRAINING

Consultation with Agencies

- Region I, II, and III COSII Partnership Meetings held in May. The meetings focused on reviewing the soon to be released COD Clinical Guidelines.
- Eureka Counseling staff had training on 4/2/10 on stages of change by Catherine Chichester
- Motivational Interviewing training was provide to CSI on two different occasions by Catherine Chichester
- York Hospital Cottage Program: consultation on COD capability provided by Catherine Chichester 5/12/10

- Shelter Welcoming training provided to York County Shelters, Tedford Shelter and Preble St. Resource Center
- Guy Cousins, Claudia Bepko and Catherine Chichester attended national COSIG grantee conference June 28-30 in Bethesda, MD; shared lessons and networked with 15 other states.

Trainings/Conferences

- Buprenorphine Treatment: A Training for Multidisciplinary Addiction Professionals: Offered around the State by Eric Haram (Machais, Portland, Augusta).
- Second Annual Institute for COD Studies: Recovery-Oriented Systems of Care: Creating Co-Occurring Disorder Services and Support: Attended by 107 people at Bates College
- 4 week On Line Course: Substance Abuse and Depression: A Collaborative Approach to Treatment and Recovery taught by Patricia Burke in May.
- On-line participation in the basic Co-occurring Disorders course posted on the CCSME web site continues

Consultation for Project Team:

- Consultation with Ken Minkoff on sustainability issues

Regional Performance Partnership Activities

- Regional meetings were held in all three Regions in May. These meetings focused on Discussion of the Clinical Guidelines and sustainability issues.

COMMITTEES:

Workforce Development

- Met April 26th and May 17th. The group has focused on reviewing the feedback on the Interactive TV networking events and on determining logical next steps for its work to continue. The group needs "new blood," new goals and a new focus, particularly as we evolve into the one combined state working group on Integration. We will continue to focus on scope of practice definitions and competencies for COD services going forward.

Steering Committee

- Met June 17th . (meets bi-monthly, prior meeting March 29th). The group approved the publication of the Clinical Guidelines as well as the application for the no-cost extension of the grant. Discussion of the Licensing Boards and Scope of Practice issues resulted in an opinion that changes with the SA licensing Board will probably require legislative

rule changes. The group discussed goals for the extension period and topics that will cope up for discussion moving forward.

Clinical Practices Committee

- Met April 26th and May 18th . This group completed its work on the Clinical Guidelines and discussed a merger with the Workforce Development Committee. Anyone who is interested will move to the new committee that will be formed by September. This Committee is now disbanded

Consumer Input Group

- This remaining members of this former group, which is now disbanded, will work together with other consumers to produce a video training module for providers and others.

EVALUATION ACTIVITIES
HORNBY ZELLER ASSOCIATES April 2010

- HZA staff attended the Pilot Site and Pilot Site Review meetings.
- HZA staff prepared and presented a data presentation at the Region I Regional Forum.
- HZA staff submitted an abstract for a presentation to the Maine Public Health Association at the Annual Meeting in October.
- HZA staff participated in and presented data at a COSIG grant site visit from national evaluators.
- HZA staff assisted with planning the COSII Recognition Event by participating in a planning meeting and preparing materials for the event.
- HZA continued work to assist the COSII pilot and enhancement agencies in data collection and database maintenance. Staff handled the most recent data upload by receiving uploads from each agency as well as cleaning and processing the data.

HELP DESK

- HZA's Help Desk had 9 contacts with agencies:

- 9 contacts concerned quarterly data uploads

EVALUATION ACTIVITIES

- HZA staff attended the Region II Regional Forum.
- HZA staff attended a planning meeting to begin preparations on a presentation to the Maine Public Health Association at the Annual Meeting in October.
- HZA staff assisted with planning the COSII Recognition Event by participating in a planning meeting and preparing materials for the event.
- HZA staff began work on editing and formatting the clinical guidelines document.
- HZA staff conducted agency interviews for the COSII final report.
- HZA continued work to assist the COSII pilot and enhancement agencies in data collection and database maintenance.
- HZA prepared slides for the APS data presentation.

HELP DESK

- HZA's Help Desk had 2 contacts with agencies:

- 1 contact concerned updating the most recent data upload with additional data
- 1 contact concerned assistance with lost data due to an agency technical difficulties

June 2010

EVALUATION ACTIVITIES

- HZA staff assisted with planning the COSII Recognition Event by participating in planning meetings and preparing materials for the event.
- HZA staff assisted with set up at the event and attendance.
- HZA staff edited and formatted the clinical guidelines document, making it ready for production.
- HZA staff conducted agency interviews for the COSII final report.
- HZA staff continued work to assist the COSII pilot and enhancement agencies in data collection and database maintenance.
- HZA staff prepared slides for the APS data presentation.
- HZA staff performed a webinar (APS), presenting both the MAT and COSII data.
- HZA staff attended the national COSII meeting in Bethesda, MD.
- HZA staff met with COSII staff on the data project to review codes for inclusion in the COGNOS database to produce co-occurring reports.
- HZA prepared a final list of procedure codes for submission to Jay Yoe.

HELP DESK

- HZA's Help Desk followed up with pilot agencies on data downloads.

EMERGING CHALLENGES/STRENGTHS

- Attendance at the COSIG National Conference provided helpful information about SAMHSA'S current priorities, healthcare reform, and a new focus on prevention of COD
- We will plan new goals based on this new information if our grant is extended
- Providers are becoming increasingly aware of COD expectations as a result of the AC-OK screening requirement