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Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

TESTIMONY OF THE MAINE HOSPITAL ASSOCIATION

Proposed FY 2021 Supplemental Budget

January 26, 2021

Senators Breen and Claxton, Representatives Pierce and Meyer, and members of the Appropriations and Health & Human Services Committees, my name is Jeffrey Austin and I am here on behalf of the Maine Hospital Association.

I am here today to express our support for most of the budget but opposition to a single item in the proposed supplemental budget.

The Maine Hospital Association (MHA) represents all 36 community-governed hospitals including 33 non-profit general acute care hospitals, 2 private psychiatric hospitals, and 1 acute rehabilitation hospital. In addition to acute-care hospital facilities, we also represent 11 home health agencies, 18 skilled nursing facilities, 19 nursing facilities, 12 residential care facilities, and more than 300 physician practices.

Our acute care hospitals are nonprofit, community-governed organizations. Maine is one of only a handful of states in which all of its acute care hospitals are nonprofit.

Summary

Overall, the supplemental appears to be a responsible approach given the pandemic, reduced state revenues and priority spending areas.

However, we are quite disappointed that it includes a meaningful cut to hospital reimbursement.

Hospitals are on the front lines of this pandemic, have suffered significant financial losses as a result of the pandemic and the proposed cut would be unfair from a policy perspective in any year and is particularly unfair during a pandemic.

Maine's hospitals ask that you not impose unfair cuts to hospitals during this pandemic.

Hospital Financial Condition - Pandemic

As many of you know, the financial condition of hospitals is frequently precarious. For example, the aggregate margin for all hospitals in 2018 was 0.9%,

The pandemic dramatically hurt hospital finances. In March, the Governor asked hospitals to stop providing non-emergent services (sometimes called "electives"). That, combined with a fearful public, led to a fairly dramatic drop in hospital activity and revenues. For roughly 6 weeks in the spring, hospital revenues plummeted by 50%. For several weeks thereafter, workloads and revenues slowly climbed back to around 90-95%,

To be clear, hospitals did not shed half of their costs during the slowdown. Hospitals had to keep its workers employed. They were simply bracing for a rush of cases that, thankfully, did not materialize in April.

MHA estimates that hospitals lost approximately $650 million during the late winter, spring, and summer last year. Thankfully, the federal government provided significant financial relief. The aggregate total of that relief was approximately $350 million.

Accordingly, net hospital losses associated with the pandemic are roughly $300 million.

State Financial Assistance

Hospitals have not seen very much financial assistance from the state.

Keep in mind, hospital losses were frequently gains to payers, like Medicaid.

Insurance companies have experienced the largest surpluses in recent years due to the pandemic.

Similarly, Medicaid – the State - saved money as Medicaid recipients delayed care during 2020. That savings is recognized in this supplemental and used to balance the budget.

One of the last actions the Appropriations Committee took in 2020 was to pass a supplemental budget. That budget contained no additional funding for hospitals to manage the pandemic.

The state received approximately $1.3 billion in CARES Act funding. The administration provided that funding to businesses, state agencies and schools.

Hospitals received $2.5 million of the $1.3 billion – *less than 2 tenths of 1%* (by comparison schools have received $300 million). In addition to the $2.6 million, the Governor provided hospitals $3 million in assistance in June (it was matched with additional federal funds).

We have been asking for assistance for months and months and to date have received a total of $5.6 million from state resources.

Not receiving very much state financial assistance has been difficult for hospitals; being handed a reimbursement cut by the state at the same time is wrong.

Supplemental Budget Proposal (Bottom of page A-48; cut of $295,659 GF Only)

We appreciate that the state is facing a difficult budget. We appreciate that there are few programmatic cuts in the budget. However, the supplemental budget contains a notable cut to hospital reimbursement in the Medicaid program that we feel is unfair.

Hospital cut. The initiative would cut reimbursement for hospital outpatient services. The budget reflects a cut of $300K (General Fund only). However, this cut is maintained in the biennial budget, and when fully implemented, DHHS estimates the **loss to hospitals is approximately $7 million per year** (state and federal funding). Accordingly, this cut is much more meaningful to us than you might think given the supplemental budget figures. While we think $7 million is a good faith estimate, given that the structure of the cut is not yet finalized, this is a rough estimate. Our folks have estimated that the cut is actually above $10 million per year.

While the details of the cut are not yet clear, it appears it is a reduction in the reimbursement hospitals receive for medicines it administers on an outpatient basis, if the drug was purchased through the federal drug discount program known as "340B." MHA staff and DHHS staff have been discussing this cut since it was announced as part of the curtailment order in September.

While DHHS believes a cut of some sort is being required, we do not agree. However, even if some modification of reimbursement for 340B drugs is necessary, any savings should not be pulled out of the hospital outpatient reimbursement system.

Hospital outpatient rates are fixed in law. The reimbursement rate for hospital outpatient services is set at 83.7% of the Medicare reimbursement rate. [1] A 2015 study of hospital costs demonstrated that Medicaid reimbursement only covered 70% of hospitals' outpatient costs.

Medicaid rates for hospital outpatient services are low. According to the DHHS 2020 rate study, which is being finalized now, hospital outpatient services are reimbursed at slightly lower levels by Maine's Medicaid program than by comparison states' Medicaid programs.

In fact, out of 787 different Medicaid rates for hospital outpatient services, 97% of them are lower than in comparison states; 3% are higher.

Comparison to other state Medicaid rates is never a perfect exercise. Maine doesn't need to mirror other states with regard to Medicaid reimbursement. However, in the context of a proposal to cut rates, **it is worth noting that hospital outpatient Medicaid rates are already well below hospital costs, below Medicare rates and slightly below Medicaid rates in other states**. This is not the place to go looking to cut further.

[1] There are two types of hospitals PPS hospitals (larger) and CAH hospitals (smaller). PPS hospitals are reimbursed using bundled rates (APCs) which are not tied to cost. CAH hospitals are reimbursed differently; their reimbursement is based upon their costs. This cut applies to CAHs (which is a mystery to us in that CAHs are already reimbursed based upon their costs). My testimony today focuses on the PPS hospitals. While roughly half the hospitals in Maine are CAH, they are smaller and only account for roughly 15% of Medicaid's hospital spending.

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Following is the summary information from the draft DHHS 2020 rate study:

SECTION 45 - HOSPITAL OUTPATIENT SERVICES	
RATE COMPARISON SUMMARY INFORMATION	
Minimum Comparison Rate Percentage	54.6%
Maximum Comparison Rate Percentage	117.6%
Average Comparison Rate Percentage	91.8%
Median Comparison Rate Percentage	89.8%
MaineCare Procedure Code Count	787
MaineCare Count Below Comparison Rate But Not Outlier	763
MaineCare Count Low Outlier	0
MaineCare Count Above Comparison Rate But Not Outlier	23
MaineCare Count High Outlier	0
MaineCare Average % of Comparison States	97.0%
MaineCare Average % of Medicare	83.7%
MaineCare Average % of Commercial 50th Percentile	88.8%
TOTAL CURRENT SPEND AS % OF SPEND IF CODES PAID AT COMPARISON RATE	95.7%
TOTAL SELECTED APC Units	3,638,299
TOTAL OUTPATIENT APC UNITS	3,638,299
TOTAL SELECTED APC EXPENDITURE	$149,455,333
TOTAL INPATIENT APC EXPENDITURE	$149,455,333
PERCENT OF SECTION EXPENDITURES ANALYZED	100.0%

If you agree with DHHS that some adjustment to 340B drug reimbursement should occur, any savings that materialize should be kept in the hospital outpatient rate system and used to bolster MaineCare's demonstrably low hospital outpatient rates.

Bottom Line: MaineCare pays Maine hospitals slightly less than other Medicaid programs, substantially below Medicare rates and approximately 30% below cost. And this is the area DHHS proposes to cut? Somehow, someway they figured some justification to propose cutting this already low reimbursement rate by another $7 million per year.

This is not reasonable and not fair given the facts about outpatient reimbursement and that we are still in the midst of a pandemic.

Thank you for accepting the testimony of the Maine Hospital Association.

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MaineHealth

Testimony of Katie Fullam Harris
MaineHealth
In Opposition to Sections of LD 42
The Proposed Supplemental Budget
Before the Joint Standing Committees on Appropriations and Financial Services and Health and Human Services
January 26, 2021

Senator Breen, Representative Pierce, Senator Claxton, Representative Meyer and distinguished members of the Joint Standing Committees of Appropriations and Financial Services and Health and Human Services, I am Katie Fullam Harris of MaineHealth, and I am here to testify in opposition to two specific reductions in the proposed Supplemental Budget.

MaineHealth is Maine's largest integrated non-profit health care system that provides a full continuum of health care services to the residents of eleven counties in Maine and one in New Hampshire. Our scope of services range from primary and specialty physician services to behavioral health care and community and tertiary hospital care, home health care and a lab.

During the pandemic, MaineHealth's hospitals have played a vital role in caring for patients with COVID-19. As of the beginning of January, our nine MaineHealth acute care hospitals have treated over 62% of the hospitalized COVID-19 patients statewide. As part of our mission of "Working Together So Maine's Communities are the Healthiest in America," we are now fully engaged in leading the effort to vaccinate the residents of the counties we serve. This is a massive undertaking, and one that is requiring the redeployment of limited staff and resources across our system.

At the same time that MaineHealth has gone "all in" to meet our goal of helping Maine people get through the pandemic – we adopted the slogan of "We are in this until we win this," we have sustained challenging economic losses. **In FY '20, MaineHealth finances were unfavorably impacted by $110 million –net of federal and state support.** We significantly cut back on services during the first surge, labor costs have escalated during the pandemic, and needed supplies, such as Personal Protective Equipment, increased dramatically in price. Now, during the second surge, we are trying to balance maintaining services for our patients and caring for even higher numbers of patients with COVID-19. Yesterday, we had 98 patients with COVID-19 being cared for in our hospitals.

Maine's hospitals can ill afford any reductions in revenue. We recognize that, like our hospitals, the State of Maine is also experiencing challenging financial times. However, the reduction to the 340B program that is included in the Supplemental Budget will directly affect the very hospitals that are committing scarce resources to addressing the pandemic. The 340B program is

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critical in helping us provide access to care to vulnerable Mainers, including our rural communities. The proposed reduction represents a cut of over $3.1 million annually to MaineHealth, and it is one that we can ill afford, particularly right now.

In addition to our opposition to the 340B reduction, I will add two points:

1. We share Northern Light's concerns related to the cut to the nursing facility bed hold payments;
2. Access to behavioral health services in Maine continues to deteriorate. Though this is a supplemental budget and I'm sure that we will discuss in more detail during the biennial budget hearing, it is worth noting that we are facing increasing challenges in the behavioral health service realm, and particularly with increases in people getting stuck in our hospital emergency departments due to lack of access to appropriate treatment options.

We appreciate the Governor's leadership in submitting a budget that does not make major changes during this challenging time. However, we also feel strongly that Maine's health systems must be held harmless as they face ever more challenging times in helping Maine get to the other side of the pandemic. The 340B program is vital to helping us meet our goal of providing affordable access to high quality care for the communities we serve.

Thank you for your consideration, and I would be happy to answer questions.

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TESTIMONY

In Opposition of

LD 42, An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government

Patricia Thorsen

Maine Long-Term Care Ombudsman Program

Before the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services

January 26, 2021

Senator Breen, Representative Pierce, Senator Claxton, Representative Meyer and committee members, my name is Patricia Thorsen and I am the Ombudsman Program Manager. The Maine Long-Term Care Ombudsman Program is a statewide non-profit organization that provides advocacy for older adults and adults with disabilities who receive long-term services and supports in all settings. We serve residents in nursing homes, assisted housing including residential care and assisted living facilities, adult day programs and recipients of home care services. Additionally, we serve patients in hospitals who experience barriers in accessing long-term services and supports.

HHS 0148 Nursing Facilities: Reduces funding for savings achieved by eliminating direct care costs claims on nursing home bed hold days

We are concerned about the elimination of funding for direct care costs from payment to nursing homes for bed hold days when nursing home residents are hospitalized. With prior approval,

MaineCare provides payment to hold the resident's bed up to seven days. (MaineCare Benefits Manual, Chapter II, 67.05) For residents diagnosed with COVID-19 who require hospitalization, the bed hold may be extended up to fourteen days. We greatly appreciate that the Department of Health and Human Services has implemented this measure because we know well the devastating impact of the pandemic on nursing home residents across the state. The bed hold provision is very important to residents because it provides protection for their placement at the nursing home. The goal of bed hold is to provide a continuous place of residence. When older adults and adults with disabilities must move into a nursing home, the nursing home becomes their home. We know from our experience with facility closures as well as other circumstances, that when residents must move from one nursing home to another it is particularly difficult for them.

Direct care reimbursement in nursing homes pays for the costs for staffing. It is unlikely that a nursing home would reduce their staff during the hospitalization of a resident. This is important to staff who need the security of consistent employment. It is also critical as our state faces such an urgent need for staffing in long-term care.

Thank you for your consideration. I will be glad to answer any questions you may have.

MHCA

Maine Health Care Association

TESTIMONY OF Richard A. Erb
President and CEO
Maine Health Care Association

January 26, 2021

To the Joint Standing Committees
on Appropriations and Financial Affairs
and Health & Human Services

In Opposition to L.D. 162

An Act To Make Supplemental Allocations from the Highway Fund and Other Funds for the Expenditures of State Government and To Change Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Year Ending June 30, 2021

Good morning, Senator Breen, Representative Pierce, Senator Claxton, Representative Meyer and members of the Committees. My name is Rick Erb and I am the President and CEO of the Maine Health Care Association. Our organization represents a majority of the state's 93 nursing homes. I testify today in opposition to the provision that seeks to eliminate a large portion of MaineCare reimbursement for nursing facility bed-hold days.

Some of you will be familiar with this issue from previous sessions. MaineCare reimburses nursing homes for a limited length of time when a resident is out of the facility for medical or therapeutic reasons. These so called bed-hold payments are designed to assure residents that their place will be held while they are away and that the facility will be reimbursed for doing so.

The MaineCare rate is comprised of direct, routine, and fixed costs. The proposal eliminates the direct care portion of the payment, which is the largest piece of the per diem reimbursement. This would effectively reduce the average bed-hold payment by 54%.

Most of the Direct Care component covers the salaries of nurses, CNAs, and other caregivers. This is especially critical in Maine, where direct care hours per patient day are 15% above the national average and the 4th highest in nation.

Historically, Maine has had few unoccupied nursing home beds. Prior to COVID-19, Maine's average occupancy rate was 90%, 12% above national average, 5th highest in US. If a bed does open up, it will usually be filled quickly.

DHHS has expressed concerns on the allowability of bed hold payments even though the MaineCare benefits manual provides the framework for payment. Maine has been paying bed hold payments for decades with the knowledge that providers continue to bear the same costs regardless of census. Facilities pay no less in staffing because one, or even a few, residents are temporarily absent.

Payments are reported to CMS and subject to their review. To my knowledge, there has never been an indication from CMS that there is an issue with these payments. According to a 2019 national Ombudsman Study, 90% of all states pay for bed holds. More than half of those states pay the full Medicaid rate.

If Maine eliminates the direct care payment, it will have one of the most regressive bed hold policies in the country, even though we care for one of the highest need nursing home populations in the US.

Our elderly and disabled residents should not have to live under the fear that a hospitalization could preclude them from returning to the places they now call home. This could very well happen under the proposed change. We question why the State would consider implementing a policy that promises to save such a small amount of state

dollars, especially when we are receiving the enhanced federal matching rate during the public health emergency.

This is a losing proposition for residents, their families and nursing homes. As such, I hope you will reject this proposal. Thank you.

MACSP
Maine Association For
Community Service Providers

Appropriations and Financial Affairs Committee
Tuesday, January 26, 2021
Written Testimony Regarding LD 42 *An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government (Emergency)*

Senator Breen, Representative Pierce, Senator Claxton, Representative Meyer, and members of the Appropriations and Financial Affairs and Health and Human Services Committees, my name is Laura Cordes, executive director of the Maine Association for Community Service Providers. MACSP is the statewide association of more than 70 organizations providing services and support for thousands of children, adolescents, and adults with intellectual and developmental disabilities (IDD) so that they may live and thrive in our Maine communities. I am providing testimony today neither for nor against *LD 42 An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government (Emergency).*

Despite the incredible work of our members to keep staff and the communities we support safe, particularly in congregate IDD settings, the additional costs of the pandemic and high COVID infections have severely impacted staffing levels and our ability to maintain the quality care and programs for thousands of vulnerable Mainers.

We are greatly encouraged by and thankful for funding to support IDD services in the Governor's proposed *biennial* budget. Governor Mills' commitment to address outdated rates to rebuild our fragile network in the long term is very promising. However, we also ask for your support in the current supplemental budget for help immediately to stabilize the thousands of Direct Support Professionals (DSPs) who make up our essential frontline workforce during this ongoing public health crisis.

It comes as no surprise that the pandemic alone has deeply compounded the state's well-known workforce shortage crisis in our sector.

Outdated and fixed MaineCare reimbursement rates have not kept up with minimum wage and the gap continues to widen. As of January 1, there is nearly a one-dollar gap (ninety-four cents to be exact) between the $11.21 reimbursable wage component for the IDD residential service rate and the state's current $12.15 minimum wage rate.

Further adding to the crisis of providing for the most vulnerable in the IDD communities, is the challenge to meet the new Portland emergency time-and-a-half wage requirement. MACSP members serve an estimated 700 people supported by 425 staff in Portland. These members are having to cut both staff and service hours in order to pay the $18 emergency wage rate while courts consider the

Portland ordinance. The alternative is to move their services out of Portland which they do not want to do but feel forced to simply because the state system on which they rely is not designed to accommodate wage increases mandated by an emergency.

An October survey of all of our members statewide found that 65% of IDD providers would not be able to offer some type of hazard or incentive pay to their employees through the end of the year. Additionally, 65% of providers reported that they are unsure whether they will be able to operate all of their programs - even with a line of credit - by the Spring.

Without a sustainable wage, hero or incentive pay during the pandemic, our DSP workforce continues to rapidly shrink. **Recent estimates among our members suggest a loss of nearly 1600 frontline workers (16% of our DSPs) over the last ten months**. Essential DSP staff, especially those who have person to person contact are fatigued and frustrated and continue to leave for higher-paying and lower risk positions. Providers also report an increase in the resignation of skilled and valued veteran staff due to the current challenges, as well fewer new applicants, and high overtime rates for the remaining staff just to keep the most basic supports in place.

It is worth noting that DSPs have seen rate increases over the past year come to other sectors who do similar care work in Maine, and new programs in other states who quickly deployed Cares Act dollars to create incentive and stabilization funds for their essential workers. DSPs wonder why they have been left behind.

We are very appreciative of the staffing flexibilities that the Department has secured in the State's Appendix K Waiver, as well as the additional allowance for virtual/remote supports. The short term, three month 10% rate increase for our services gave providers the ability to give DSPs hero and incentive pay early on in the pandemic. Unfortunately, these rate increases ended last May and have not been reinstated by the Department. Other state and federal programs including PPP loans, Federal Provider Relief Fund, FEMA grants, and Maine's Health Care Financial Relief Program were promising, but have fallen short of providing the relief that is needed for this emergency.

Last fall, following the surge of the pandemic throughout our state, providers moved quickly to follow Department guidance and closed in person center based Community Supports programs. These are the programs that help ensure skill development and exploration, and integration and engagement in the community for thousands of adults with IDD every day in our state. A MACSP Community Supports survey completed last week found a 29% or $890,000 loss in revenue across 29 providers in their Community Supports programs from the start of the pandemic through the end of the year. These same providers reported a loss of 39% or over 900 fewer people in their programs from March 2020 through the end of the year.

There are simply not enough funds to stabilize staff with the hero pay they deserve, to defray the costs of the pandemic and to hold up the costs of maintaining community support programs so that these frontline staff and programs are still there once this public health emergency ends for the Mainers who need and depend on them. Without additional state or federal dollars, services and programs will continue to collapse under the weight of ongoing expenses.

We ask for your support to stabilize our statewide frontline workforce and essential IDD programs in the supplemental budget and to consider funding a short-term incentive or stabilization program to support staff who remain in their positions as other states have done, or to utilize the state's existing CMS approved emergency Appendix K Waiver for HCBS Services to reinstate and increase the temporary rate increase and to retain vital Community Supports services.

Attached to my testimony is additional detail with estimated costs of providing relief to our sector through April of this year. Depending on what is adopted, the estimated cost of the state share after the federal match for one month of support is 1.5 - 3.9 million dollars.

Thank you for your time and consideration. Please contact me with questions you may have.

Respectfully Submitted,
Laura Cordes, Executive Director
laura.cordes@meacsp.org

Temporary Rate Increases and Community Supports Retainer Payments through Maine's CMS Appendix K Waiver

The federal Centers for Medicare and Medicaid (CMS) Appendix K Waiver is the vehicle which allows each state to amend waiver services for Home and Community Based Services (HCBS) during a public emergency. Last spring, providers received a temporary three-month (March - May, 2020) 10% rate increase through Maine's Appendix K Waiver. Reinstating and raising these temporary rate increases to 25% will allow providers to give DSPs hazard/incentive pay, help defray additional pandemic costs - PPE, cleaning supplies, and technology. The projected costs of reinstating and raising temporary rate increases for providers for a four-month period are in the table below.

States can also request time-limited retainer payments for Community Support programs through its Appendix K Waiver. In Maine, center based Community Support programs that continue to follow DHHS guidance are likely to remain shuttered through the winter. Retainer payments will help ensure these programs remain in place and are available to adults with intellectual and developmental disabilities when the COVID numbers decrease to safer levels. To date, CMS has approved retainer payments through the Appendix K Waiver for 31 other states. We encourage Maine to request retainer payments as well.

Estimated cost of reinstating and raising temporary rate increases in Maine's Appendix K Waiver

Appendix K Temporary Rate Increases*	Per Month	January - April 2021 (4 months)
Increase of 10%	$4,333,333*	17,333,333
Estimated cost to state after current FMAP reimbursement (63.69%)	*$1,573,433*	*$6,293,733*
Increase of 25%	$10,833,332	$43,333,333
Estimated cost to state after current FMAP reimbursement (63.69%)	*$3,933,582*	*$15,734,331*

*In May of 2020 when DHHS announced temporary three-month (March -May) 10%r rate increases, the estimated cost cited was "nearly 13 million" for the three month period. Divided by three, after the federal match, the estimated state share is $1.5 million per month. https://www.maine.gov/tools/whatsnew/index.php?topic=DHS+Press+Releases&id=2477487&v=dhhs_article_2020 (4/30/20)

EMERGENCY DIRECT SUPPORT PROFESSIONALS (DSP) STABILIZATION and HAZARD PAY PROGRAMS

An alternative path to stabilize the DSP workforce would be to create a DSP stabilization program as neighboring states have done. Both Vermont and New Hampshire utilized providers to pass through weekly or monthly stipends to frontline workers who continue to provide in-person care and infection control measures throughout the pandemic in high-risk settings. Late last summer, MACSP proposed and discussed the creation of a similar program using CARES Act Coronavirus Relief Funds with staff from the Governor's office, DAFS and DHHS.

The projected costs of reinstating and raising temporary rate increases for providers for a four-month period are in the following table. Additional information regarding the authorization of similar programs in Vermont and New Hampshire follow below.

Estimated cost of DSP Stabilization Program in Maine

10,000 Direct Support Professionals *7,000 FT (70% more than 30hrs/wk.)* *3,000 PT (30% less than 30hrs/wk.)*	**Cost per month**	**January - April** **4 months**
$1200 per month ($300 per week) for each full-time worker	$8,400,000	$33,600,000
$600 per month ($150 per week) for each part time worker	$1,800,000	$7,200,000
TOTAL before FMAP reimbursement	$10,200,000	$40,800,000
TOTAL Maine cost after current FMAP reimbursement (63.69%)	*$3,703,620*	*$14,814,480*

ADDITIONAL BACKGROUND: VERMONT and NEW HAMPSHIRE STABILIZATION and HAZARD PAY GRANT PROGRAMS

New Hampshire's ***"LONG TERM CARE STABILIZATION PROGRAM"*** was created through a Governor's Emergency Order and Vermont's ***"FRONT-LINE EMPLOYEES HAZARD PAY GRANT PROGRAM"*** was enacted through their General Assembly. Both programs utilized CARES ACT funds.

Vermont's grant program is administered through the Vermont Agency of Human Services and utilizes Medicaid providers to pass-through payments to their frontline workforce who remain in their positions through their specified period.

Vermont Act 136 and a supplemental memo define the grant program and how it met the requirements of the CARES Act as an allowable use of funds.vThe relevant language and links to the full bill and supplemental memo follow below.

Act 136 ***An act relating to health care- and human services-related appropriations from the Coronavirus Relief Fund***
https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT136/ACT136%20As%20Enacted.pdf (full grant program description page 1 - 15)

** * * Coronavirus Relief Fund; Administrative Provisions * * **

Act 136 Sec. 2. CONSISTENCY WITH CARES ACT AND GUIDANCE (page 1)

(a) The General Assembly determines that the expenditure of monies from the Coronavirus Relief Fund as set forth in this act complies with the requirements of Sec. 5001 of the CARES Act, Pub. L. No. 116-136 and related guidance because the costs to be covered:

(1) are necessary expenditures incurred due to the public health emergency with respect to Coronavirus Disease 2019 (COVID-19); (2) were not accounted for in Vermont's fiscal year 2020 budget; and (3) were, or will be, incurred during the period beginning on March 1, 2020, and ending on December 30, 2020.

(b) Additional details regarding the consistency of each appropriation with the requirements of the CARES Act and related guidance are contained in a supplemental memorandum that accompanies this act.

From the supplemental memorandum:

Sec. 6. Front-Line Employees Hazard Pay Grant Program

Sec. 6 appropriated $28,000,000.00 to the Agency of Human Services to provide grants to certain public health, health care, human services, and public safety employers for the provision of hazard pay to their employees who were engaged in activities related to mitigating or responding to the COVID-19 public health emergency and whose job placed them at an elevated risk of exposure to SARS-CoV-2 or COVID-19, or both, during the first two months of the COVID-19 public health emergency in Vermont. The General Assembly determined that the expenditure of monies from the Coronavirus Relief Fund as set forth in this section was necessary because the eligible employees faced a significant risk of exposure to COVID-19, and the significant economic disruption caused by the COVID-19 public health emergency has made it difficult or impossible for many of the covered employers to provide the eligible employees with hazard pay without the grant funding authorized pursuant to this section.

New Hampshire's program uses similar language in Emergency Order #45
https://www.nhes.nh.gov/services/employers/documents/emergency-order-45-ltcs-program-051820.pdf

> "Whereas on March 27, 2020 the United Staes Congress passed, and President Trump, approved the CARES Act which included Coronavirus Relief Funds totaling approximately $1.25 billion in "flex funds" that may only be used to cover costs incurred by the State that (i) are necessary expenditures incurred due to the public health emergency with respect to Coronavirus Disease 2019 (COVID-19); (ii) were not accounted for in the budget most recently approved as of the date of enactment of the CARES Act; and; (iii) were incurred during the period that begins on March 1, 2020, and ends on December 30, 2020.

WABAN
Making a Difference

Senator Breen, Representative Pierce, Senator Claxton, Representative Meyer and HHS and AFA Committee,

I'm Jennifer Putnam, Executive Director for Waban, a nonprofit providing medically necessary services to children and adults with intellectual disabilities and autism (I/DD). I'm testifying today neither for nor against *LD 42 An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government (Emergency).* I'd like to say at the outset that we are thrilled and grateful to hear that Governor Mills' budget includes rate increases for I/DD services.

When I last spoke in June, Waban had right around 420 employees. Now, we have 370. We remain an economic driver in our Sanford, Maine community, though, and many organizations like ours scattered throughout Maine, are economic drivers in their community as well. Sometimes there is a misconception that I/DD services are not an integral part of the State's economy; but in fact, hundreds of millions of dollars flow into Maine communities through Medicaid waiver services that agencies like ours provide.

COVID-19 has hit the I/DD community very hard, particularly group homes and day programs- formally called community supports. At Waban, our 20 group homes have had multiple staff test positive and many more quarantined due to exposure. Not a single resident has tested positive in our homes, but we are an outlier. Just about every other agency in Southern Maine has had an outbreak and many are struggling to adequately staff those homes. Providers are in the position of asking minimum wage DSP's to put themselves and their families at risk to care for sick group home residents.

Day programs have been closed to in person services since mid-November, and this was our second program closure of the pandemic. Many individuals we serve are not capable of participating in remote support and for those that are, few participate for the five or six hours of in-person programming that they used to.

Last February, we had seventy-four adults attending our day program. Now, we have 40% fewer participants (53) and far fewer units of service provided.

The financial assistance that has been provided thus far has been wholly inadequate for a disaster of this scale. What we need is not even to be made whole, but something to keep this destabilized system in place so we can hold onto the staff necessary to support and care for thousands of kids and adults with I/DD and autism.

Our sector was already teetering on the edge of a crisis before COVID. Waban already had hundreds of open shift hours. Now, we have a thousand per month. Our workforce is essentially at a breaking point. Few applicants come through our doors. Who would want to come work in a high- risk congregate setting for barely minimum wage? We must retain our current DSP's, who like everyone else, have endured tremendous hardships: closed schools and

daycares, sick family members, partners out of work, Covid exposures that result in quarantine. We've put in place some stopgap measures here: an employee loan program, payment for the employee's portion of health insurance premium, free meals to all residential staff on shift, an additional $2/hour incentive pay since April. We've continued to pay the extra hazard wages from our savings since then, but not all providers are able to. Our costs for the hazard pay are nearing $800k.

The Paycheck Protection loan got many of us through the initial impact of the pandemic. For Waban, the PPP loan covered five payrolls, just over two months. But the money has been spent, wages paid, and we are faced with looming program revenue losses.

The State's Appendix K waiver offered some minor relief, mostly expanding the ways in which we can deliver Section 21 & 29 services. It provided for a 90-day rate increase of 10% for our waiver services but the state let that 10% increase expire on last May.

We did receive federal provider relief funds, about $340,000. For some context, one two week payroll for Waban is $500,000.

We did not qualify for the State's assistance for large employers, due to our PPP loan.

Our FEMA application for reimbursement for PPE remains open, but not funded. We first submitted in April. We've spent over $125,000k on masks, cleaning supplies, etc.

Waban closed residential homes, stopped operating our day program in person and furloughed administrative staff. Our services are cut to the bone. There are similar stories across I/DD providers in Maine. Some will not survive and all are hurting.

Our agency and <u>all</u> IDD providers will be operating at a structural deficit under these conditions. Last year, Waban provided over 820,000 hours of critical medically necessary services. In the upcoming year, for every hour of service that we provide, our expenses will exceed our revenues by 80 cents. (.80) You can do the math... this is hundreds of thousands of dollars of deficit. Six months into this budget year, we have an operating loss of $353k. Without those provider relief funds, our loss at six months exceeds our budgeted loss for the year ($653,000 projected operating deficit for Waban in FY21.

We need to preserve community-based services across the State before it's too late. We need to pay our direct care workers the hazard pay they need and deserve, or we will continue to lose them.

Here is what we recommend:

- *Amend the K Waiver: extend and increase the rate to 25%.*

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- *Provide retainer payments for Community Supports programs, basing payment on January 2020 billing for services (over 30 states provided retainer payments in their K waiver to preserve services; why didn't Maine?)*
- *Stabilize the direct care workforce through direct payments to direct care workers, as NH and others have done.*

Respectfully Submitted,

Jennifer Putnam, Executive Director
Waban Projects, Inc.
January 25, 2021

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TO: Appropriation and Financial Affairs Committee
Health and Human Services Committee

RE: Written Testimony: "***LD 42 An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government (Emergency)"***

FROM: Michelle Raymond, Chief Executive Officer of Northern Maine General, Town of Eagle Lake

DATE: Hearing dated January 26, 2021

Northern Maine General is a Social Services organization that has operated in Aroostook County since 1907. Although we began as a hospital, and many people know us as a nursing home provider or a boarding home, NMG provides services for all ages and across many spectrums to include Home and Community Based Services for people with intellectual or developmental disabilities (IDD). An essential employer in Aroostook County, we currently employ approximately 170 people.

After the court ordered closing of the state's institution, Pineland Center, DHHS recruited providers to develop supports for people with IDD in a more humane, normalized, and smaller environment, known as waiver or group homes. This residential service, as opposed to the previous institutional models, resulted in individual gains in independence, community inclusion, and health and safety. However, it's a service that NMG, like many of our colleagues across the State, has worked creatively to maintain over the past six years as recruitment and retention of staff have become more difficult due, in part, to a reduced population/workforce available and because the program's reimbursement rate was not adjusted regularly for cost of living. As I'm sure people can appreciate, not just anyone can do this work, so the right people need to be able to take home a living wage. Providers continue to operate under a reimbursement rate that was formulated in 2007, using a direct care staff rate of $11.21. Although I am thankful that lawmakers supported increases in 2017 and 2018 to catch us up with the minimum wage requirements, our direct care staff are still at or barely above minimum wage, now $12.15. We have certified Direct Support Professionals (DSP) working for 20 or 30+ years struggling to

make ends meet and looking at alternatives, not because they don't want to do this work, but because they can no longer afford to. Over the last five years, NMG closed six homes and relocated many long standing residents to other parts of Maine as we could no longer sustain the staffing levels needed to maintain the supports. Some of those individuals were living in our community for over 20 years. This was heartbreaking for those residents, their families and our employees, but we had no alternative. Today, instead of 35 people with IDD in our waiver homes, we now can only serve 9. Instead of employing 100 DSP's in that program alone, we now employ 24 and have 6 posted vacancies, with a reduction of 40% in applications this year as opposed to last year. Turnover in that program is about 49% because of the imbalance between the responsibilities and demands of the job and the wages.

The current rate simply doesn't allow for recruitment and it doesn't provide for hazard pay to retain and incentivize people to keep doing this work during a time when working increases their and their families' risk of coming into contact with the virus. Since NMG operates various programs, I have seen the relief that was provided to the long term care nursing homes and PNMI mental health services to help us through the pandemic, but the IDD program has not seen the same level of financial support to keep and recruit staff and keep our people safe and cover the extraordinary costs of this pandemic. I am appreciative that the Department did provide some support by allowing flexible staff patterns and a 10% increase over a 3-month period from March-May through the K Waiver, but it doesn't meet the current staffs' demand for more pay at a time, more than ever, when they are proving to be one of our most valuable resources in our State. This program cannot survive any more cuts and we can't keep swimming against the current. In order for us to keep supporting the vulnerable individuals in need, the needs of those doing the supporting have to be met. It's imperative that our frontline workers in the IDD services also receive financial support in this supplemental budget to carry us through the end of this current year. I ask that you consider adding short term immediate financial relief in this supplemental budget for the IDD Home and Community Based services to stabilize the DSP workforce and programs.

Thank you for your consideration. Please feel free to contact me with any questions you have.

Respectfully,

Michelle Raymond, CEO
Michelle.raymond@nmgeneral.org

Ryan Brown, Residential Manager, GMS

Good morning, Senator Breen, Representative Pierce, Senator Claxton, Representative Meyer, and Members of Appropriations and Financial Affairs and Health and Human Services Committees, my name is Ryan Brown.

I have been working in the Intellectual and Developmental, IDD, community for many years and I have had the pleasure of working with many different populations, in many different roles of service. I am currently a residential manager for multiple group homes in the Greater Portland area. But I started out working as a Direct Support Professional, DSP, for many years and developed lifelong relationships with amazing people, who taught me a lot about life and myself.

DSPs are an often-overlooked area of expertise. They need to be well trained, patient, understanding and good-natured in order to provide the delicate care needed to keep up with the various challenges, (both medical and behavioral) that are unique to people with disabilities.

The importance of hiring good DSPs to work with people with disabilities has long been acknowledged, but perhaps not sufficiently appreciated. Not often enough, do we give ample credit to these wonderful people, people who dedicate their lives to serving those in need of constant assistance, guidance and supports. People with IDD and Autism need consistency in their lives, so, they can learn, develop and feel safe in being able to predict what their days will

entail. Having a Strong DSP – someone who is reliable, caring, and flexible can have an extremely significant impact on the quality of life of the developmentally disabled.

In this field, we talk a lot about how to improve the lives of people with disabilities by providing them with quality supports, by well trained staff. This is of great importance to the person served, family members, guardians' staff, agencies, and other stakeholders. Since DSPs are typically the ones who have the most interaction with people with disabilities on a daily basis, we also need to think about what steps we can take to improve the quality of life and work experience of DSPs.

DSPs perform their job responsibilities under stressful and challenging working conditions. They do not always have opportunities for career advancement and are often among the lowest paid workers. In fact, many of the DSPs I work with hold a second full-time job at another agency supporting people with IDD. Many of them are single women with children and people of color just trying to survive to support their families and work in a field that they are passionate about. Given the nature of these jobs, and the wage that it pays, it's not surprising to learn that long-term care providers have difficulty recruiting and retaining staff. I deal with the constant turnover on a daily basis. It is exhausting!

Let us not forget what an important service DSPs provide to our disability community. I believe, it's our responsibility to ensure that DSPs are receiving the training, support, recognition and compensation they need, to be successful at working with Maines most vulnerable population.

Please add short-term immediate financial relief in the supplemental budget for IDD Home and Community Based Services to stabilize the DSP workforce and programs - to keep vital staff in place for people we love and support throughout this pandemic.

Thank you for your consideration. I am happy to answer any questions you may have.

Testimony of Donald O. Lagace Jr.

Before the Joint Standing Committees on Appropriations and Financial Affairs and Health and Human Services

In Support of LD 42

"An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government (Emergency)"

Tuesday, January 26, 2021

Good morning Senator Breen, Representative Pierce, Senator Claxton, Representative Meyer and Distinguished Members of the Joint Standing Committees of Appropriations and Financial Affairs and Health and Human Services.

My name is Donald O. Lagace Jr. and I am the guardian and brother of Roxanne Lagace. Roxanne is a 62-year-old beautiful young woman with developmental disabilities who receives vital support services which enables her to experience a full life right here in Augusta. I am also a member of the Board for UPLIFT Inc., a private, non-profit agency that provides residential, integration, and employment services to adults with disabilities. So, I am really wearing two hats and following my parent's commitment to my sister as her Guardian and working with UPLIFT, Inc to support disabled individuals within our community to help them lead happy and healthy lives.

As you address the Supplemental Budget I come before you today as a brother, guardian, and board member to urge you to consider raising rates for service providers for the intellectually and developmentally disabled.

The typical daily roles and responsibilities our Direct Support Providers (DSPs) undertake are incredibly vital to the success and normalization for the developmentally disabled. Those roles and responsibilities have been exponentially amplified given eleven months of operations under COVID-19 pandemic conditions. Some organizations like Uplift have been able to provide an incentive or hazard pay to our DSPs given PPP loans however, those funds have been depleted thereby increasing uncertainty and instability for our DSPs and service providers. In addition, service providers continue to absorb significant personal protective equipment and other related COVID-19 expenses.

I have firsthand experience with the adverse impacts associated with DSP turnover, instability, and the resulting stress on my sister and other group home residents. Frequent staff turnover is very emotional and unsettling for residents and families. It disrupts scheduling and inhibits the goal of normalization and achieving a good quality of life for those in need. COVID is only making this situation worse as DSPs incur

added stressors for themselves, their families and those they support leading to breaking points and seeking higher pay and lower risk jobs. Direct Support Professionals represent those on our front lines who strive to provide love, care, residential integration, and employment services to all with disabilities.

Increasing short-term financial relief via the supplemental budget for service providers will ensure that appropriate and quality care is provided to our most vulnerable until we get on the other side of this pandemic.

Thank you for this opportunity and for your support to my sister Roxanne and all those in need.

Testimony of Todd Goodwin, Chief Executive Officer, John F. Murphy Homes, Inc.

Before the Joint Standing Committee on Appropriations and Financial Affairs

Testifying Neither For Nor Against *Supplemental Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds, and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Year Ending June 30, 2021.*

Hearing Date: January 26, 2021

Senator Breen, Representative Pierce, Senator Claxton, Representative Meyer and Members of the Appropriations and Financial Affairs and Health and Human Services Committees, my name is Todd Goodwin, Chief Executive Officer of John F. Murphy Homes in Auburn. We are a nonprofit provider of disability services to children and adults across several Maine counties. I am testifying neither for nor against the Governor's proposed supplemental budget.

As we all know, the Covid-19 pandemic has wreaked havoc on so many areas of our economy. The devastating impact has been particularly acute in the intellectual and developmental disability services sector (IDD). Put very simply, pandemic response policy at both the state and federal levels has failed to provide sustained and substantive relief to Maine's IDD providers and the thousands of Maine citizens we serve.

While I was heartened to learn that the Governor's proposed biennium budget directs funding to support a variety of IDD service areas, our sector is in need of relief now after weathering nearly a year of unprecedented pandemic-driven challenges to an already unstable and tenuous service system. I implore you to add short-term immediate relief for IDD providers in the supplemental budget. We are in desperate need for stabilization of our front line Direct Support Professional workforce and relief from the consequences of state-ordered closure of community support programs.

Many of you may hear that a variety of state and federal pandemic relief programs (e.g., Paycheck Protection Program, FEMA, state economic recovery grants, etc) have served to provide meaningful support to IDD providers. This simply has not been the case for John F. Murphy Homes. Our agency neither qualified for Paycheck Protection Program funds nor state economic recovery grants. Moreover, after four months of seeking relief from FEMA we still have no idea when or if we will see anything.

The lack of financial relief to date has prevented us from extending hazard pay across the board to our large Direct Support Professional workforce. At the same time, we continue incurring expenses at unprecedented levels as we respond to the pandemic's ongoing challenge to our operations. Despite being unable to provide universal hazard pay:

- We have stood up – at our own expense – a segregated, medically outfitted isolation unit to care for Covid-19 positive residents (to date = 14);
- We have provided premium pay – at our own expense – to those staff who have worked directly with Covid positive residents;
- We have provided a Covid PTO benefit – at our own expense – to those direct care staff who have contracted the virus themselves (to date = 76).

In the face of an already stressed system, these measures are the right and decent thing to do despite the $734,000 (and counting) unreimbursed price tag.

Lastly, I would like to add a final comment on our workforce. As many of you know, the IDD sector has been living a Direct Support Professional workforce crisis for years. The failure of state reimbursement models to respond to the state's minimum wage statute has had the net effect of diminishing the total available pool of workers willing to do the important work of caring for Maine's disabled citizens. The pandemic has exacerbated this downward spiral. At this moment we are contending with 70 open positions. Prior to the pandemic, our agency could expect to see anywhere from 15-20 new hires in our weekly orientation and training program. Over the last several months we are lucky to see three or four people per week willing to give this work a try. Moreover, for every new person in the door, we see one or two leave. The story is the same: extraordinary demands that bring great personal risk for poverty wages. This is the reality of our state's disability system. We need your help.

Respectfully submitted,

Todd Goodwin
Office: 207-440-6247
todd.goodwin@jfmh.org

Kim F Humphrey
Auburn
LD42

Temporary LD 42: An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government (EMERGENCY): Testimony, Kim Fulmer Humphrey, MPH, Auburn, ME
1/26/2021

Senator Breen, Senator Claxton, Representative Pierce, Representative Meyer and distinguished members of the Joint Standing Committees on Appropriations and Financial Affairs and on Health and Human Services,

My name is Kim Humphrey. I'm from Auburn ME. I am the parent of an adult named Dan. He receives section 21 waiver services. It provides his basic daily supports which allow him to be successfully integrated into his community through a group home administered by John F. Murphy Homes. I am also the founder and President of Community Connect ME, a grassroots family driven non-profit organization with the mission of connecting families, caregivers and communities to improve the system of care for the Developmental Disabilities (DD) community and related conditions.

While I applaud the inclusion of funding to support wage increases for Direct Support Professionals (DSPs) and reducing the waitlist beginning in July, I fear the consequences of waiting until July. My son has severe autism which requires a delicate balance of highly coordinated support. Such a system is not to be taken for granted. As many of you know, the service providers that administer these homes and community programs are experiencing both a COVID-19 and workforce crisis. Like many people within the I/DD population, my son can only do well when he receives appropriate supports; without them, his success is replaced by aggressive behavior and a rapid loss of skills. Thankfully, since living in this home for over 10 years, he has been remarkably stable. Like many individuals with I/DD and their families, I worry about the sustainability of a services that are essential to his survival, that have worked well but are more challenged than ever.

The state's current reimbursement rate for DSPs is $11.21/hour yet minimum wage is $12.15/hour. Not having an automatic increase in wages when minimum wage increases discriminates against the people working in this field and endangers those who are supported by it. The k-waiver provided a small, appreciated, 10% rate increase for providers from March to May of 2020 to help with the immense expenses and challenges of the pandemic. Additional funding sources such as this need to be found and allocated to bridge the gap until July. I assure you the work done by the DSPs that I know deserve much more than minimum wage. With great sadness, I have witnessed the discrepancy between what they are paid and the skillful work they do. Maine can do better.

People waiting for placements may not find them as providers don't have staff to support new programs, especially if the clients' needs are complex. Who is tracking the skills loss and the suffering caused by people forced to wait in limbo without necessary daily support? Those being supported or waiting for support require this human service. Please use this emergency budget to bridge the gap until July, to assure the sustainability of home and community based services. There is No Plan B for my son, and many like him.

MOBIUS
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Appropriations and Financial Affairs Committee
Tuesday, January 26, 2021

Written Testimony Regarding LD 42 An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government (Emergency)

Rebecca Emmons, Executive Director, Mobius, Inc.

Senator Breen, Representative Pierce, Senator Claxton, Representative Meyer, and Members of Appropriations and Financial Affairs and Health and Human Services Committees, thank you for the opportunity to provide written and oral testimony.

I entered the field of disability services as a high school volunteer at Mobius over twenty years ago. Since that time, I have served as a Behavioral Health Professional, a Direct Support Professional, and a program manager. Presently, I am the Executive Director of Mobius. I am also the Board President for the Maine Association of Community Service Providers (MACSP) and Chair the MACSP Community and Work Support Services Committee. Since March 2020 Mobius community support services have incurred a revenue loss of 83% and without State-directed support, our ability to meet future demand for this Home and Community Based Waiver service is tenuous.

Direct Support Professionals (DSPs) across Maine have done incredible work to keep adults with developmental disabilities safe. Every day, they risk COVID-19 exposure to support our community's most vulnerable residents. The network of community support providers across the state is steeped in advocacy and dedication to the premise of community inclusion. For adults with disabilities, the formality of service provision assured them access and a sense of belonging within their community. While all Mainers have experienced some form of isolation since the onset of the pandemic, adults with disability have incurred an additional loss – their medically necessary, habilitative services. Social distancing guidelines have increased social isolation and loneliness for many adults with disabilities, as their caregivers and family members have been unable to visit.

After temporary closures in March of 2020, many service providers were able to re-open their community support services. Through the early adoption of pandemic precautions and low case counts across the state, many providers were able to re-open services. With the support of DHHS, OMS, and OADS, virtual community support services became a new resource afforded

to our clients through the CMS approved Appendix K Waiver. Appendix K is a standalone appendix that may be utilized by states during emergency situations to request amendment to approved 1915(c) waivers. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority to respond to an emergency. The new experience of virtual connectivity was met with excitement and creativity by both participants and staff. These offerings often require further follow up and engagement at home; most of this work is not reimbursable and have resulted in increased program management costs. Providers retrained staff and redesigned their offerings to meet this new reality.

It has been eight months since our sector received any state-directed support. Since that time, we have experienced program closures, competed with unemployment benefits to recruit and retain frontline staff, and incurred increased facility, fleet, and equipment costs. A recent impact survey of MACSP members showed a 29% community-supports revenue loss from March 2020 to January of 2021. While we are serving more people, the time people spend in our programs has decreased. Our once stable client base has become fluid, with program engagement varying by the day. These variances make it difficult to appropriately staff our virtual and one-on-one support programming. The toll this inconsistency takes on clients and families has been even more difficult.

In October 2020 case counts began to climb and understandably so the Office of Aging and Disability Services directed the closure of group community-support services. To support social distancing, some providers invested in new spaces, air filtration systems and hiring staff to provide one-on-one services. One-on-one services cost more as they require more staff to serve clients. The Pandemic has compounded a long-standing workforce shortage and with the state-directed closures newly leased or remodeled program spaces are not affordable. Providers are having to make hard decisions, like closing program locations. Based upon the MACSP community support impact survey, eight programs have closed since March 2020.

COVID-19 continues to significantly impact in-person services both in terms of staff shortages and overall client safety. Additionally, virtual services continue to be a barrier for some. Many of the individuals we serve have been severely affected by program closures. Based upon a recent survey of our Members, that is the number of participants we have lost across twenty-nine community-support provider agencies. 905 Mainers with disabilities. 905 individuals and their families. Where are these people? When will they return to services? Will there be community support services for them to return to? How have they fared since they last walked through our doors?

When community supports programs return to pre-pandemic levels, providers will be forced to incur significant costs to hire and train new staff. There will also be an influx of individuals who

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previously qualified for services but had been unable to receive them. Agencies will be unable to accommodate these needs, reconnect with our client-base or remain financially viable without short-term aid. The inclusion of adult disability services in the Supplemental Budget is imperative.

Rebecca Emmons, MPH
Executive Director
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MPHA

Maine Public Health Association

Testimony of Rebecca Boulos, Executive Director
Maine Public Health Association
LD 42: An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government

Joint Standing Committee on Appropriations and Financial Affairs
Joint Standing Committee on Health and Human Services
Tuesday, January 26, 2021

Good morning Senators Breen and Claxton, Representatives Pierce and Meyer, and members of the Joint Standing Committees on Appropriations and Financial Affairs and Health and Human Services. My name is Rebecca Boulos, and I am executive director of the Maine Public Health Association. I am here to provide testimony regarding LD 42: An Act Making Certain Supplemental Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government. In particular, we are in support of "Part Q" (page 19).

MPHA is the state's largest, oldest, and most diverse association for public health professionals. The mission of MPHA is to improve and sustain the health and well-being of all people in Maine through health promotion, disease prevention, and the advancement of health equity. As a statewide association, we advocate, act, and advise on critical public health challenges, assuring that all Maine residents lead healthful lives, regardless of their income or where they live. We are not tied to a national agenda, which means we are responsive to the needs of Maine's communities, and we take that responsibility seriously.

Each year, Maine receives an annual payment resulting from the 1998 Tobacco Master Settlement Agreement; those monies are deposited into the Fund for a Healthy Maine (FHM). FHM dollars are essential for public health programming in Maine, particularly tobacco prevention and control, because they allow the state to leverage federal, local and private funding for disease prevention and health promotion programming. Over time, we have seen smaller allocations from FHM used for public health, and a greater share used for medical care.

In the last budget cycle, the legislature approved transferring $14.5 million from FHM into the MaineCare Stabilization Fund to support the cost of expansion; legislators included a provision that if the funds were not needed, they would be returned to FHM. As you heard during orientation, MaineCare expansion expenditures have not exceeded what was budgeted; thus, the language in Part Q follows through on that provision and returns $14.5 million from the MaineCare Stabilization Fund to FHM.

We are appreciative and in strong support of this provision. Thank you.

122 State Street, Augusta, ME 04330 • 207-808-0487 • mainepublichealth.org

American Heart Association.
You're the Cure

Senator Breen and Representative Pierce
Appropriations and Financial Services
Senator Claxton Representative Meyer
Health and Human Services Committees

Governor's Recommended Fiscal Year 2021 Supplemental General Fund Budget
DHHS-Related Initiatives and Language: Language Part "Q" and ME CDC Initiative related to Tobacco Control Funding

Dear Senators Breen and Claxton and Representatives Pierce and Meyer,

The American Heart Association (AHA) is the nation's oldest and largest voluntary organization dedicated to fighting heart disease and stroke, whose mission is to be a relentless force for a world of longer, healthier lives. We are writing in support of the portions of the Governor's proposed supplemental budget proposal for FY 2021 that pertain to funding for the state's tobacco prevention and treatment program, specifically, AHA supports the language part "Q," which amends a provision in the biennial budget that transferred a portion of Fund for a Healthy Maine revenue to the MaineCare Stabilization Fund. In the current FY 2021 budget passed by the 129th Legislature, a portion of the revenue that was available in the Fund for a Healthy Maine was transferred to the MaineCare Stabilization Fund. The majority of the revenue that makes up the Fund for a Healthy Maine (FHM) comes from annual payments made to Maine as a result of the 1998 Tobacco Master Settlement Agreement. The FHM is the primary source of state dollars for prevention and health promotion, including tobacco prevention and treatment. The FHM leverages millions of dollars in federal, local and private funds, most of which are filtered back into the community. We believe it is important to recognize that the FHM is a special source of funding – it is primarily tobacco settlement funds and not taxpayer or general fund dollars. It is also important to recognize it has a special purpose – to fund evidence-based prevention and health promotion programs. In addition, the statute that governs the FHM requires any unencumbered balances at the end of the fiscal year to lapse back into the FHM. In recognition of the special source and purpose of the FHM and that unspent balances are intended to be returned so that they can continue to be preserved for prevention and health promotion, during biennial budget deliberations in the 129th Legislature, the Appropriations Committee included a provision in the budget with the intention of returning the FHM dollars if Medicaid expansion expenditures did not exceed what was budgeted – i.e., if the MaineCare stabilization fund was not needed. As you have heard in your committee orientation, MaineCare expansion expenditures have not exceeded what was budgeted and, as such, language Part Q follows through on returning the $14.5 million to the Fund for a Healthy Maine.

We would also like to call your attention to the Maine CDC initiative on p. A-45, described as "Reduces funding by allocating a communications contract to other allowable funding sources within the Fund for A Healthy Maine. This initiative relates to the curtailments ordered in Financial Order 001152" with a corresponding reduction of $100,000 in General Fund dollars. It

is our understanding that this is general fund revenue allocated to the state tobacco prevention and treatment program as a result of the passage of legislation in the 129th Legislature that equalized the tax on non-cigarette tobacco products. This legislation updated Maine's tobacco tax code so that all tobacco products are taxed at the same relative rate. While the bill's fiscal note estimated annual revenue of more than $10 million per year associated with the tax equalization, in FY 21, only $4.1 million was allocated to the state tobacco prevention and treatment program, with the remainder used for other purposes not related to tobacco control. In the Governor's curtailment order due to COVID, this allocation was reduced by $100,000. Nearly all aspects of our work and personal lives have been impacted by COVID-19. The state tobacco prevention and treatment program was not immune to these changes. While the program was able to quickly make adjustments to continue to carry out evidence-based activities despite COVID, it is likely that a reduction of $100,000 in program funding could be absorbed due to short-term savings resulting from the unanticipated adjustments. The reason why we are calling attention to this section of the supplemental is to make you aware of where these funds originally came from and their budgeted use. Also, as your committees move forward in budget deliberations a few facts are worth considering:

1. In FY 20, Maine brought in over $175 million in tobacco-related revenue (made up of roughly $49 million from the tobacco masters settlement agreement and over $130 million in tobacco tax revenue).[1]
2. The US CDC recommends that Maine spend $15.9 million per year[2] on evidence-based tobacco prevention and treatment efforts, less than 10% of Maine's tobacco-related revenue.
3. It is estimated that the tobacco industry spends roughly $46 million/year marketing their deadly products in Maine.[3]
4. Tobacco use remains the leading preventable risk factor for cancer and the leading cause of preventable death in Maine and across the nation, accounting for 29% of cancer deaths and 2,400 smoking-related adult deaths annually in Maine.[4]
5. More than 1 in 6 Maine adults smoke cigarettes[5] and nearly 1 in 3 Maine high school students have used some form of tobacco product in the past 30 days.[6]

Tobacco control programs play a crucial role in the prevention of many chronic conditions such as cancer, heart disease, and respiratory illness. Comprehensive tobacco prevention and cessation programs prevent kids from starting to smoke, help adult smokers quit, educate the public, the media and policymakers about policies that reduce tobacco use, address disparities,

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[1] Revenue Forecasting Committee – December 2020 Report, http://legislature.maine.gov/doc/4784.

[2] Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs — 2014*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

[3] Campaign for Tobacco-Free Kids, *The Toll of Tobacco in Maine*, updated October 20, 2020, http://www.tobaccofreekids.org/facts_issues/toll_us/maine

[4] Ibid.

[5] Ibid.

[6] Maine CDC, *Tobacco Use Among Maine Youth Data from the 2019 Maine Integrated Youth Health Survey (MIYHS)*, https://data.mainepublichealth.gov/miyhs/files/Snapshot/2019MIYHSTobaccoInfographic.pdf.

and serve as a counter to the ever-present tobacco industry. Recommendations for state tobacco prevention and cessation programs are best summarized in the Centers for Disease Control and Prevention's (CDC) *Best Practices for Comprehensive Tobacco Control Programs*. In this guidance document, CDC recommends that states establish tobacco control programs that are comprehensive, sustainable, and accountable and include state and community interventions, public education interventions, cessation programs, surveillance and evaluation and administration and management.[i] There is more evidence than ever before that tobacco prevention and cessation programs work to reduce smoking, save lives and save money. The 2014 Surgeon General Report, *The Health Consequences of Smoking – 50 Years of Progress*, calls for a number of specific actions, including: "Fully funding comprehensive statewide tobacco control programs at CDC recommended levels."[ii] The report also notes that, *"States that have made larger investments in comprehensive tobacco control programs have seen larger declines in cigarettes sales than the nation as a whole, and the prevalence of smoking among adults and youth has declined faster, as spending for tobacco control programs has increased."* Importantly, the Report finds that long term investment is critical. It states, *"Experience also shows that the longer the states invest in comprehensive tobacco control programs, the greater and faster the impact."*

We recognize the challenges of focusing on anything other than the immediate threat during a global pandemic. However, delaying other core public health work like tobacco prevention and treatment is one that will cost the state in terms of lives and dollars. Unfortunately, cancer doesn't stop because we are experiencing a global pandemic. We must do everything in our power to keep our communities healthy and safe—which means building strong public health infrastructure including comprehensive tobacco control measures. We look forward to working with you in the Maine Legislature to ensure there are no cuts in funding for the state tobacco prevention and treatment program.

Thank you for the opportunity to provide this testimony. We look forward to working with you on this critical funding.

Sincerely,
Allyson Perron Drag
American Heart Association/ Stroke Association
Government Relations Director

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[i] U.S. Centers for Disease Control and Prevention (CDC), *Best Practices for Comprehensive Tobacco Control Programs*, Atlanta, GA: U.S. Department of Health and Human Services (HHS), January 30, 2014. http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices.

[ii] HHS, *The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General,* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. http://www.surgeongeneral.gov/library/reports/50-years-of-progress/index.html

Allyson Perron Drag
American Heart Association
LD42

Senator Breen and Representative Pierce
Appropriations and Financial Services
Senator Claxton Representative Meyer
Health and Human Services Committees
Governor's Recommended Fiscal Year 2021 Supplemental General Fund Budget
DHHS-Related Initiatives and Language: Language Part "Q" and ME CDC Initiative related to Tobacco Control Funding

Dear Senators Breen and Claxton and Representatives Pierce and Meyer,

The American Heart Association (AHA) is the nation's oldest and largest voluntary organization dedicated to fighting heart disease and stroke, whose mission is to be a relentless force for a world of longer, healthier lives. We are writing in support of the portions of the Governor's proposed supplemental budget proposal for FY 2021 that pertain to funding for the state's tobacco prevention and treatment program, specifically, AHA supports the language part "Q," which amends a provision in the biennial budget that transferred a portion of Fund for a Healthy Maine revenue to the MaineCare Stabilization Fund. In the current FY 2021 budget passed by the 129th Legislature, a portion of the revenue that was available in the Fund for a Healthy Maine was transferred to the MaineCare Stabilization Fund. The majority of the revenue that makes up the Fund for a Healthy Maine (FHM) comes from annual payments made to Maine as a result of the 1998 Tobacco Master Settlement Agreement. The FHM is the primary source of state dollars for prevention and health promotion, including tobacco prevention and treatment. The FHM leverages millions of dollars in federal, local and private funds, most of which are filtered back into the community. We believe it is important to recognize that the FHM is a special source of funding – it is primarily tobacco settlement funds and not taxpayer or general fund dollars. It is also important to recognize it has a special purpose – to fund evidence-based prevention and health promotion programs. In addition, the statute that governs the FHM requires any unencumbered balances at the end of the fiscal year to lapse back into the FHM. In recognition of the special source and purpose of the FHM and that unspent balances are intended to be returned so that they can continue to be preserved for prevention and health promotion, during biennial budget deliberations in the 129th Legislature, the Appropriations Committee included a provision in the budget with the intention of returning the FHM dollars if Medicaid expansion expenditures did not exceed what was budgeted – i.e., if the MaineCare stabilization fund was not needed. As you have heard in your committee orientation, MaineCare expansion expenditures have not exceeded what was budgeted and, as such, language Part Q follows through on returning the $14.5 million to the Fund for a Healthy Maine.

We would also like to call your attention to the Maine CDC initiative on p. A-45, described as "Reduces funding by allocating a communications contract to other allowable funding sources within the Fund for A Healthy Maine. This initiative relates to the curtailments ordered in Financial Order 001152" with a corresponding reduction of $100,000 in General Fund dollars. It
is our understanding that this is general fund revenue allocated to the state tobacco prevention and treatment program as a result of the passage of legislation in the 129th Legislature that equalized the tax on non-cigarette tobacco products. This legislation updated Maine's tobacco tax code so that all tobacco products are taxed at the same relative rate. While the bill's fiscal note estimated annual revenue of more than $10 million per year associated with the tax equalization, in FY 21, only $4.1 million was allocated to the state tobacco prevention and treatment program, with the remainder used for other purposes not related to tobacco control. In the Governor's curtailment order due to COVID, this allocation was reduced by $100,000.

Nearly all aspects of our work and personal lives have been impacted by COVID-19. The state tobacco prevention and treatment program was not immune to these changes. While the program was able to quickly make adjustments to continue to carry out evidence-based activities despite COVID, it is likely that a reduction of $100,000 in program funding could be absorbed due to short-term savings resulting from the unanticipated adjustments. The reason why we are calling attention to this section of the supplemental is to make you aware of where these funds originally came from and their budgeted use. Also, as your committees move forward in budget deliberations a few facts are worth considering:

1. In FY 20, Maine brought in over $175 million in tobacco-related revenue (made up of roughly $49 million from the tobacco masters settlement agreement and over $130 million in tobacco tax revenue).1
2. The US CDC recommends that Maine spend $15.9 million per year2 on evidence-based tobacco prevention and treatment efforts, less than 10% of Maine's tobacco-related revenue.
3. It is estimated that the tobacco industry spends roughly $46 million/year marketing their deadly products in Maine.3
4. Tobacco use remains the leading preventable risk factor for cancer and the leading cause of preventable death in Maine and across the nation, accounting for 29% of cancer deaths

and 2,400 smoking-related adult deaths annually in Maine.4
5. More than 1 in 6 Maine adults smoke cigarettes5 and nearly 1 in 3 Maine high school students have used some form of tobacco product in the past 30 days.6
Tobacco control programs play a crucial role in the prevention of many chronic conditions such as cancer, heart disease, and respiratory illness. Comprehensive tobacco prevention and cessation programs prevent kids from starting to smoke, help adult smokers quit, educate the public, the media and policymakers about policies that reduce tobacco use, address disparities,
1 Revenue Forecasting Committee – December 2020 Report, http://legislature.maine.gov/doc/4784.
2 Centers for Disease Control and Prevention. Best Practices for Comprehensive Tobacco Control Programs — 2014. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
3 Campaign for Tobacco-Free Kids, The Toll of Tobacco in Maine, updated October 20, 2020, http://www.tobaccofreekids.org/facts_issues/toll_us/maine
4 Ibid.
5 Ibid.
6 Maine CDC, Tobacco Use Among Maine Youth Data from the 2019 Maine Integrated Youth Health Survey (MIYHS), https://data.mainepublichealth.gov/miyhs/files/Snapshot/2019MIYHSTobaccoInfographic.pdf.
and serve as a counter to the ever-present tobacco industry. Recommendations for state tobacco prevention and cessation programs are best summarized in the Centers for Disease Control and Prevention's (CDC) Best Practices for Comprehensive Tobacco Control Programs. In this guidance document, CDC recommends that states establish tobacco control programs that are comprehensive, sustainable, and accountable and include state and community interventions, public education interventions, cessation programs, surveillance and evaluation and administration and management.i There is more evidence than ever before that tobacco prevention and cessation programs work to reduce smoking, save lives and save money. The 2014 Surgeon General Report, The Health Consequences of Smoking – 50 Years of Progress, calls for a number of specific actions, including: "Fully funding comprehensive statewide tobacco control programs at CDC recommended levels."ii The report also notes that, "States that have made larger investments in comprehensive tobacco control programs have seen larger declines in cigarettes sales than the nation as a whole, and the prevalence of smoking among adults and youth has declined faster, as spending for tobacco control programs has increased." Importantly, the Report finds that long term investment is critical. It states, "Experience also shows that the longer the states invest in comprehensive tobacco control programs, the greater and faster the impact."
We recognize the challenges of focusing on anything other than the immediate threat during a global pandemic. However, delaying other core public health work like tobacco prevention and treatment is one that will cost the state in terms of lives and dollars. Unfortunately, cancer doesn't stop because we are experiencing a global pandemic. We must do everything in our power to keep our communities healthy and safe—which means building strong public health infrastructure including comprehensive tobacco control measures. We look forward to working with you in the Maine Legislature to ensure there are no cuts in funding for the state tobacco prevention and treatment program.
Thank you for the opportunity to provide this testimony. We look forward to working with you on this critical funding.
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i U.S. Centers for Disease Control and Prevention (CDC), Best Practices for Comprehensive Tobacco Control Programs, Atlanta, GA: U.S. Department of Health and Human Services (HHS), January 30, 2014.
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ii HHS, The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General, Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
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Alliance for Addiction and Mental Health Services, Maine

The unified voice for Maine's community behavioral health providers

Malory Otteson Shaughnessy, Executive Director

Testimony in Support of An Act to Make Supplemental Appropriations and Allocations for the Expenditures of State Government and to Change Certain Provisions of the Law Necessary to the Proper Operations of State Government

January 26, 2021

Good morning Senator Breen, Representative Pierce, Senator Claxton, Representative Meyer, Members of the Joint Standing Committee on Appropriations and Financial Affairs, and Members of the Joint Standing Committee on Health and Human Services. My name is Malory Shaughnessy; I am a resident of Westbrook; and the Executive Director of the Alliance for Addiction and Mental Health Services. The Alliance is the statewide association representing the majority of Maine's safety net community based mental health and substance use treatment providers. The Alliance advocates for the implementation of sound policies and evidence-based practices that serve to enhance the quality and effectiveness of our behavioral health care system.

On behalf of the Alliance, I am here today to speak to the supplemental budget for the year ending June 30, 2021.

We are thankful for the support provided by the federal government, and that the administration has implemented curtailments that do not impact direct services needed by Maine men, women, and children. This is quite a feat given the roller coaster ride of the economy this past year. We thank the administration for their leadership in this effort.

We do have some concerns to share today however. So many in our state have been adversely impacted and the needs across the state are great. As a part of the budget, we see the transfer of $41,000,000 before the end of this fiscal year into the Maine Budget Stabilization Fund -- otherwise known as the "rainy day fund".

We have to point out that it is already raining today in Maine...indeed in many ways there is a nor'easter hitting some of our communities.

Currently our behavioral health safety net is significantly overburdened. Maine men, women, and children are unable to receive key behavioral health residential or community-based treatment and support services that keep them healthy and productive in their home communities. Maine's investment in these services has not kept pace with the increasing intensity of need being seen in children and in adult mental health and substance use presentations, nor with increases in inflation and the movement towards livable wages. There are many more Mainers that need intensive residential care with extra supports and guidance than we have spaces to treat. The Opioid epidemic has not abated and supercedes the death rate of the COVID-19 pandemic. After years of unfettered substance use growth in Maine, young children are being found that have severe polysubstance use and a high intensity of need living in multi-generational families struggling with addiction challenges.

We do not have the resources to address these issues.

This lack of access to appropriate residential, and community-based care shows up in many forms, including:

- Expensive institutional settings being overutilized, such as hospital emergency departments, hospital inpatient units or correctional facilities
- Excessive numbers of people on wait lists or having initial appointments scheduled months out
- Inability to refer for appropriate level of services along the entire age continuum (child, adolescent, adult, older adult) leaving people getting services that may not truly meet their needs.
- Inability to find comprehensive service offerings in all communities/geographies in Maine

Alliance member organizations can provide specific examples of the lack of access to mental health services in communities throughout Maine. An example of a profound access challenge is in the medication management programs for both adults and children, where now only a handful of provider organizations continue to operate medication management clinics. Wait lists for these clinics run in the hundreds if not thousands of Mainers. Wait times can exceed 180 days to get an appointment, virtually cutting off the system to consumers who need it. Another example is in emergency department settings where patients get "stuck" awaiting access to secure stable community mental health services.

A contributing cause of this lack of access are reimbursement rate levels that are outdated and incapable of sustaining service providers to operate in an already vulnerable and overburdened system. A lack of appropriate reimbursement rates leads to an inadequate and vulnerable service network and agencies that are fiscally beholden to community Boards of Directors that have had to cut staffing levels, locations of service, and entire programs to remain viable.

Inadequate reimbursement rates lead to:

- non-competitive compensation offerings in the market causing staff shortages
- burnout and fatigue among staff, and
- overall difficulty in retaining the personnel who provide safe and compassionate care.

Then in 2020, on top of all of these existing problems, COVID-19 came and increased the need for mental health and substance use disorder services -- as well as exacerbating the worker shortage as folks roll into and out of quarantine, or do not want to work on the front lines due to pre-existing immune systems or family concerns.

The safety net for behavioral health care in Maine is at a crisis point. We need swift action.

We call on this body to divert some of this funding from the 'rainy day" fund and instead provide support today through enhanced investments in the safety net to address mental health and substance use challenges.

We call on this body to **direct some of this funding to cover hazard pay for our dedicated front-line direct care and clinical care workers**. They have continued to provide care through tough circumstances for nearly a year and this safety net system cannot continue without them.

Thank you for your time and consideration of these concerns.