Attachment C

MaineCare Return On Investment Analysis Phase III Products/Services

Value of Annual Discounted Reduction in MaineCare Cost Less Proposed Annual MaineCare Investment in HealthInfoNet

	Demonstration Phase			Production Phase				
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
Projected Annual Cost Reduction 1	$ -	$ 164,885	$ 494,655	$ 824,425	$ 1,648,850	$ 3,297,701	$ 4,122,126	$ 10,552,643.12
Projected Annual Investment 2	$ 2,000,000	$ -	$ 471,077	$ 663,077	$ 663,077	$ 1,131,855	$ 1,131,855	$ 6,060,942.40
Investment less Exp. Reduction 3	$ (2,000,000)	$ 164,885	$ 23,578	$ 161,348	$ 985,773	$ 2,165,846	$ 2,990,271	
Cumulative Return Balance 4	$ (2,000,000)	$ (1,835,115)	$ (1,811,537)	$ (1,650,189)	$ (664,416)	$ 1,501,430	$ 4,491,701	

Break Even: Year 5
NPV: $3,057,179
IRR: 26.64%
Annual ROI: 29%

Assumes 5% interest rate

1. Discounted annual projected reductions in the growth of medical expenses carried over from modification schedule.
2. Value-Based annual fees based on MaineCare's 30% proportion of health care expenses in State
3. Projected annual cost reductions less projected annual HIN MaineCare fees and initial $2,000,000 investment
4. Cumulative total of investment less cost reduction for MaineCare as a Value-Based client of HealthInfoNet

Attachment D

Statewide Return On Investment Analysis- Phase III Products/Services

Value of Annual Projected Discounted Reduction in Statewide Cost Less Annual Investment in HealthInfoNet

	Demonstration Phase			Production Phase				
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
Projected Annual Cost Reduction 1	$ -	$ 560,171	$ 1,680,512	$ 2,800,854	$ 5,601,708	$ 11,203,415	$ 14,004,269	$ 35,850,928.63
Projected Annual Investment 2		$ 5,058,798	$ 1,960,178	$ 3,688,205	$ 3,809,449	$ 3,838,130	$ 3,870,314	$ 22,225,074.00
Investment less Exp. Reduction 3	$ -	$ (4,498,627)	$ (279,666)	$ (887,351)	$ 1,792,259	$ 7,365,285	$ 10,133,955	
Cumulative Return Balance 4	$ -	$ (4,498,627)	$ (4,778,293)	$ (5,665,644)	$ (3,873,386)	$ 3,491,900	$ 13,625,855	

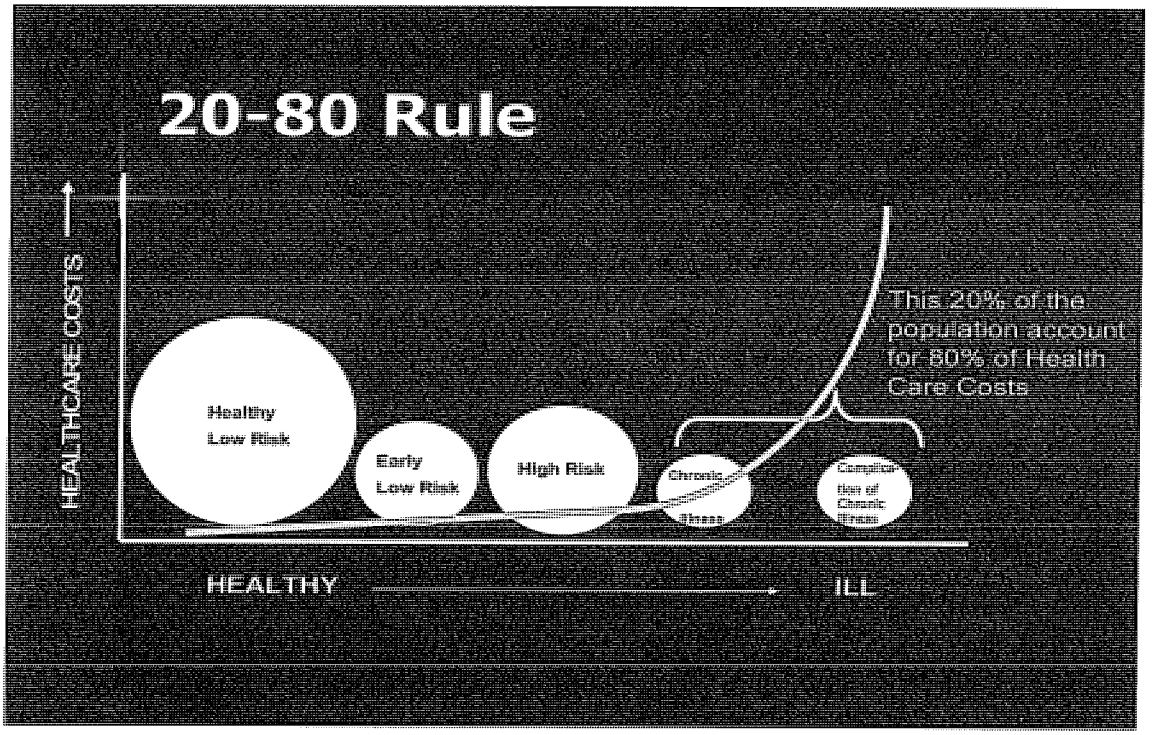
Break Even: Year 5
NPV: $1,294,847
IRR: 7.89%
Annual ROI: 26.7%
Assumes 5% interest rate

1. Discounted annual projected reductions in annual medical expense
2. Projected annual costs of operation and capital investment for HealthInfoNet
3. Projected annual cost reductions less projected annual HIN investment
4. Cumulative total of investment less cost reduction for State of Maine
5. Expenses projected in years 3-6 include the interest expenses associated with borrowing $4.5 million at the start of year 3 to cover capital expense required to move to production phase.

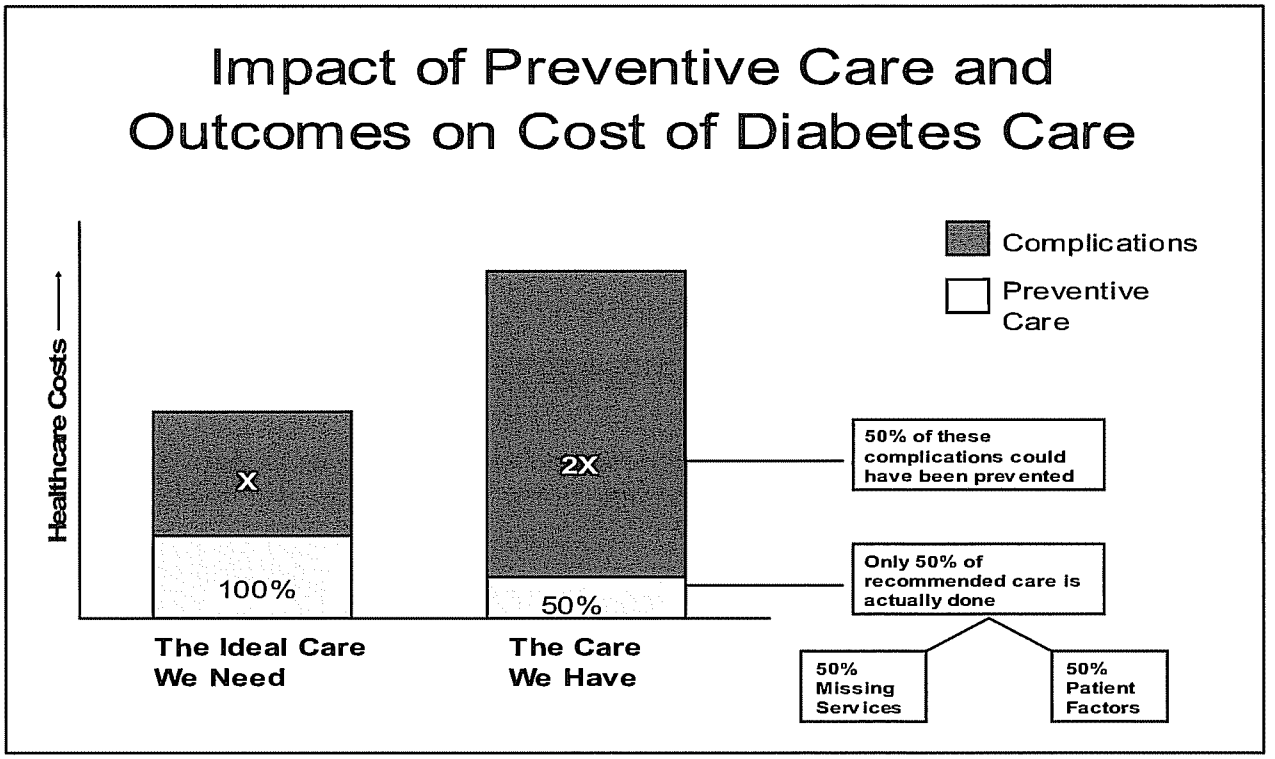
TESTIMONY FOR APPROPRIATIONS AND FINANCIAL AFFAIRS COMMITTEE AND HEALTH AND HUMAN SERVICES COMMITTEE
2-22-07

Senators Rotundo and Brannigan, Representatives Fischer and Perry, and members of the committees, Good Afternoon. I am Dr. Larry Anderson. As a practicing rheumatologist in Portland, I helped provide care for Maine citizens with arthritis and related disorders for 28 years. Today I am representing our local healthcare system, MaineHealth, where I am now doing work in quality improvement through our Physician-Hospital Organization affiliated with the Maine Medical Center (the MMC PHO). I am here to make the case for local care management for patients with chronic illnesses, a model different from the $24 million line item in the proposed budget for the contract with Schaller-Anderson. My goal for today is to impart to you the sense of urgency that I feel for adding more support for improving the care of patients with chronic illness, not only to relieve the burden of their suffering from the preventable complications of chronic illness but also to address the considerable burden of the costs of caring for these complications.

In healthcare economics, we refer to the "20-80 rule": the 20% of the population with chronic illnesses account for 80% of healthcare costs. Commissioner Brenda Harvey reported that the MaineCare budget has grown to $2.4 billion. To the extent that the 20-80 rule applies, the costs of caring for chronic illness for MaineCare members in our state approaches $2 billion annually. On last evening's national news, we learned that the national healthcare costs are on track to exceed $4 trillion annually, such that one out of every five dollars will be spent on healthcare and, by the 20-80 rule, over $3.3 trillion will be spent on chronic illness care.



The good news is that there are interventions, some under your control, that have the potential to contain these rapidly escalating costs. To illustrate the point, I will explain the "50% rule" thatappli es to chronic illnesses like diabetes. This first graph displays the nearly doubling of healthcare costs with *the care we have* as compared to *the care we need* and could have if the best available science were applied with "ideal care."



The numbers are derived from two important studies reported in the New England Journal of Medicine four years ago. The first study[1], from Denmark, demonstrated over a 50% reduction in the complications of diabetes in patients treated with ideal care compared to usual care. In the second study[2], from the RAND Corporation, we learned that, in spite of the fact that the value of ideal care for diabetes is well known and accepted, only 50% of ideal care is actually realized. The 50% shortfall in ideal care can be roughly divided, 50% from missing services on the part of providers (such as busy physicians and their practice teams failing or forgetting to order tests or provide the correct medication) and 50% from patient factors (such as patients not changing lifestyle or taking medication as directed). Today we will be addressing just the patient side of this equation.

---

[1] Gaede EA, et al, "Multifactorial Intervention & Cardiovascular Disease in Patients with Type 2 Diabetes" New England Journal of Medicine, Vol. 348, No. 5, January 30, 2003, pp. 383-393

[2] McGlynn EA, et al, "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, Vol. 348, No. 26, June 26, 2003, pp. 2635-2645

Achieving engagement of the patients (and their families) requires an intense effort in education and motivation for patients to learn the skills of self management and to accept responsibility for doing their part to stay as healthy as possible. Who can accomplish this task? Since surveys confirm high trust in one's physician, the responsibility logically lies with the patient's physician and practice team, most of whom simply do not have adequate time in the busy practice day to do this well. This time-intensive effort is best accomplished by a practice team member with dedicated time, such as a nurse care manager.

The most common care management model in use today is long-distance telephonic contact by a care manager who specializes in one disease such as diabetes or cardiovascular disease and who focuses on utilization management. At the MMC PHO we offer a different model: in our model, a generalist, practice-based nurse care manager works with the physician and the patient to focus on reducing the gaps in ideal, evidence-based care for patients who often have more than one illness. Introduction and endorsement of the care manager by the physician leverages the patient's trust in the practice team. The care managers more quickly and completely gain trust from the patients through personalized, face-to-face contact than can be expected through long-distance telephonic contact. Trained in the care of chronic illness and highly skilled in motivational interviewing, these compassionate nurse care managers, with dedicated time, are best positioned to solve the conundrum of the patients who are persistently unwilling or unable to assume responsibility for their role in maintaining or restoring their health.

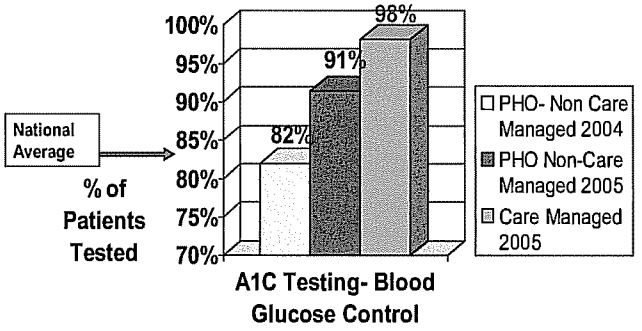
Supported by the MMC PHO, our care managers serve all patients, including MaineCare, Medicare, the commercially-insured, and the uninsured, and are offered to all of our primary care practices, at no charge to the patient or to the practice.

We have a three-year experience with this care management model, now with 20 RN care managers who serve 67 practices and 219 physicians. Because of the association with the physician and practice team, our care managers experience an 84% acceptance rate by the patients, much higher than other models. Over 2,500 patients (11% of these are MaineCare members) of our PHO primary care physicians are now being actively care managed.

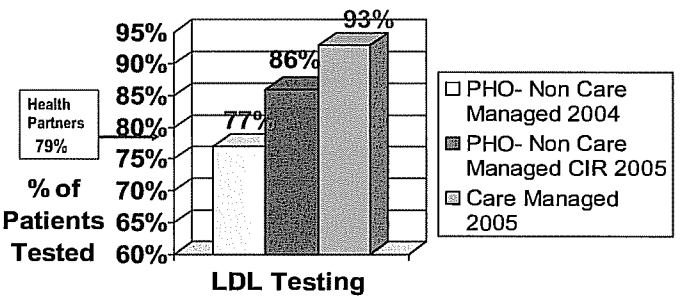
The following graphs illustrate the significant gains in the processes of diabetes care that can be demonstrated on the part of our physicians from our PHO program, with the red arrows indicating comparison with national benchmarks, when available. One can also see that those patients whose care included our care managers come closest to achieving the ideal care we are seeking.

Improved Processes of Care for Diabetes

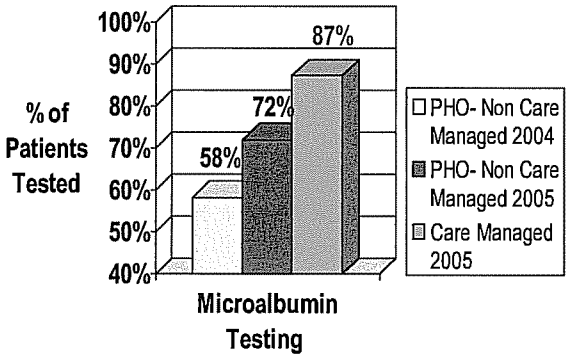
Testing for Blood Sugar Control



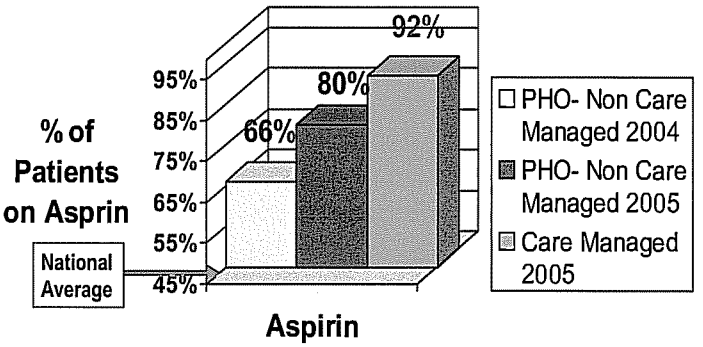
Testing for LDL ("bad cholesterol")



Testing for Urine Protein (Kidney Disease)

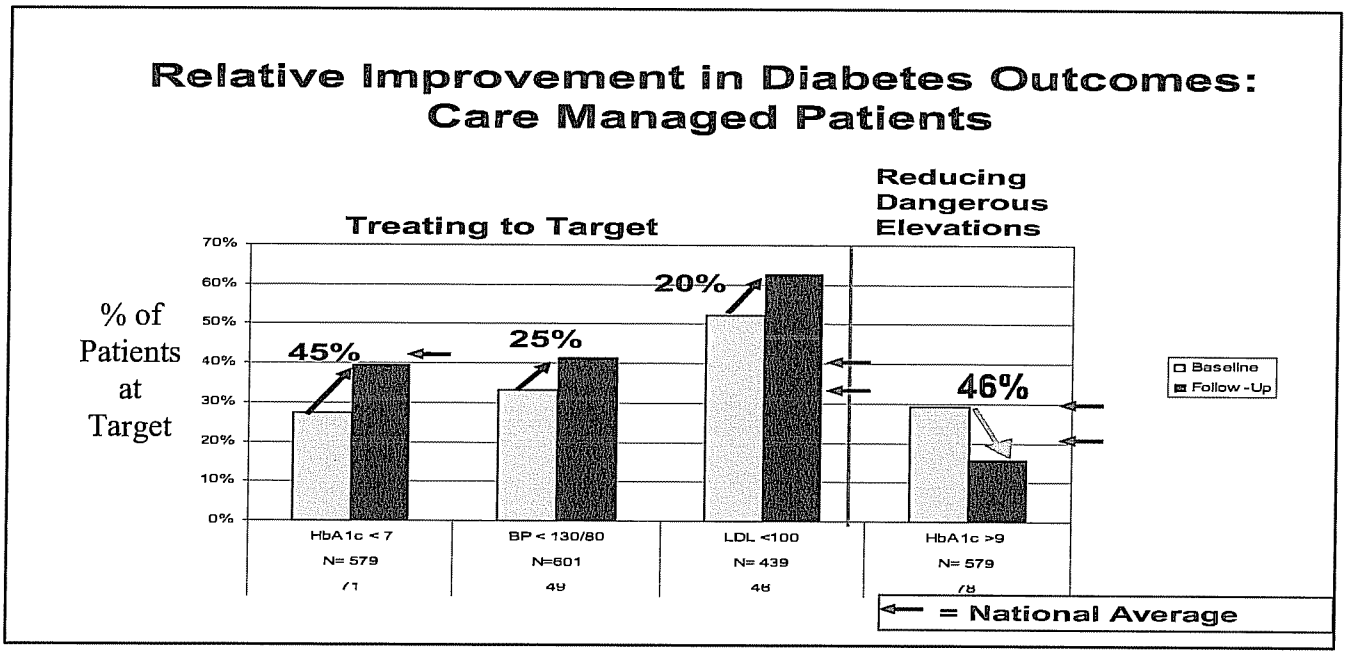


Aspirin Use



Most importantly, we can demonstrate significant gains in the outcomes of diabetes care, shown on the graph below. The goal is to treat the "ABC's" of diabetes "to target": the **A**1c indicator of blood sugar control, **B**lood pressure and LDL (the "bad" **C**holesterol). Controlling these risk factors, along with treatment with aspirin, will reduce the short-term (heart attack and stroke) and long-term (kidney failure, blindness, and amputation) complications of diabetes. Especially important is the right-hand column demonstrating the 46% reduction in the percentage of patients with dangerously high A1c levels, the patients most at risk for heart attack and stroke

Improved Outcomes in Diabetes



These data, indicating trends towards ideal care, translate to reduced suffering and cost savings from averted future complications of diabetes.

We in the healthcare industry and you as legislators need to shift our focus from *treating chronic illness* to *keeping people healthy* and preventing chronic illnesses and their complications. To the extent that we continue to shortchange necessary funding of preventive services in the budget crunch to meet the need for illness treatment, we perpetuate the dangerous upward spiral of healthcare costs. Given the evidence behind and the logic of the 20-80 and 50% rules and "penny-wise, pound-foolish" wisdom, it seems unwise that line items in the proposed budget include double digit millions for preventive services like patient care management and runaway billions for illness treatment, billions that will eventually become unaffordable unless we place more value on prevention.

Budget allocation for care management of chronic illnesses for MaineCare members is an important first step. To implement a coordinated care management program, the firm engaged by the department should work closely with organizations with programs already in place, like the MMC PHO. Next steps to consider include authorizing care management for MaineCare members as a reimbursable service to facilitate state wide implementation of a local, practice-based care management model like that of the MMC PHO.

In summary, we urge that you consider these points in your deliberations surrounding the MaineCare budget:

- Healthcare dollars invested upfront for improving prevention in chronic illness care will result in significant downstream savings
    - Sparing patient suffering
    - Reducing the high costs of treating the complications of chronic illness
- The patient side of improving preventive care can be strengthened significantly with dedicated and compassionate nurse care managers committed to improving the health status of the community.
- Success in engaging patients may be enhanced with local, physician-endorsed, practice-based care managers.

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May 24, 2007

Dear Sir or Madam,

It has come to my attention that the Maine Legislature through the Appropriations Committee is moving to adopt legislation that would limit MaineCare patients to four Brand Name prescriptions per month. As the President and CEO of the Arthritis Foundation for Northern and Southern New England, I ask that you not consider such legislation for the following reasons:

In the poorest and most vulnerable population, convincing people to remain compliant on their medications can be challenging; restrictive policies will only make it more difficult for these patients to maintain their medicines and to refill others.

Medicaid patients who are diagnosed with chronic and/or multiple conditions, such as diabetes and its related complications, will be most impacted.

In addition to jeopardizing the health of MaineCare patients, the limitation on treatment and the resulting noncompliance of medicinal therapy could increase acute care and long term care Medicaid expenditures, costing the state more money in the long-run.

Lastly, disruption of existing treatments can result in adverse health consequences and increase health care costs.

Again, I urge you not to consider such legislation as it would impact the most vulnerable population and prior studies show it would have negative clinical outcomes.

Sincerely,

Stephen Evangelista

President and CEO

State of Maine

Department of Health and Human Services
And
Office of Information Technology,
Department of Administrative and Financial Services

Memorandum

To: Senator Margaret Rotundo, Chair, Representative Jeremy Fischer, Chair and Joint Standing Committee on Appropriations and Financial Affairs
Senator Joseph Brannigan, Chair, Representative Anne Perry, Chair and Joint Standing Committee on Health and Human Services

From: DHHS Commissioner Brenda Harvey; Tony Marple, Director, OMS, DHHS; DHHS Deputy Commissioner Kirsten Figueroa

Cc: DAFS Commissioner Rebecca Wyke; Richard B. Thompson, CIO, OIT, DAFS

Date: April 20th, 2007

Re: Monthly MECMS and Fiscal Agent Progress Report for Activities through March 2007

Executive Summary

Federal Funding Update

DHHS and CNSI have agreed upon an operations and limited development contract that has received the endorsement from the Centers for Medicare and Medicaid Services (CMS). CMS also continues to be in close communication with DHHS as efforts continue on the transition to procuring a new MMIS system and fiscal agent operating model.

On April 18, 2007 CMS approved the "Planning Advance Planning Document" (PAPD) which was submitted the first week of April. The PAPD highlights the State's approach to all activities related to the planning and procurement of the new MMIS and fiscal agent contract. As a reminder, CMS partnership, including federal financial participation, is absolutely essential to any migration to the proposed fiscal agent model. This CMS approval provides DHHS with federal matching of 90/10 for all "planning" activities that will be performed.

Fiscal Agent Transition

DHHS is preparing for the transition to a new MMIS (currently MECMS) application and transition of most claims processing functions to a Fiscal Agent. This is expected to be a very complex, time and resource consuming effort. The current timeline for this transition would be no less than 18 months (typically 24-36 months). This plan was developed to address the usual and customary timeframes and costs, but it is DHHS' intention to move

this work with urgency and focus. During this time period, it is expected that MECMS will continue to operate as the core claims processing engine for MaineCare.

The following short term milestones have been established for the Fiscal Agent Planning effort and will be tracked and updated each month in this report.

Key Milestone	Target Completion Date	Actual Completion Date	CMS Approval	Status
Planning APD	5/15/07	4/9/07	4/18/07	G
Develop IAPD	9/3/07			Y
RFP Preparation Complete	10/17/07			Y
Proposal Scoring and Vendor Selection	3/17/08			Y
Contract Negotiations Complete	4/30/08			Y
MMIS Development Project Begins	6/2/08			Y

Milestone Descriptions:

- **Planning APD:** The date on which the development of the "Planning Advance Planning Document" (PAPD) is completed. The PAPD highlights the State's approach to all activities related to the planning and procurement of the new MMIS and fiscal agent contract and secures federal match of 90/10.
- **Develop IAPD:** The date on which the Implementation Advance Planning Document (IAPD) is completed. The IPAD includes all information for CMS' review and approval for activities and costs associated with the design, development and implementation of the new MMIS system development effort and fiscal agent contract.
- **RFP Preparation Complete:** Date on which the Request for Proposal (RFP) will be completed by the State and submitted to CMS for review and approval prior to distribution to the vendor community.
- **Proposal Scoring and Vendor Selection Complete:** The date on which the State will have completed its scoring of proposals submitted and the winning vendor is selected.
- **Contract Negotiations Complete:** The date that the selected vendor has completed negotiations with the State of Maine, resulting in a signed contract for the

development of the MMIS system and transition to the Fiscal Agent operating model.

- **MMIS Development Project Begins:** The date on which the development of the new Medicaid Management Information System (MMIS) transfer system will begin.

MECMS Update

Claims Processing Throughput

MECMS Throughput reached its highest auto-adjudication rate to date in February and March. The weekly claims adjudication rate (Paid + Denied claims) reached and exceeded 95% processing performance during the past two month.

- **The claims turn-around-time performance dipped slightly in March to 96% of all "fresh claims" processed within 14 calendar days after reaching an all-time high in February of 97.3%.** Also, MECMS and the claims unit staff were able to process 97.3% of all new claims within 30 calendar days in March after posting 98.3% performance rate in February. Commercial industry standard is 99% of claims processed within 30 calendar days.
- Claims volumes remained relatively consistent and no new production issues surfaced during the months of February and March.

Suspended Claims

Suspended claims inventory have been reduced to 63,961

- However, 22.2% of suspended claims have been suspended in the system for 330 days or more, with a billed charges value of nearly $15.1M.
- This performance and level of stability is expected to continue until such time as key MECMS production patches can be implemented, which should allow more suspended claims to be resolved, therefore reducing the overall inventory.

Interim Payments

The Interim Payment team continues to produce incremental reductions in total outstanding interim payment balances.

- Through April 20th, the balance of interim payments made to providers stands at $522.6 million.
- For the same timeframe, $339 million (65%) of interim payments have been recovered.
- Providers accounting for $69.5 million in interim payment balances are in a recovery plan.
- **The pre-2006 claims hold functionality was implemented successfully in MECMS on March 28th.** The recovery results of the first cycle in which pre-2006 claims were held amounted to $158,832 recovered from 116 claims.
- A production patch to extend the hold date to all claims submitted with dates of service prior to 10/1/2006, for Providers with interim balances, is being tested and will be implemented within the next month.

System Initiatives

DHHS and CNSI have contractually agreed upon a scope of work that will repair some of MECMS more critical outstanding defects. The scope of work includes nine system initiatives that are going to be defined, developed and implemented by CNSI and the MECMS Team over the coming months. The following table lists the system initiatives, provides a brief description of the repair effort, updates progress on targeted implementation dates and highlights overall initiative status. The MECMS Team is working aggressively with CNSI to improve all target dates provided in this table.

System Initiative	Description	Target "Go-Live" Date	Actual "Go-Live" Date	Status	Comment
Pre-2006 Claims Hold	Functionality to allow MECMS to hold any claim with a date of service before 2006 for any Provider with a balance of un-returned interim payments.	3/28/07	3/28/07	G	Implemented successfully. Ongoing results continue to be monitored closely.
J-Codes	Allow MECMS to identify J Codes by a corresponding National Drug Code (NDC) so that rebates can be collected.	6/7/07		G	Currently finishing User Acceptance Testing
Voids	Provide MECMS with the ability to process void claims submitted by providers, as well as allow system initiated voids of individual or batches of claims.	10/1/07		Y	Complex scope defined, Technical Design Plan under review
Limits	Correct MECMS logic that incorrectly adjudicates claims involving benefit or payment limits.	TBD		Y	Planning expected to be completed by 5/15/07
EPF	The correction of processing defects that cause claims to drop into a status of "edits processing failures".	1/7/08		G	Planning Completed 4/17/07, scope and requirements defined
Modifiers	Repair existing issues of incorrect identification of certain modifiers and correct the process of storing the sequence of modifiers as they are on a claim.	1/7/08		G	Planning Completed 4/17/07, scope and requirements defined
Cost of Care	The scope of Cost of Care (COC) is limited to COC calculation and application issues within the MECMS system only. COC issues having to do with interfaces (e.g., WELFRE) are out of scope for this project	TBD		Y	Planning expected to be completed by 5/15/07
Adjustments	Provide MECMS the ability to process adjustment claims, as well as conduct system initiated mass adjustments.	TBD		Y	Planning expected to be extend beyond 5/15/07
Co-Pays	Full scope is still TBD. Work is being conducted to understand MaineCare policy specification and current MECMS co-pay logic.	TBD		Y	Planning and scoping is expected to be completed by 5/15/07

Other Initiatives

- The new CMS 1500 form is being accommodated by a data entry solution that will have no impact to MECMS. Goold Health, MECMS data entry vendor, will be able to provide a work-around using their keying software to accommodate the new form changes. This solution is expected to be operational ahead of CMS' new implementation date of July 1st, 2007
- The CMS 2082 Report requires the submission of five files to CMS on a quarterly basis. MECMS has been unable to produce this report since the January 2005 go-live date. The MECMS team, working with the Decision Support System is now close to finalizing the missing extracts that should complete the 2082 file submissions.
- MR standardized rates are due to be applied July 1st, 2007. The MECMS team is currently working with the mental retardation subject matter and technical experts to outline the testing expectations and process for ensuring MECMS ability to accommodate the standardized rate changes.
- Production Patches are being carefully considered for their utility and potential impact on the system and its processing capabilities.

Past Expenditures

- Since August 2001 when the State entered into a contract with CNSI, approximately $53MM has been expended on the MECMS project.
    - $29MM has been paid to CNSI
        - $19.9 million for development of MECMS to date
        - $9 million for operations of MECMS.
    - Approximately $17MM has been paid to other contractors brought in to supplant CNSI.
- Of the $53MM, $23.6MM of general funds has been expended, including $13.9MM that would have been federal dollars under an approved APD.

MECMS Update April 20th, 2007

Claims Processing Performance

- The data, charts and graphs provided within the attachment to this document contain detailed information related to Claims Processing Throughput, Suspended Claims Inventory and Interim Payments.

System Throughput

Monthly Performance Recap

Total Claims Processed - March 2007	621,881

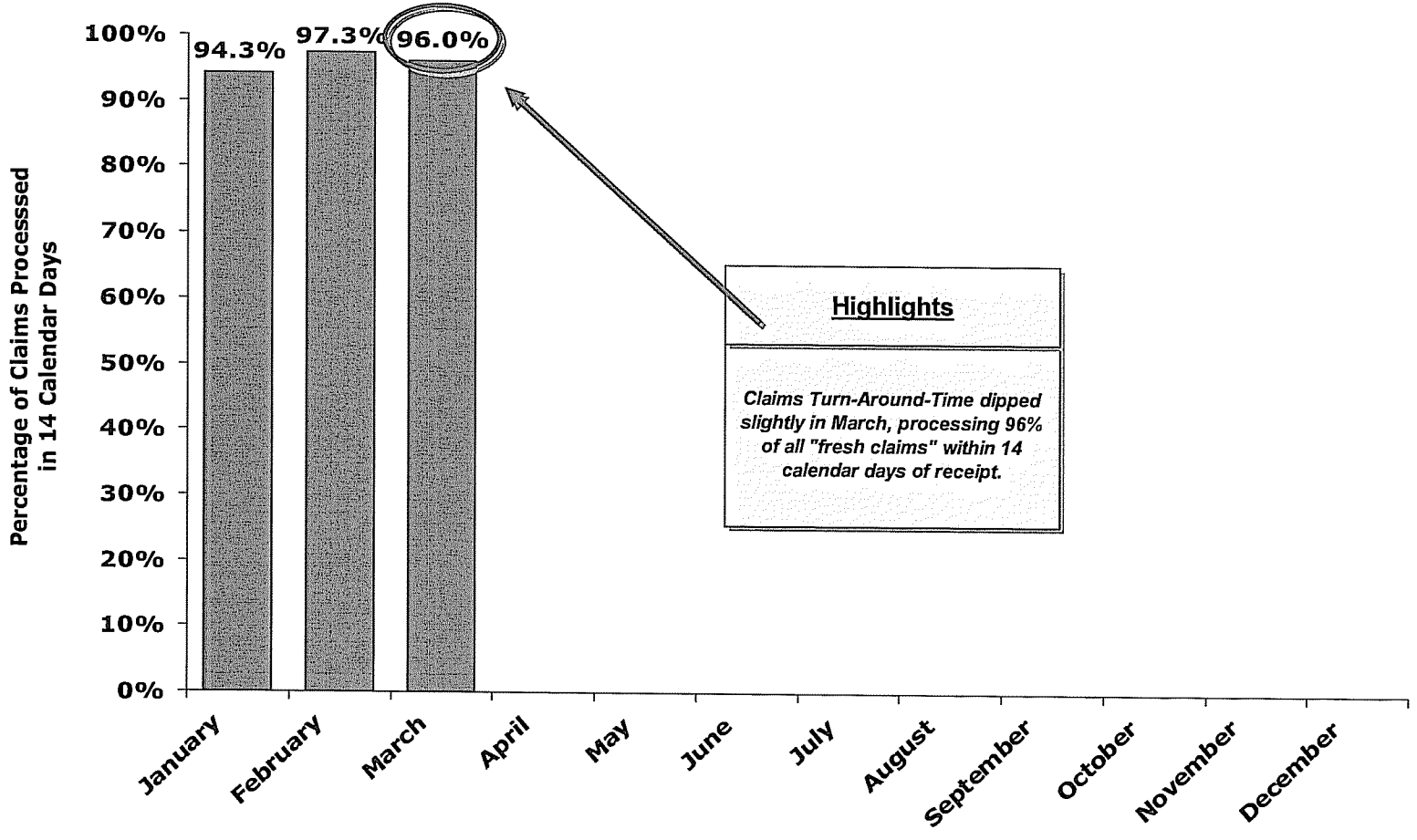
Fresh Claims	Total	591,860	95%
Claim Results	Volume	% of Total	$ Value
Total System Adjudicated	563,777	95%	
Paid	*494,748*	*84%*	$106,231,703
Denied	*69,029*	*12%*	
Suspended	28,083	5%	
Remaining Backlog	3,021	<1%	

Recycled Claims	Total	30,021	5%
Claim Results	Volume	% of Total	$ Value
Total System Adjudicated	25,008	83%	
Paid	*8,738*	*29%*	$3,083,339
Denied	*16,270*	*54%*	
Suspended	5,013	17%	
Adjudicated but not released			$10,172,077

Highlights

System Auto-Adjudication remained strong during March with 95% of all incoming fresh claims being processed immediately by the system without manual intervention. However, the total volume of claims currently held in MECMS increased again to a total of $10,172,077 in the past month.

System Throughput
Supporting Analysis



Suspended Claims
Monthly Recap

Total Suspended Inventory	Total	$ Value
February '07	61,462	$71,108,866
March '07	63,961	$72,135,706
Change	2,499	$1,026,840

Highlights

54% of all suspended claims are less than 90 days old. However, 22.2% of all suspended claims are more then 331 days old.

As of April 2nd, 2007

Days	Claim Inventory	% of Total Inventory	Billed Charges	% of Total Charges
0-30	21,827	34.1%	$20,049,857.30	27.8%
31-60	7,353	11.5%	$9,247,124.13	12.8%
61-90	5,368	8.4%	$6,624,293.58	9.2%
91-120	3,807	6.0%	$4,562,686.70	6.3%
121-150	2,566	4.0%	$2,364,776.44	3.3%
151-180	2,485	3.9%	$2,735,643.[illegible]	3.8%
Subtotal	**43,406**	**67.9%**	**$45,584,[illegible]1.33**	**63.2%**
181-210	1,448	2.3%	$1,81[illegible],644.10	2.5%
211-240	1,180	1.8%	$[illegible]98,227.24	3.6%
241-270	1,070	1.7%	$2,293,222.12	3.2%
271-300	1,099	1.7%	$1,876,358.28	2.6%
301-330	1,544	2.4%	$2,855,982.40	4.0%
331+	14,214	22.2%	$15,110,890.59	20.9%
Subtotal	**20,555**	**32.1%**	**$26,551,324.73**	**36.8%**
Total	*63,961*	*100.0%*	*$72,135,706.06*	*100.0%*

Interim Payments
Monthly Recap

IPRT Weekly Snapshot
Summary by Provider Recapture Initiative

Week Ending: April 20, 2007
Cycle week #42

Type	Count of Providers	As of April 20, 2007 Interim Payments	Recaptures and Returns	Agreements	Research	Pending	Balance	Suspended Claims
High Impact	156	$ 78,098,050	$ 58,735,965	$ 12,494,753	$ 6,867,331	$ -	$ 19,362,085	$ 913,526
Letter 2 Release	820	$ 190,754,131	$ 117,088,643	$ 27,579,268	$ 46,086,221	$ -	$ 73,665,488	$ 7,837,558
Ad-Hoc Recoveries	132	$ 14,582,490	$ 11,644,260	$ 206,068	$ 2,732,163	$ -	$ 2,938,231	$ 976,522
Schools	257	$ 12,131,177	$ 11,379,553	$ 751,624	$ -	$ -	$ 751,624	$ 13,681
MR Provider Recovery	674	$ 135,832,655	$ 105,365,144	$ 14,108,395	$ 15,540,008	$ 819,108	$ 30,467,510	$ 3,652,159
Phase III Recovery	2,455	$ 81,011,284	$ 31,093,538	$ 14,091,625	$ 13,119,877	$ 22,706,245	$ 49,917,746	$ 35,704,938
Pilot Recoveries	28	$ 10,254,327	$ 7,904,314	$ 216,747	$ 1,776,361	$ 356,905	$ 2,350,013	$ 767,692
Total	**4,522**	**$ 522,664,114**	**$ 343,211,417**	**$ 69,448,478**	**$ 86,121,960**	**$ 23,882,259**	**$ 179,452,698**	**$ 49,866,076**

Highlights

65% ($339M) of Interim Payments issued have been either Recaptured or Returned to the State.

Highlights

Of the $179.4M remaining to be collected, appoximately $69.5 are under agreement to be repaid

STATE OF MAINE
GOVERNOR'S OFFICE OF HEALTH POLICY AND FINANCE
15 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0078

JOHN ELIAS BALDACCI
GOVERNOR

TRISH RILEY
DIRECTOR

To: Appropriations and Financial Affairs Committee
From: Trish Riley and Karynlee Harrington
Subject: Funding the MaineCare Parent Expansion
Date: Monday, May 07, 2007

Please find outlined below our response to the questions raised last Friday afternoon.

Q: Does Dirigo prohibit SOP funds from paying for MaineCare parents?

R: Dirigo initially prohibited payment of MaineCare with SOP funds but that was revised in 2005. However, concerns continued about the feasibility of using SOP funds to match Medicaid for those who go directly to MaineCare and not through a Dirigo business. As a result, the Dirigo Health Agency agreed to continue to fund MaineCare expansion parents with state, not SOP, funds. (Please refer to the attached memo from Karynlee Harrington dated January 24, 2006) In addition the Legislature established the Savings Offset Payments Working Group in L.D 1577 (Chapter 400, Part B, Sec B-1), charged with defining "subsidy" within the Dirigo Health Program. The law states that the SOP funds the subsidy. That working group developed a definition of subsidy that does not include the cost of the parents that go directly to MaineCare.(Please find attached the Final Report to the Dirigo Health Agency, Board of Directors by the Savings Offset Payment Working Group, October 21, 2005.)

In summary, while the law was amended to allow SOP funds to fund MaineCare expansion parents, the Legislature asked Dirigo to assure that no SOP funds were so spent and further created a workgroup that reinforced the concern that SOP funds should not fund Dirigo parents unless they come through Dirigo employers

Q: What is the current language in statue specific to the parent expansion?

R: The language that created the parent expansion is found in 22 MRSA §3174-G(1)(E)):

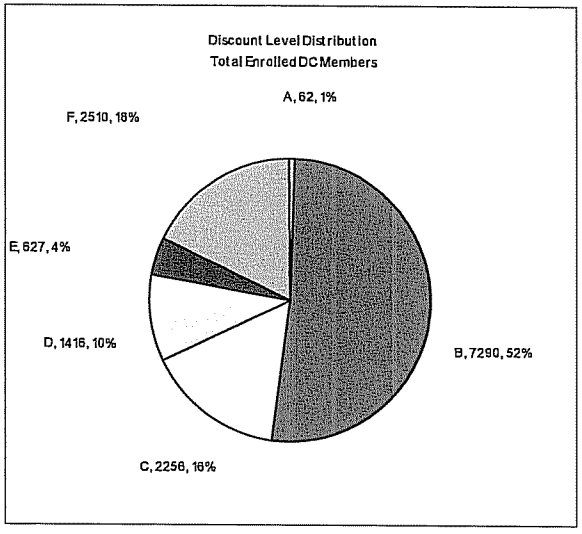
The parent or caretaker relative of a child described in paragraph B or D when the child's family income is equal to or below 200% of the nonfarm income official

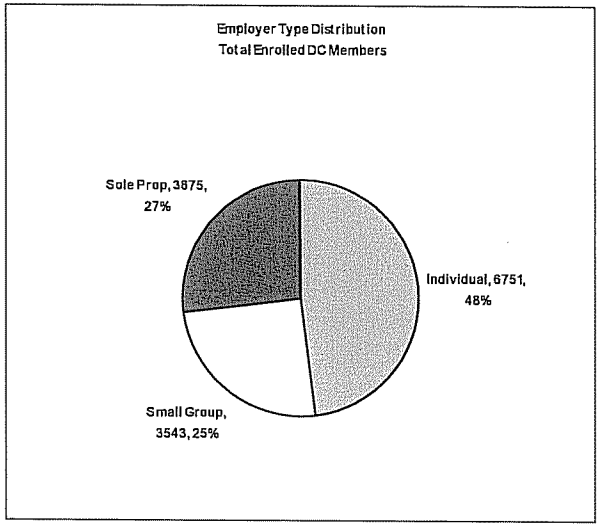
poverty line, subject to adjustment by the commissioner under this paragraph. Medicaid services provided under this paragraph must be provided within the limits of the program budget. Funds appropriated for services under this paragraph must include an annual inflationary adjustment equivalent to the rate of inflation in the Medicaid program. On a quarterly basis, the commissioner shall determine the fiscal status of program expenditures under this paragraph. If the commissioner determines that expenditures will exceed the funds available to provide Medicaid coverage pursuant to this paragraph, the commissioner must adjust the income eligibility limit for new applicants to the extent necessary to operate the program within the program budget. If, after an adjustment has occurred pursuant to this paragraph, expenditures fall below the program budget, the commissioner must raise the income eligibility limit to the extent necessary to provide services to as many eligible persons as possible within the fiscal constraints of the program budget, as long as the income limit does not exceed 200% of the nonfarm income official poverty line; and [2003, c. 469, Pt. A, §5 (amd); c. 673, Pt. Y, §3 (aff).]

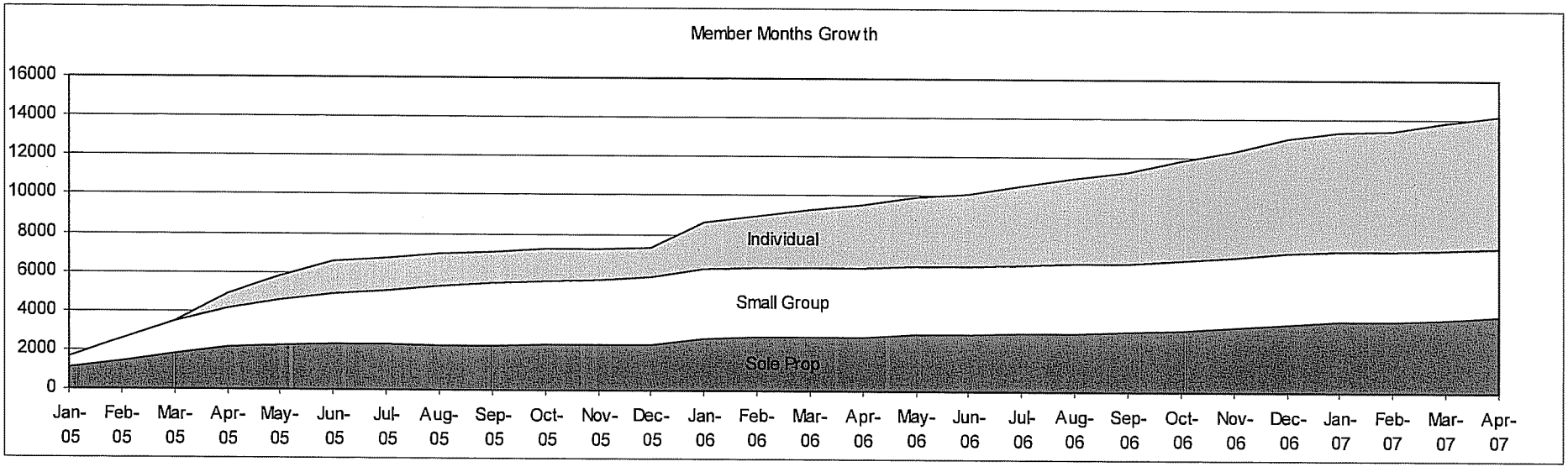
We would be happy to answer any additional questions.

Dirigo Health Monthly Numbers April 2007
Reported by Dirigo Health Agency 05/01/2007

Total Members Served, DC + Parents	25288
New DC Members	528
New Parents	72
Total Enrolled DC Members	14138
Total Enrolled Parents	5414
Total Enrolled DC Small Groups	732







Notes:

1. Total Members Served refers to the total number of members ever enrolled (beginning 01/01/2005) for any period of time in the DirigoChoice or MaineCare Parent Expansion programs
2, Total New Members refers to the number of new members enrolled in the reporting month.
3. Total Enrolled Members refers to the number of members currently enrolled in the reporting month.
4. Current report does not include April Parent Expansion numbers.

Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
Augusta, ME 04333-0011

John Elias Baldacci
Governor

Brenda M. Harvey
Commissioner

March 28, 2007

To: Senator Margaret Rotundo, Chair
Representative Jeremy R. Fisher, Chair
Members of the Joint Standing Committee on Appropriations and Financial Affairs

Senator Joseph C. Brannigan, Chair
Representative Anne C. Perry, Chair
Members of the joint Standing Committee on Health and Human Services

From: Brenda M. Harvey, Commissioner

Subject: Summary of transfers to the Department of Health and Human Services from the Dirigo Health Agency

The following summarizes the revenue transfers related to the expansion of parents to the Department of Health and Human from the Dirigo Health Agency. The change package entries on pages 53 and 78 are meant to align actual transfers with the allocations.

- The parent expansion, covering parents with federal poverty levels of 151-200%, occurred as a result of PL 2003, chapter 469, and started in May 2005.
- For the period May 2005 through June 2006, $2.7MM for parent expansion costs was transferred to DHHS. This is the state share of charges paid to providers, pharmacy charges, and hospital costs. This timeframe was recently reconciled to ensure all costs paid through MECMS have been included. As a result of this true up, Dirigo Health Agency will transfer an additional $178,269 to DHHS.
- For the period July 2006 through December 2006 (January 2007 for pharmacy), $2.1MM for parent expansion costs was transferred to DHHS.
- In fiscal year 2005, $2.1MM in administrative dollars were transferred to DHHS to be used for eligibility determination staff, member services, contractual items, and an eligibility liaison. Approximately $168,000 remains, and are anticipated to be used to cover the costs of an EQRO review.
- Approximately $12.9MM in total costs, state and federal, have been expended for this expansion group. In FY07, parent expansion population has averaged 5,000 people.

Through December 2006 (January 2007 for pharmacy), DHHS has billed the Dirigo Health Agency for all charges DHHS has paid for relating to parent expansion. If it hasn't come through MECMS or MEPOPS, we haven't yet billed Dirigo, but we've billed them for everything that has. Parent expansion costs (charges paid to providers and hospital costs) will be invoiced to Dirigo Health Agency quarterly. Dirigo Health Agency will continue to transfer pharmacy costs monthly upon receipt of the MEPOPS report.

Perspectives On Funding Outpatient Mental Health Services In Maine

by Keith Cook, Ed.D., Licensed Psychologist April 2007
Waterville, ME

As a healthcare professional with over 35 years of experience, I am writing to offer information and perspectives on Medicaid (MaineCare) costs for outpatient mental health services in Maine and some ways that savings could be ethically achieved. This paper addresses three major areas of interest: 1) MaineCare costs, overhead and profits, 2) the fallacy of managed care for outpatient services, and 3) a new alternative model for funding healthcare including MaineCare.

1. MaineCare Costs, Overhead and Profits.

A few years ago someone realized there were profits to be made in poverty. Organize yourself as a for-profit outpatient mental health center, sign up masters degree counselors who cannot directly bill MaineCare to provide mental health services, contract with MaineCare to bill them $110. - $120. for each client hour, pay counselors $55./hour, use part of the remaining $55.-$65./hour to cover your administrative overhead and bank the substantial profit.

This model operates with 50-54% administrative overhead and profit. By comparison, Medicare operates at 8-12% overhead and most commercial insurers at 20-25%. One can readily see how a significant profit is generated. Earning a profit is good business. But should it be with public funds and at the expense of delivering fewer services to people in need?

Other mental health professionals have quickly recognized the opportunity in this model, often simply a robust billing service, and have initiated similar groups across the State through which masters degree counselors can serve MaineCare clients, and the owner/administrator can generate a handsome profit. It is quite predictable under these circumstances that more professionals will continue to follow suit and more funds will go to administration and profit rather than to client services. With less available funding, it appears to make a case for needing managed care to "use funds carefully" which creates additional bureaucracy and administrative jobs and profits to provide such oversight. (See Section 2 for further discussion of that issue.)

Simultaneously with this growing bureaucratic situation there is another currently operating model of delivery and funding of outpatient mental health services to MaineCare clientele. For many years, Maine doctoral level psychologists in private practice have successfully provided these outpatient mental health services and billed DHHS directly. They are currently paid $55.81/hour. Out of this $55.81 psychologists pay or provide their own overhead and administrative costs such as office rent and utilities, billing service, liability insurance, office equipment, social security self-employment tax, continuing professional education and licensing, bookkeeping, case consultation. After paying this overhead the remainder pays them for the service rendered to the client.

Compare these figures with groups that contract with DHHS for $110- 120./hour and you can readily see not only the inequities but also the potential for saving funds and/or increasing services to Maine residents. While I do not have access to exact figures, the following example will demonstrate the potential for savings.

Example: Suppose "Mental Health Billing Agency A" contracts with 50 mental health counselors (LCPC's and LCSW's) and bills MaineCare on their behalf for delivering outpatient mental health services.

If each counselor sees 60 clients/year (5/month, a conservative figure because some counselors are part time) for an average of 8 sessions/client.*

- 50 counselors x 60 clients each = 3000 clients/year
- 3000 clients x 8 sessions each = 24,000 client sessions billed annually to MaineCare.

~~ So let's compare ~~

• Billing Agency A

24,000 sessions x $110./hr. = $2,640,000.
24,000 sessions x $120./hr. = $2,880,000.

• Independent Practice Psychologists

24,000 sessions x $55.81/hr. = $1,339,440.

Difference = **$1,300,560. - $1,540,560. potential savings for one agency.**

• For 10 such agencies = over **$13 - 15 Million potential savings in administration, overhead and profit.**

{***NOTE**: 8 sessions is a conservative average number of sessions per client. National research shows that the modal number of therapy sessions for people in counseling is 1 session. The distribution is actually bi-modal, with another peak at 12 sessions. Naturally, a few people need much longer therapy, so 8 is a conservative average. It could actually be higher.}

This discussion is not to imply that true mental health agencies should not be funded. It is to demonstrate that millions of dollars can be used differently for services to people rather than to support bureaucracy, administrative overhead and profit in what are largely billing services. And as will be seen in Section 2, with these kinds of savings from changing policy, structure and procedures, it becomes unnecessary to appropriate additional millions of dollars to hire a managed care company. Existing organizations such as those that already process Federal Medicare claims with far less overhead could be employed to handle claims processing.

This discussion is also not to imply that all outpatient mental health services should be provided by private practice psychologists.

One Possible Solution. One way to assure adequate numbers of mental health professionals providing services across the State while reducing the costs of administration and profit would be to allow licensed masters level mental health professionals (LCSW's and LCPC's) to directly bill MaineCare for the outpatient services they provide, let them pay their own overhead out of what they are paid just as psychologists have done for years, and let market forces work. This would give the public a greater array of service professionals from which to choose, and stimulate professionals to improve and become more creative in the quality of their services. Clients in the MaineCare community talk to each other. Word spreads quickly.

The DHHS current solution to "contain costs" is to limit clients to 16 sessions/year if they are seeing a private practice psychologist (the most cost-effective service). If the client is going to a more costly agency they are permitted unlimited sessions. This is both inequitable and illogical. It also pushes psychologists themselves to form or join the more administratively costly mental health center model in order to be able to effectively treat seriously traumatized clients who need longer treatment. It is easy to see why increasing numbers of professionals will take this more costly direction as time goes along.

Additionally, the number of psychologists currently accepting MaineCare clients has dropped significantly over the past nine years. In 1998 there were 445. In 2000, 233. In 2004, 179. A drop of 266 or 59.8%. We are approaching a two-tier system of mental health care where the more highly educated and trained professionals tend not to serve low income or disabled people even though their trauma or disability may be a major factor in their remaining low income. Most want to be self-supporting. Resolution of trauma and coping with disability is often essential for this to occur.

2. About Managed Care for Outpatient Mental Health Service.

Managed care started as a way to contain healthcare costs but, as most today recognize, it has become a way to maximize profits for insurance companies by denying services to patients. It has turned out to be an attempt whose time has passed. Even one of the originators of the idea of Managed Care, Robert Gumbiner, MD, has called the current system a failure, saying we need some kind of national system to pay for healthcare. (Physicians for a National Health Program web site. http://www.pnhp.org/)

I urge you not to slip into the common trap of a decision-making body under pressure, i.e. settling on an idea that has peaked and proven to not work without realizing that has occurred. The consequences are too serious.

Managed care for outpatient mental health is based on several assumptions:

a. People use therapy unnecessarily and excessively.
b. People are clamoring to get into counseling.
c. Large amounts of money are wasted on therapy.
d. Unethical therapists keep people in therapy when they want to stop.
e. You can save money by paying a corporation to determine who needs therapy and for how long.

For outpatient mental health services, research as far back as 1995 has demonstrated these assumptions to be unsupported, and that managed care is unnecessary. None other than Consumer Reports magazine (Nov. 1995) conducted the largest consumer-focused study ever on the benefits and value of counseling and psychotherapy as experienced by ordinary consumers. Among their interesting findings -

- Outpatient therapy is not used excessively. People know when they are ready to stop and they do.

- Those who use more of it, know when they need it and benefit from it.

- People do not need to have their therapy managed because it is not used excessively or unnecessarily.

- Outpatient therapy is essentially self-limiting.

And beware of the patronizing, demeaning and inaccurate belief advanced by some that MaineCare clients don't know what they need and can't decide for themselves.

Still other research on the use of free counseling, such as EAP's, has found that even when it is free, people don't use more of it than if they were paying. They know when they are ready to stop, and they do. Remember, nationally the modal number of counseling sessions used is 1.

This fits with professional experience. Many people starting counseling tell us that they do so with apprehension and after much deliberation, sometimes for months. They don't just jump into it. It has been profitable, however, for insurance companies to promulgate the belief in rampant overuse in order to justify managing care and generating larger profits. This myth of overuse is also useful for administrators in some top-heavy agencies to justify the need for their role.

Medicaid managed care in New Mexico from 1997 - 2001 led to administrative burdens, payment problems, stress, and high turnover among professionals. (See Appendix A.)

The research literature is clear that outpatient mental health services are cost-effective in that they often *offset* higher medical costs that may occur without these services.

It is evident that any savings from managed care result from -

a. denying necessary services to people who are least able to advocate for themselves.
b. using funds that could go to patient services to pay external corporations to deny services.

In a carefully constructed Integrated Care Plan, Bell South, using no managed care until after 52 sessions per year reported a 20% decrease in mental health costs.

Managed care has continued because people have been led to believe it is needed and insurance companies and administrative agencies have generated massive profits with it.

3. Balanced Choice: A New National Health Care Model.

This section is offered to inform you of a new way to think long term about funding health care including MaineCare for mental health. This issue will not be fully resolved in this Legislative session. It will continue to recur until an enduring plan is in place that truly addresses the needs of consumers, employers and professionals.

The problem of the increasing cost of health care in the United States has been a growing concern for the past 15 - 20 years. Initially, insurance companies attempted to control costs and increase profits with managed care and rationing services. This approach has produced very mixed results ranging from showing some savings to wreaking havoc with lives of many people in need of treatment. It has met with increasing disfavor by both the public and the professional community.

Among its failings, managed care has not addressed one of the significant root causes of increasing health care costs. Specifically that Americans have come to expect insurance to do a job it was not designed to do - i.e. cover the cost of almost all of our health care. We expect our insurance to pay for doctor's visits, hospital stays, outpatient treatment, inpatient treatment, prescriptions, services of allied health professionals, medical equipment, etc. Insurance was never designed to do this for all of us.

Insurance was designed to provide the security of knowing that if you were injured or sick, then you would receive help in paying for necessary medical services. It has operated on the principle that the cost of treatment for the few who will need it is paid for by everyone paying an insurance premium. You never know when you will become one of the few in need. Now, however, what was designed to pay for services for the few, has come to be expected to pay for services for all and costs have escalated. By analogy, we don't expect automobile insurance to pay for routine maintenance and repairs. Only some policyholders file claims.

Many are recognizing that conventional insurance is now outmoded. Saul Friedman in Newsday recently quoted Dr. Marcia Angell, Senior Lecturer at Harvard Medical School and former editor of the New England Journal of Medicine, who wrote in the Boston Globe about the problem with private, for-profit insurance companies. *"They all have the same fatal flaw ... no workable mechanism to control costs. ... We need to change the system completely and get the insurance industry as well as employers out of it."*

A new model and a new way to think about funding health care is necessary. Balanced Choice is just such a model. This creative, robust plan is a nonprofit, nonpartisan initiative that covers all citizens for life, that reduces costs to employers, and that allows professionals the freedom to practice. It redirects $258 billion of administrative overhead to increase coverage for the uninsured and reduce costs to employers, truly a breath of fresh air in the staleness of healthcare finance. How does it work? Is this a single payer model with government controls? Not really, but somewhat. Is this a market driven model of free enterprise? Yes, but not entirely. Dr. Ivan Miller's new book masterfully melds the best of both private and government models into this exciting new plan. It is being advanced by a national team of volunteers working on their own time and expecting no compensation other than knowing they have helped create a better way to fund and provide health care that is helping millions of American adults and children cradle to grave, that is reducing employers' costs which helps with economic development, and that allows professionals to use their expertise without interference in delivering services.

You probably have not yet heard of Balanced Choice because it is a grassroots effort and has no budget for advertising. It is a model that is conceptually well developed and needs mathematical modeling as the next step closer to implementation. Bright, creative and forward-looking legislators can help provide leadership for this to happen.

You will find more information at: http://www.balancedchoicehealthcare.org/index.html

Appendix A

Willging, C., Waitzkin, H., and Wagner, W. (August, 2005). "Medicaid managed care for mental health services in a rural state." *Journal of Health Care for the Poor and Underserved* 16, pp. 497-514.

In 1997, the rural State of New Mexico, in which one of every five people holds Medicaid coverage, implemented Medicaid managed care for both physical and mental health services. The reform led to administrative burdens, payment problems, stress, and high turnover among providers. In addition, restrictions on inpatient and residential treatment worsened access problems for Medicaid-insured individuals with mental health problems, according to this study. These findings suggest that for rural, medically under served States, the advantages of managed care for mental health care may be diminished.

The investigators conducted interviews, made field observations, and reviewed legal documents and State monitoring data to examine the impact of Medicaid reform on mental health safety net institutions and on the patients they served in an urban and rural county in New Mexico. MMC made it increasingly difficult for safety net institutions to maintain their tradition of service to the poor. Patients also faced greater barriers in obtaining inpatient care and community-based services such as outpatient therapy and case management.

Continuity of care for some patients became compromised when their providers ceased participation in Medicaid because of work-related stress and low reimbursements. Reduced case management, due to large caseloads and low wages, decreased coordination of mental health. Social services tasks fell to clinicians or were neglected entirely. Sixty child and adolescent mental health programs closed between 1998 and 2001, and one hospital ended its adolescent residential treatment program to conserve financial resources.

NOTE: Colorado has also recently discontinued managed care for its Medicaid clients because it has become financially unworkable.

MaineCare CASELOAD

	Traditional Medicaid	SCHIP Medicaid Expansion	SCHIP "Cub Care"	Medicaid Expansion Parents ≤ 150% FPL	Non-Categorical Adults ≤ 100% FPL	Medicaid Expansion Parents >150% FPL	SUBTOTAL	DEL\Maine RX Drug Programs	TOTAL
Oct-04	205,195	9,985	4,454	17,657	22,623	0	**259,914**	98,662	**358,576**
Nov-04	205,862	10,011	4,420	17,904	23,072	0	**261,269**	98,588	**359,857**
Dec-04	207,217	10,064	4,372	17,821	23,669	0	**263,143**	98,515	**361,658**
Jan-05	207,966	10,150	4,225	18,116	24,383	0	**264,840**	98,514	**363,354**
Feb-05	208,138	10,087	4,127	17,972	24,925	0	**265,249**	98,611	**363,860**
Mar-05	209,545	10,067	4,000	18,078	24,460	0	**266,150**	98,942	**365,092**
Apr-05	210,550	10,040	3,899	18,070	23,333	0	**265,892**	96,318	**362,210**
May-05	210,394	10,165	3,816	18,270	22,021	611	**265,277**	95,006	**360,283**
Jun-05	210,096	10,047	3,942	18,354	20,556	1,631	**264,626**	92,697	**357,323**
Jul-05	209,973	10,073	4,076	18,339	19,248	2,442	**264,151**	90,084	**354,235**
Aug-05	209,974	10,145	4,200	18,319	18,029	3,075	**263,742**	90,018	**353,760**
Sep-05	209,806	10,106	4,262	18,447	16,895	3,766	**263,282**	91,875	**355,157**
Oct-05	210,191	10,220	4,360	18,587	15,933	4,040	**263,331**	93,247	**356,578**
Nov-05	210,502	10,254	4,498	18,607	15,087	4,288	**263,236**	89,773	**353,009**
Dec-05	210,666	10,200	4,505	18,453	13,634	4,340	**261,798**	90,360	**352,158**
Jan-06	211,114	10,417	4,504	18,669	12,972	4,545	**262,221**	89,237	**351,458**
Feb-06	212,099	10,408	4,482	18,671	12,462	4,749	**262,871**	88,944	**351,815**
Mar-06	213,767	10,111	4,568	18,500	11,824	4,907	**263,677**	86,548	**350,225**
Apr-06	213,195	10,276	4,504	18,749	11,430	5,010	**263,164**	85,735	**348,899**
May-06	213,410	10,235	4,489	18,776	11,058	5,091	**263,059**	84,463	**347,522**
Jun-06	213,643	10,270	4,509	18,876	10,795	5,108	**263,201**	84,780	**347,981**
Jul-06	212,833	10,325	4,483	18,920	10,872	5,048	**262,481**	84,119	**346,600**
Aug-06	212,515	10,310	4,504	18,824	16,123	5,100	**267,376**	78,888	**346,264**
Sep-06	212,686	10,264	4,505	18,730	18,091	5,005	**269,281**	76,213	**345,494**
Oct-06	212,938	10,343	4,530	18,891	19,249	5,090	**271,041**	74,707	**345,748**
Nov-06	212,796	10,292	4,533	18,918	20,249	5,129	**271,917**	73,691	**345,608**
Dec-06	213,104	10,216	4,609	18,955	20,910	5,194	**272,988**	73,640	**346,628**
Jan-07	213,955	10,298	4,638	19,051	20,356	5,249	**273,547**	74,479	**348,026**
Feb-07	214,345	10,075	4,632	18,959	19,483	5,342	**272,836**	75,210	**348,046**
Mar-07	215,380	9,913	4,615	18,806	20,134	5,414	**274,262**	75,302	**349,564**
Apr-07	215,513	9,922	4,601	18,985	19,351	5,377	**273,749**	75,634	**349,383**

DHHS Eligibility Descriptions:

- Traditional Medicaid includes adults and children in receipt of a financial benefit (TANF, IV-E); aged and disabled persons in receipt of a financial benefit (SSI, SSI Supplement), institutionalized persons (NF), and others not included below.
- SCHIP (State Child Health Insurance Program) Medicaid Expansion Children (M S-CHIP) (effective July 1998) are children with family incomes above 100% and up to and including 150% of the Federal Poverty Level
- SCHIP "Cub Care" Children (S S-CHIP) (effective July 1998) are children with family incomes above 150% and up to and including 200% of FPL.
- Medicaid Expansion Parents are persons who function as the primary caretakers of dependent children and whose income is above 100% and up to and including 150% of FPL (effective September 2000); and beginning May 2005, up to and including 200% of FPL.
- Non-Categorical Adults (effective October 2002) are persons who are over 21 and under 65, not disabled, not the primary caretakers of dependent children, and whose income is not more than 100% of FPL.
- DEL\MaineRX Drug Programs include persons eligible for Medicaid, but not for "full benefits" (e. g., QMB, SLMB, QI) who meet the criteria for participation in DEL and/ or Maine Rx; and persons who meet ONLY the criteria for participation in DEL and/ or Maine Rx.

MaineCare CASELOAD

	Traditional Medicaid	SCHIP Medicaid Expansion	SCHIP "Cub Care"	Medicaid Expansion Parents ≤ 150% FPL	Non-Categorical Adults ≤ 100% FPL	Medicaid Expansion Parents >150% FPL	SUBTOTAL	DEL\Maine RX Drug Programs	TOTAL
Jul-01	160,039	6,629	3,593	10,410	0	0	**180,671**	55,916	**236,587**
Aug-01	159,946	6,686	3,601	10,957	0	0	**181,190**	59,265	**240,455**
Sep-01	160,408	6,877	3,612	11,243	0	0	**182,140**	62,468	**244,608**
Oct-01	161,379	7,209	3,707	11,522	0	0	**183,817**	65,282	**249,099**
Nov-01	162,219	7,456	3,931	11,758	0	0	**185,364**	92,728	**278,092**
Dec-01	163,662	7,690	4,068	12,188	0	0	**187,608**	109,411	**297,019**
Jan-02	166,222	7,963	4,137	12,665	0	0	**190,987**	109,384	**300,371**
Feb-02	167,920	8,194	4,218	13,060	0	0	**193,392**	110,143	**303,535**
Mar-02	169,974	8,484	4,346	13,543	0	0	**196,347**	110,898	**307,245**
Apr-02	171,777	8,698	4,401	13,800	0	0	**198,676**	111,401	**310,077**
May-02	173,222	8,913	4,243	13,922	0	0	**200,300**	112,140	**312,440**
Jun-02	173,613	9,029	4,130	14,052	0	0	**200,824**	111,726	**312,550**
Jul-02	174,393	9,208	4,069	14,330	0	0	**202,000**	112,071	**314,071**
Aug-02	175,329	9,199	4,065	14,425	0	0	**203,018**	112,430	**315,448**
Sep-02	176,047	8,442	4,061	13,147	0	0	**201,697**	112,897	**314,594**
Oct-02	181,134	8,294	4,079	13,500	2,846	0	**209,853**	111,811	**321,664**
Nov-02	184,050	8,328	4,307	14,245	5,571	0	**216,501**	110,778	**327,279**
Dec-02	185,859	8,415	4,449	14,379	7,774	0	**220,876**	109,864	**330,740**
Jan-03	190,665	7,954	4,575	13,727	10,036	0	**226,957**	108,851	**335,808**
Feb-03	190,905	8,414	4,619	14,665	11,535	0	**230,138**	107,025	**337,163**
Mar-03	192,472	8,504	4,684	14,778	12,845	0	**233,283**	102,669	**335,952**
Apr-03	193,887	8,413	4,752	14,778	13,719	0	**235,549**	98,551	**334,100**
May-03	195,694	8,023	4,697	14,387	14,591	0	**237,392**	94,175	**331,567**
Jun-03	195,499	7,943	4,720	14,400	15,007	0	**237,569**	90,373	**327,942**
Jul-03	196,151	7,944	4,701	14,300	15,538	0	**238,634**	86,277	**324,911**
Aug-03	196,291	8,221	4,709	14,396	15,853	0	**239,470**	82,078	**321,548**
Sep-03	198,110	8,056	4,808	14,195	16,248	0	**241,417**	80,212	**321,629**
Oct-03	200,419	7,940	4,890	12,064	16,854	0	**242,167**	80,055	**322,222**
Nov-03	199,704	8,011	4,853	12,900	17,176	0	**242,644**	79,810	**322,454**
Dec-03	198,172	8,281	4,804	13,639	17,458	0	**242,354**	79,806	**322,160**
Jan-04	201,189	8,225	4,693	13,542	18,344	0	**245,993**	102,052	**348,045**
Feb-04	201,928	8,369	4,712	14,110	19,086	0	**248,205**	103,667	**351,872**
Mar-04	201,924	8,916	4,577	15,428	19,859	0	**250,704**	104,290	**354,994**
Apr-04	202,258	9,169	4,491	15,952	20,262	0	**252,132**	101,574	**353,706**
May-04	202,690	9,408	4,449	16,393	20,552	0	**253,492**	99,767	**353,259**
Jun-04	202,923	9,483	4,484	16,681	20,901	0	**254,472**	98,977	**353,449**
Jul-04	203,722	9,634	4,481	16,942	21,376	0	**256,155**	98,914	**355,069**
Aug-04	203,765	9,684	4,489	17,054	21,712	0	**256,704**	98,879	**355,583**
Sep-04	204,625	9,816	4,397	17,486	22,194	0	**258,518**	98,761	**357,279**

Updated 5/18/07

Prepared by the Office of Fiscal and Program Review from DHHS-OMS Data
g:\ofpr\humserv\medicaid\MaineCare Caseload\OFPR Summary

DEL/ Me Rx Caseload
Department of Health and Human Services

	MaineCare Eligible				NOT MaineCare Eligible				Grand Total			
	ME Rx only	DEL and Me Rx	DEL only	TOTAL	ME Rx only	DEL and Me Rx	DEL only	TOTAL	ME Rx only	DEL and Me Rx	DEL only	TOTAL
July 2005	233	8,405	3	8,641	47,997	33,444	2	81,443	48,230	41,849	5	90,084
August 2005	767	8,023	1	8,791	48,027	33,196	4	81,227	48,794	41,219	5	90,018
September 2005	147	8,705	1	8,853	49,734	33,285	3	83,022	49,881	41,990	4	91,875
October 2005	5	9,101	0	9,106	50,518	33,620	3	84,141	50,523	42,721	3	93,247
November 2005	1	9,112	1	9,114	47,698	32,958	3	80,659	47,699	42,070	4	89,773
December 2005	0	9,183	0	9,183	48,441	32,736	0	81,177	48,441	41,919	0	90,360
January 2006	0	9,364	0	9,364	48,524	31,349	0	79,873	48,524	40,713	0	89,237
February 2006	0	9,847	0	9,847	48,276	30,821	0	79,097	48,276	40,668	0	88,944
March 2006	0	10,554	0	10,554	46,637	29,356	1	75,994	46,637	39,910	1	86,548
April 2006	0	11,686	0	11,686	46,366	27,682	1	74,049	46,366	39,368	1	85,735
May 2006	0	13,265	0	13,265	45,722	25,475	1	71,198	45,722	38,740	1	84,463
June 2006	0	14,281	1	14,282	46,295	24,201	1	70,497	46,295	38,482	2	84,779
July 2006	0	14,717	0	14,717	45,729	23,672	1	69,402	45,729	38,389	1	84,119
August 2006	0	15,042	0	15,042	40,506	23,339	1	63,846	40,506	38,381	1	78,888
September 2006	0	15,229	0	15,229	37,700	23,283	1	60,984	37,700	38,512	1	76,213
October 2006	0	15,482	0	15,482	36,147	23,078	0	59,225	36,147	38,560	0	74,707
November 2006	0	15,691	0	15,691	35,124	22,876	0	58,000	35,124	38,567	0	73,691
December 2006	0	15,863	0	15,863	34,836	22,941	0	57,777	34,836	38,804	0	73,640
January 2007	1	16,070	0	16,071	35,617	22,791	0	58,408	35,618	38,861	0	74,479
February 2007	1	16,214	0	16,215	36,404	22,591	0	58,995	36,405	38,805	0	75,210
March 2007	0	16,960	0	16,960	35,987	22,355	0	58,342	35,987	39,315	0	75,302
April 2007	0	30,701	0	30,701	36,639	8,294	0	44,933	36,639	38,995	0	75,634

Please Note:

Due to the change in DEL eligibility guidelines (particularly converting many DEL eligibles to Qualified Medicare Beneficiary (QMB – "Quimby") status; i.e. increasing the income disregard) there are significant (anticipated) count changes this month compared to prior months in the DEL-related columns on the MaineCare Caseload report and the DEL/Me Rx Caseload report.

Per Chapter 332: MaineCare Eligibility Manual – Section 3200.10

A Qualified Medicare Beneficiary is an individual who:

I. is entitled to Medicare Part A or voluntarily enrolled in Medicare Part A, and

II. has income equal to or less than 100% of FPL.

Under this group:

A. Medicaid pays the cost of Medicare premiums, deductibles and coinsurances. (See Appendix 3-1.)

B. an individual may be eligible for QMB and Medicaid at the same time.

C. coverage begins the month after an eligibility decision is made. There is no 3 month retroactive period; and

D. effective January 1, 2006, there is no asset limit.

http://www.medicareadvocacy.org/FAQ_MedicareSavingsProgs.htm

Friends of the Fund for a Healthy Maine

April 2007

Explanation of Scheduled FY08/FY09 Program Allocations

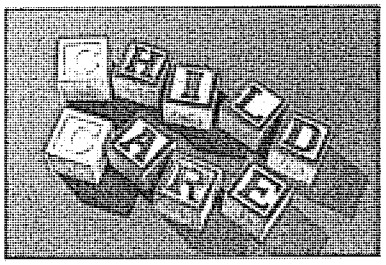
Overview

The Fund for a Healthy Maine (FHM) payments have been scheduled since 1998 when the tobacco settlement was agreed upon by the 46 participating states (including Maine). The schedule called for several up-front payments (1999 – 2000), a short period of gradually increasing payments (2001 – 2003), followed by a four-year dip in payments (2004 – 2007), and a subsequent bump up in payments with regular small increases from that point on (2008 and beyond).
(See chart of MSA payments attached)

The Fund for a Healthy Maine (FHM) has seen over $93 million in settlement funds diverted to the General Fund since 2001. The original plan to set aside some of the up-front payments in a Trust Fund to be used to offset the period of the payment dip was scrapped in 2001. Programs were cut and then left without the safety net of the Trust Fund.
(see pie charts attached)

FHM programs have never returned to their original levels but were assured that the bump up in settlement payments would restore the original cuts and continue to reduce the burden on our health care system.
(see graph of FHM revenue/expenditures attached)

The language and intent of the FHM statute is to provide resources for programs that invest today in prevention so health costs are reduced down the road. LD 499 appropriately allocates the scheduled tobacco settlement payments to FHM programs that show a need and demand for funds to serve more Maine people with disease prevention and health promotion programs.
(see program description attached)



Child Care and Head Start

Fund for a Healthy Maine Prevention and Health Promotion Response:
The Fund for a Healthy Maine has allowed thousands of Maine Children to access quality pre-school, school age, and Head Start programs in virtually every community in Maine. This, in turn, has proven to be an essential investment in the health and well being of children, families and communities.

Approximately 7,600 children received child care, Head Start or After School Programs because of the Fund for a Healthy Maine. The majority of these funds were used to provide services either not allowed or not mandated by other public funding streams.

Maine's unmet prevention and health promotion needs:
Currently, there are over 30,000 pre-school children eligible for a child care subsidy, unable to access one because of lack of funding.

Currently, Federal Head Start Funding does not allow these programs to provide the full-day, full-year programming that is required by the families needing this service. The Fund for a Healthy Maine funding is a key component these Head Start providers need to serve this population.

What LD 499's proposed funding restoration would provide:
Adjustments to these programs would delay implementation of child care voucher system for one year as it is properly implemented and transfer child care "slots" funding into voucher system waiting lists.

The number of families needing "out of home" child care just to stay employed has increased to 75%. Combine the factors of inflation and increasing standards of care and it would take an increase of $3 to $4 million just to provide the same level of care as what was available in 2002!

Dental Education

What LD 499's proposed funding restoration would provide:

Funding would expand the number of dental health professionals recruited, retained, and trained to serve disenfranchised Mainers who reside in geographically underserved areas.

Oral Health and Donated Dental

Fund for a Healthy Maine Prevention and Health Promotion Response:

The health of Maine residents is imperiled by the lack of good oral health. We have serious problems of both availability and affordability of dental services that are addressed through the Fund.

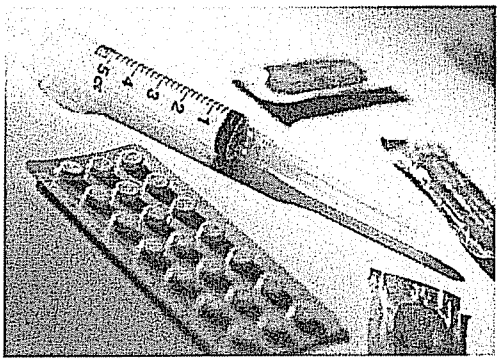
Fund dollars leverage private and community contributions to dental care by coordinating donated dental services, building local community capacity for providing services through community and school based settings with private and non-profit providers; providing partial subsidies to non-profit dental clinics that provide care on a sliding fee scale, and contributing to a tuition loan repayment fund for dentists who will practice in the areas in Maine where there are dentist shortages.

Maine's unmet prevention and health promotion needs:

MaineCare only covers emergency dental care for adults, so the entire adult MaineCare population is in need of public health hygienist services, donated dental care, and sliding scale access to dental care. At least 40% of the Mainers (youth and adults) are without dental insurance and need of access to these services as well.

What LD 499's proposed funding restoration would provide:

What are the primary elements of your program (before any restoration)? 1. Donated dental services, currently a half-time coordinating position, will become three-quarters time, which will allow us to leverage hundreds of thousands more dollars of donated dental care. There are currently funds for seven capacity building grants, the restoration will allow eight; non-profit slide fee scale subsidies will be extended to cover more, but by no means all of the shortfall in revenues in non-profit dental clinics, and the tuition repayment fund will be able to add one more dental student



Family Planning

Fund for a Healthy Maine Prevention and Health Promotion Response:

The Maine Family Planning Outreach Education program addresses the high rates of teen pregnancy in certain communities in Maine. Our program promotes good health by providing teens and their families with information and resources to help them make responsible choices in their relationships and prevent teen pregnancy.

The Outreach Educators design and present educational programs based on the stated needs of community organizations, businesses, schools and individuals. These educational programs focus on topics local communities want, including healthy sexuality, relationships, reproductive anatomy and physiology, puberty and family planning. On an annual basis, the Outreach Program reaches thousands of adults and teens with information that fosters open communication and responsible decision-making.

What LD 499's proposed funding restoration would provide:

Funds would be distributed among all family planning agencies to help pay for increased program costs.

Fire Marshall

What LD 499's proposed funding restoration would provide:

Allocation adjustments would more fully fund positions in the Prevention Division (three inspectors and half of a clerical position) that were intended to be funded by the FHM in order to conduct mandatory inspections of facilities that provide services to children.

Health Education Centers

What LD 499's proposed funding restoration would provide:

Expanded efforts to recruit, retain, and train health care professionals to serve disenfranchised Mainers who reside in geographically underserved areas.

Human Leukocyte

What LD 499's proposed funding restoration would provide:

Increasing public awareness and education that will encourage testing and therefore add to the national databank.

Home Visitation

Fund for a Healthy Maine Prevention and Health Promotion Response:

New parents lack knowledge of effective, safe parenting. Home visiting promotes healthy childhood growth and development, identifies health issues for newborns, recommends healthy behaviors in the household and shares available community resources. This strives to reduce child maltreatment, provide a safer household, improve child health and school readiness.

By educating, informing, and modeling health topics in the home with the parent. These topics include effects of smoking and substance use around the child; realistic child development expectations; early identification of special education needs; links to medical care, insurance, nutrition and immunization information.

Program is universally available on a voluntary basis to all first time parents in Maine, as well as pregnant and parenting teens. It is a community based home visitation program providing education, family support, referrals to community programs, and guidance in new parenting challenges.

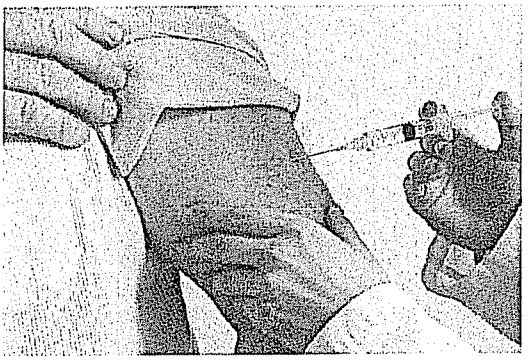
Maine's unmet prevention and health promotion needs:

We have several geographic pockets in Maine that have no home visitation available at all- such as Freeport, parts of Cumberland county, southern York County and in the mid-coast area. Approximately 70% of first time births (n=~6100) are not connected with a home visiting program, but increasing awareness will result in longer waiting lists.

What LD 499's proposed funding restoration would provide:

Funding will help serve more families with home visiting services. This translates to 350 more families getting home visits, 2,600 new home visits total and 600 new families served when you include education and support groups affected.

Immunization



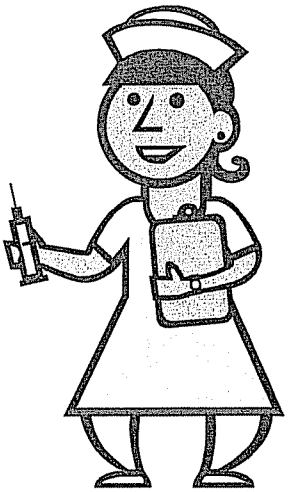
What LD 499's proposed funding restoration would provide:

Provide increased numbers of vaccines for seasonal influenza and pneumovax. It will also allow for greater vaccine-related outreach and public education.

Public Health Infrastructure

What LD 499's proposed funding restoration would provide:

Expand the scope and coverage of the Healthy Maine Partnerships and integrate Comprehensive Community Health Coalitions into Maine's Public Health Infrastructure so all FHM programs can benefit from this successful local capacity.

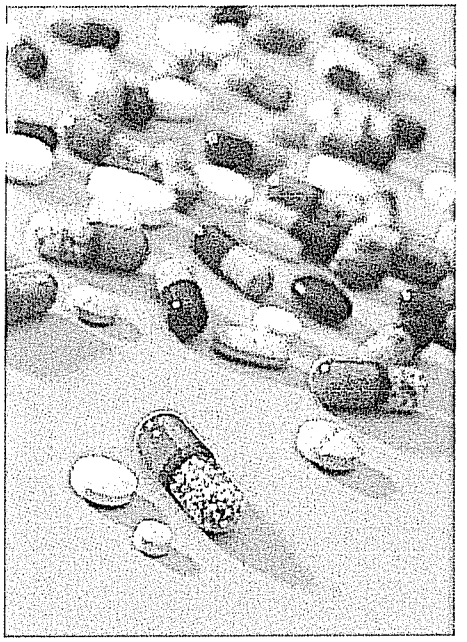


School Nurse Consultant

What LD 499's proposed funding restoration would provide:

The addition of regional trainings and provide technical support for school nurses on health issues such as overweight/obesity, medication resistant infections, and all hazards/pandemic influenza planning as it relates to medically fragile children in school settings.

Substance Abuse



Fund for a Healthy Maine Prevention and Health Promotion Response:

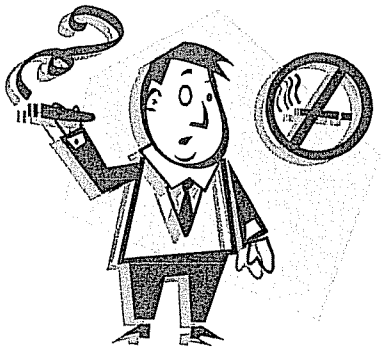
Funds are used for prevention and treatment to reduce substance abuse, and the consequences and costs that result from substance abuse. Funding supports contracts with substance abuse treatment agencies in all regions of the state and prevention services including local prevention contracts, OSA's parent media campaign, Maine's Higher Education Alcohol Prevention Partnership, Substance Abuse in the Workplace trainings, and the Methwatch initiative.

Maine's unmet prevention and health promotion needs:

Currently there is insufficient funding to ensure a base of local substance abuse prevention services in every part of the state. The service delivery system for substance abuse prevention lacks the resources to ensure that priority substance abuse prevention services are available for all target populations.

What LD 499's proposed funding restoration would provide:

Funding will allow for an Overdose Prevention Project in Portland, Augusta, and Bangor. It will allow for outreach and case management in the minority population, case management and drug testing in family drug court, and implementation of the Prescription Monitoring Program. LD 499 will also allow for use of the Prime of Life Curriculum as prevention/easily intervention/education tool in schools and communities.



Tobacco Prevention, Control and Treatment and Community/School Grants

Fund for a Healthy Maine Prevention and Health Promotion Response:

The mission of the Partnership for a Tobacco-Free Maine (PTM) is to reduce death and disability from tobacco use among Maine citizens by creating an environment supportive of a tobacco-free life. This is accomplished through school, work, and community-based initiatives (Healthy Maine Partnerships) to control tobacco use among children and adults while promoting safe, smoke-free environments. Retail enforcement efforts are undertaken to curtail tobacco sales to minors. Media campaigns are employed to encourage youth to avoid using tobacco and motivate tobacco users to quit. PTM also provides free and accessible treatment for tobacco addiction, including the Maine Tobacco HelpLine.

Maine's unmet prevention and health promotion needs:

- Young adults smoke at very high rates (36%).
- Native Americans smoke at rates that are at least twice the state average. We need to offer culturally relevant on-site treatment options at the tribal health centers provided by Native American staff.
- Persons with severe mental illness; lesbian/gay/bisexual/transgender; and people living with AIDS and HIV: all these groups smoke at double or triple the rate of the general population.
- Low-income and low education women who are pregnant smoke at alarmingly high rates and need very tailored interventions, including enhanced provider trainings that address the high rates of relapse.
- Youth, especially high-risk youth, must continue to experience prevention and education efforts that keep them from getting addicted.

What LD 499's proposed funding restoration would provide:

In addition to the Healthy Maine Partnerships, School Health Coordinators, Youth Advocacy Programs, No Buts Programs, the Maine Tobacco Helpline, and PTM's award-winning counter-marketing campaign, LD 499 would allow PTM to impact more difficult to reach populations, many of which are the primary drivers of health costs. It would allow for prevention and treatment programs targeted and tailored to specific populations with high smoking rates. This includes at-risk youth, college experimenters, straight-to-work young adults, and low-income and uneducated pregnant women.

REVISION OF PART A

Modify appropriation/allocation Initiative language in Part A, which now reads: "Initiative: Reduces funding from savings achieved by adjusting rates to a standard rate per service. A portion of the savings are reflected in the Mental Health Services - Child Medicaid and the Mental Health Services - Community Medicaid programs."

New language should show $3,000,000 General Fund savings for FY 08, and $7,000,000 General Fund savings for FY 09, spread across the lines on which the standard rate savings are shown in Part A of the bill, with the initiative language revised to read:

"Initiative: Reduces funding from savings achieved by beginning to standardize selected rates, temporarily reducing certain other, provider-specific rates for FY 08, and then in FY 09 redesigning certain services to improve efficiency, and implementing a further transition to standard rates per service coupled with cost savings through administrative simplification, pursuant to Part NN of this Act. Portions of the savings are reflected in the Mental Health Services - Child Medicaid and the Mental Health Services - Community Medicaid programs."

ADDITIONAL IMPLEMENTING LANGUAGE

PART NN

[to be relettered as appropriate]

Sec. NN-1. Administrative Burden Reduction. The Department of Health and Human Services shall convene an Administrative Burdens Work Group, no later than July 1, 2007. The charge of the Work Group shall be to identify potential savings of provider operating expenses in State fiscal year 2009 through a reduction of administrative burdens arising from requirements imposed by the Department upon contracting mental health agencies, with a target of $1,000,000. The Work Group shall comprise three representatives of mental health service providers, two designated by the Maine Association of Mental Health Services and one designated by the Department, three representatives of the interests of consumers of adult and children's mental health services identified by the Department, and representatives of the Department designated by the Commissioner. The Department shall provide the information and staff support necessary for the Work Group to perform its responsibilities.

A. The Work Group shall review and evaluate the Department's current reporting, billing, record-keeping, auditing, operational, and other administrative requirements applicable to mental health agencies for the purpose of identifying opportunities to reduce provider costs by reducing the burdens imposed by these requirements. The requirements and costs reviewed shall include without limitation the Department's rules, practices, expectations and forms in the areas of contracted services, licensing, MaineCare services, and other Department relationships with providers.

B. Based on its review and evaluation, the Work Group shall develop recommendations that detail:

1. Specific administrative requirements that are unnecessary, duplicative, and/or of insufficient value to justify the expenditures;
2. Savings that could, in the informed opinion of the provider representatives on the Work Group, be achieved through elimination or modification of these specific administrative requirements;
3. Specific regulatory, licensing, contractual or other changes that need to occur in order to accomplish each identified reduction of administrative burdens taking into account all applicable court orders, consent decrees, and related documents;
4. A timetable for implementation of each identified change.

Sec. NN-2. System Redesign. The Department of Health and Human Services shall convene a Systems Redesign Work Group, no later than July 1, 2007. The charge of the Work Group shall be to identify potential savings in General Fund expenditures for mental health care services in FY 09 to be achieved by redesigning certain elements of the community mental health system as provided in this section, with a target of $3,000,000 in savings. The Work Group shall comprise three representatives of mental health service providers, two designated by the Maine Association of Mental Health Services and one designated by the Department, three representatives of the interests of consumers of mental health services and their families designated by the Department, a representative of the contractor selected by the Department for implementation of behavioral health managed care services, once such a selection has been made, and representatives of the Department designated by the Commissioner. The Department shall provide the information and staff support necessary for the Work Group to perform its responsibilities.

A. The Work Group shall review the continuum of core services in child and adult mental health; consider whether refinements or modifications of the continuum are appropriate, consistent with the requirements of applicable court orders, consent decrees and other legal authorities; identify current system inefficiencies and service redundancies that can be corrected within a reasonable time; and recommend models for expanding flexibility for certain core service areas, and other models of service delivery that support quality, access, choice and economy in community-based services.

B. Based on its development of redesign elements as described in subsection A, the Work Group shall develop recommendations that detail:

1. The core service components that will address the comprehensive mental health needs of children and adults who have serious and persistent mental illness and address the serious mental health needs of the general population, including specialty populations and victims of trauma.
2. Standardized descriptions of the staffing levels and other resources that are required to deliver each service in order to develop a rate consistent with each description.

Sec. NN-3. Rate Standardization. The Department of Health and Human Services shall convene a Rate Standardization Work Group, no later than July 1, 2007. The charge of the Work Group shall be to create a regulatory framework for the development of standard rates for all behavioral health services for which payment is now made on the basis of provider-specific rates, and any additional services affected by system redesign pursuant to section NN-2. The Work Group shall comprise four representatives of mental health service providers, two designated by the Maine Association of Mental Health Services and two designated by the Department, and representatives of the Department designated by the Commissioner. The Department shall provide the information and staff support necessary for the Work Group to perform its responsibilities. The Department shall establish by rule a methodology for setting standard rates in a manner consistent with those recommendations and section 4 of this Part.

A. The Work Group shall develop a rate-setting methodology that relies on objective benchmarking tools to identify the key cost components, including productivity, of core services, consistent with the administrative savings achievable pursuant to section NN-1 and the service descriptions developed pursuant to section NN-2. The methodology recommended by the Work Group shall be designed to produce rates that are adequate to cover the costs incurred by efficiently and economically operated service providers to deliver services consistent with the descriptions developed pursuant to section NN-2.

B. The Work Group shall develop recommendations concerning:

1. The regulatory framework for developing rates.
2. The data to be used and methods to be applied to establish standard rates.
3. Whether alternative rate structures for certain services should be established.

C. The Work Group shall provide its recommendations in draft form to representatives of the interests of consumers of mental health services and their families designated by the Department. The comments of these representatives will be considered in developing final recommendations.

Sec. NN-4. Implementation of Rate and System Changes. The Department of Health and Human Services shall report and implement the agreed upon recommendations of the Work Groups established in this Part in accordance with this section and the standards enacted in section 5.

A. Beginning with July 2007, the Department shall report monthly to the Joint Standing Committee on Health and Human Services on the progress of the Work Groups established in this Part.

B. No later than October 31, 2007, the Commissioner shall present to the Joint Standing Committees on Health and Human Services and on Appropriations and Financial Affairs the Department's proposals for actions to be taken and savings to be realized on the basis of the recommendations of the Work Groups established in sections NN-1 and NN-2. No later than January 7, 2008, the Commissioner shall present to the same Committees the Department's proposals for actions to be taken

and potential savings to be realized on the basis of the recommendations of the Work Group established in section NN-3.

C. The Department, with the concurrence of the Work Groups, shall prepare and provide to the Joint Standing Committee on Health and Human Services, no later than January 7, 2008, drafts of all regulatory, licensing, contractual, or other language changes required to accomplish the proposals presented pursuant to subsection B, including any implementing legislation.

D. The Joint Standing Committee on Health and Human Services is authorized to introduce any legislation necessary to implement the changes recommended by the Commissioner pursuant to this section.

E. No later than March 31, 2008, the Department shall give notice pursuant to Title 5, section 8053, of any amendment or adoption of rules that may be necessary to implement the changes identified pursuant to this Part. The timetable provided in such notice or notices must provide for the necessary rules to take effect no later than June 30, 2008. To the extent that all parties concur, the Department shall implement identified changes that do not require legislation as promptly as practicable.

Sec. NN-5. Net rate standardization target. The Department will achieve additional savings through rate standardization as necessary to meet the total savings requirement of $7,000,000 for FY09, after taking into account the portion of the $7,000,000 savings requirement that can be achieved through system redesign.

RATE SAVINGS PROPOSAL

Service	Unit	Proposed Standard Rate	Savings (State) FY08	Annual Amounts - FY06 Provider rate amount * FY06 Units by provider: Total cost of services FY06	Federal Portion	State Portion	Savings to achieve in rate standardization & services changes FY08
Standardize rates FY 07					**63.30%**	**36.70%**	**3.5097%**
							3.5097%
TCM-HIV infection Sect 13.07		77.15	5,359				
TCM Children 0-5/Head Start Sect 13.08		$177.50	41,863				
MAAP (or other) Accounts for other services			**47,223**				
Sect 17 - Intensive Community Integration	Monthly	$850.77/$782.64	521,114	7,831,026	4,957,039	2,873,987	
Section 17- Skills Development	Hourly	$50.36	128,321	2,504,452	1,585,318	919,134	
Sect 17 - Daily Living Support	Hourly	$32.08	325,300	8,270,607	5,235,294	3,035,313	
TCM for BH & MR children - L1 sect 13.12	Monthly	$199.08	76,429	2,128,254	1,347,185	781,069	
Behavioral Health accounts			**1,051,163**				
TOTAL savings from Standardizing rates			**1,098,386**				
Service Redesign - Behavioral Health Services							
Sec 65 - Adult Emergency***	Hourly	OP & Cr Int rate	312,153	1,419,925	898,813	521,112	
Sec 65 - Children's Emergency***	Hourly	OP & Cr Res rate	114,790	644,993	408,281	236,712	
Total from Service Redesign			**426,943**				
Admin Burden- Reduce rates			**0**				
Subtotal			***1,525,329***				
Saving from service changes and standardizing of rates for services**			**1,474,671**				
Sect 17 - ACT	Monthly		92,026	7,144,550	4,522,500	2,622,050	92,025
Sect 17 - Community Integration	Hourly		407,872	31,665,603	20,044,327	11,621,276	407,868
Sec 65 - Adult Crisis Intervention	Hourly		79,201	6,148,841	3,892,216	2,256,625	79,200
Sec 65 - Adult Outpatient	Hourly		230,432	17,889,848	11,324,274	6,565,574	230,430
Sec 65 - Crisis Support, Out of Home	per deim		52,470	4,073,537	2,578,549	1,494,988	52,469
TCM for BH & MR children - L2 sect 13.12	Monthly		300,049	23,294,672	14,745,528	8,549,145	300,046
Sec 65 - Children's ACT	Monthly		33,011	2,562,824	1,622,268	940,557	33,010
Sec 65- Children's Crisis Res.	Hourly		34,602	2,686,353	1,700,462	985,892	34,601
Sec 65 - Children's Outpatient	Hourly		212,476	16,495,855	10,441,877	6,053,979	212,474
Sec 65 - Crisis Support, Out of Home	per deim		20,386	1,582,658	1,001,822	580,835	20,385
Sec 65 - Children's Day Treatment	per deim		12,163	944,270	597,723	346,547	12,163
TOTAL savings from rate standardization and service changes			**1,474,687**	**114,489,011**	**72,471,544**	**42,017,467**	**1,474,671**
TOTAL			3,000,016				
TOTAL SAVINGS PROJECTIONS			**3,000,000**				

**For 7/1/2007 will be reducing rates by saving % to achieve FY08 amount

*** Emergency now will be paid at same rate as Outpatient Services. 80% of units will be at OP and 20% at Crisis Intervention(Resolution)

* Cost and Unit information is Based on Dates of Service in FY06 instead of Pay Order dates in FY06

PHIP

Private Health Insurance Premium (PHIP) Benefit

Program Summary

- Voluntary benefit reimburses MaineCare members for their private health insurance premiums when cost effective for the State.
- Compare cost of the member's commercial premium (minus the deductible) to the average per member per month MaineCare cost.
- Receive approx. 30 inquiries per week (most from DHHS eligibility; approx. 2 are eligible).
- Reviewed on a quarterly to verify cost-effectiveness.

Program Numbers and Costs/Savings

- PHIP cases: 108
- Total covered: 291
- Total commercial ins. payments for services per EOBs: $1.8 million

  Total premiums paid: 300,000

  Savings (total state and federal) $1.4 million
- Staff: 1.5 FTEs.

Proposed Plan

- Increase PHIP to 2,600 (slightly more than 1% of Members; 9 times more than current PHIP)[1]

- Savings

State	$4.7 million
Federal	7.9 million
Total	$12.6 million

[1] 1% is reasonable goal given figures from other states that use Section 1906 method of PHIP: Iowa--3.2%; Pennsylvania--1.3%; and Rhode Island—3.5%.

- Additional Staff required for administering program. Look to maximize efficiency of what State is buying from TPL contractor services, coordinated by State Staff.

- Increase screening by revising MaineCare application to ask: Do you have access to health insurance? (Currently reads: Do you have health insurance?)

- Increase availability to revising health insurance regulations to make MaineCare eligibility a "qualifying event" allowing individual to enroll in commercial health care insurance.

MaineCare Private Health Insurance Premium Benefit Program (PHIPs)
Proposal: Increase participation in the PHIPs program to 2,500 cases in year two by contract with a private vendor

From 1/23/06 PHIPs Report (LD 229)

Total MaineCare 2005 Cases	224		
Total Payments for Health Care Services	$1,516,281		
Total Premiums Paid	$347,224		
Total Savings (state and fed)	$1,169,057		
Total Savings per case	$5,219		
		2007-08	**2008-09**
Increased Participation (cases)		1,026	2,276
Est. Total MaineCare Savings		$5,354,699	$11,878,454
Est. Contract Costs (10%)		($535,470)	($1,187,845)
Est. Net MaineCare Savings		$4,819,229	$10,690,609
Net GF		$1,769,000	$3,922,000

2007 Tobacco Settlement Proceeds Report

To: Members, Joint Standing Committee on Appropriations and Financial Affairs
Members, Joint Standing Committee on Health and Human Services

cc: Governor John Baldacci, Senate President Beth Edmonds, Senate Majority Leader Elizabeth Mitchell, Assistant Senate Majority Leader John Martin, Senate Minority Leader Carol Weston, Assistant Senate Minority Leader Richard Rosen, House Speaker Glenn Cummings, House Majority Leader Hannah Pingree, Assistant House Majority Leader Sean Faircloth, House Minority Leader Joshua Tardy, House Assistant Minority Leader Robert Crosthwaite, Attorney General G. Steven Rowe, Grant Penoyer and Dr. Dora Mills.

Fr: State Treasurer, David G. Lemoine

On: March 5, 2007

Re: 2007 Tobacco Settlement Proceeds

Background - In 1998, Maine and the other states became creditors of the Participating Cigarette Manufacturers (PMs) pursuant to a Master Settlement Agreement between the states and most cigarette manufacturers. NOTE: Original Participating Manufacturers (OPMs) held 94% of the market share when the Settlement was reached. Subsequent Participating Manufacturers (SPMs) also joined the Master Settlement Agreement, adding a further 4.5% of the market, and raising the market share included under the Master Settlement Agreement to 98.5%.

Variables - Maine's payment stream hinges on four (4) key issues:

1. ENFORCEABILITY: The continuing enforceability of the manufacturers' Master Settlement Agreement payment obligations.
2. FINANCIAL CAPACITY: The continuing financial capacity of the manufacturers to make timely Master Settlement Agreement payments.
3. LEGAL ACTIONS: Any legal action which delays or alters Master Settlement Agreement Payment obligations.
4. NATIONWIDE SALES: The total cigarette sales within the United States by Participating Manufacturers, notwithstanding any change in Maine cigarette sales, since this number is the primary determinant of the payment amount.

Cumulative Payments Received - The State of Maine, as of December 22, 2006, has received $366,531,435.35 million from the Tobacco Settlement.

Investment of Settlement Payments - Each payment is deposited into the Fund for a Healthy Maine (the "Fund") where it is invested in the Treasurer's Cash Pool. All earnings on these funds are deposited back into the Fund. Earnings on these funds are forecast at $90,000 for Fiscal Year 2008 and Fiscal Year 2009.

Projections – The most recent Global Insights projections for Maine's likely payment stream are attached. These projections DO NOT take into account legal actions.

Allocation to State of Maine

Global Insight Base Case Forecast as of August 2006

OPM Market Share	84.4%
SPM Market Share	9.4%
NPM Market Share	6.2%
State Annual Allocation:	0.7693505%
State SC Allocation:	1.3281978%

	National		Maine		
Payment Year	**Annual Payments**	**Strategic Contribution Payments**	**Annual Payment to State**	**Strategic Contribution Payment to State**	**Total Payment to State**
2007	6,508,956,835	-	50,076,692	-	50,076,692
2008	6,720,874,767	802,375,519	51,707,084	10,657,134	62,364,218
2009	6,807,785,106	812,751,360	52,375,729	10,794,946	63,170,674
2010	6,887,077,123	822,217,683	52,985,762	10,920,677	63,906,439
2011	6,970,628,618	832,192,527	53,628,566	11,053,163	64,681,729
2012	7,052,794,909	842,001,997	54,260,713	11,183,452	65,444,165
2013	7,133,823,535	851,675,646	54,884,107	11,311,937	66,196,044
2014	7,212,305,859	861,045,304	55,487,911	11,436,385	66,924,296
2015	7,288,858,217	870,184,551	56,076,867	11,557,772	67,634,639
2016	7,379,488,897	881,004,547	56,774,135	11,701,483	68,475,618
2017	7,470,388,056	891,856,596	57,473,468	11,845,620	69,319,088
2018	8,459,192,609	-	65,080,841	-	65,080,841
2019	8,557,459,042	-	65,836,854	-	65,836,854
2020	8,652,590,714	-	66,568,750	-	66,568,750
2021	8,757,992,562	-	67,379,660	-	67,379,660
2022	8,862,532,709	-	68,183,940	-	68,183,940
2023	8,971,658,723	-	69,023,501	-	69,023,501
2024	9,080,632,322	-	69,861,890	-	69,861,890
2025	9,199,901,183	-	70,779,486	-	70,779,486
2026	9,320,523,161	-	71,707,492	-	71,707,492
2027	9,443,937,839	-	72,656,983	-	72,656,983
2028	9,569,601,033	-	73,623,773	-	73,623,773
2029	9,698,373,337	-	74,614,484	-	74,614,484
2030	9,828,926,292	-	75,618,894	-	75,618,894
2031	9,961,330,851	-	76,637,549	-	76,637,549
2032	10,091,216,867	-	77,636,827	-	77,636,827
2033	10,225,759,351	-	78,671,931	-	78,671,931
2034	10,361,865,158	-	79,719,061	-	79,719,061
2035	10,498,259,157	-	80,768,409	-	80,768,409
2036	10,617,133,778	-	81,682,972	-	81,682,972
2037	10,752,903,973	-	82,727,520	-	82,727,520
2038	10,892,573,901	-	83,802,072	-	83,802,072
2039	11,037,408,842	-	84,916,360	-	84,916,360
2040	11,173,450,212	-	85,962,995	-	85,962,995
2041	11,313,521,622	-	87,040,635	-	87,040,635
2042	11,458,459,677	-	88155716.82	-	88,155,717
2043	11,598,554,836	-	89233539.62	-	89,233,540
2044	11,741,353,385	-	90332160.98	-	90,332,161
2045	11,887,029,751	-	91452922.82	-	91,452,923
2046	12,034,547,777	-	92587853.49	-	92,587,853
Totals	371,481,672,586	8,467,305,729	2,857,996,105	112,462,569	2,970,458,674

MaineCare Information

Provided by:

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Medicaid/SCHIP[1] and related Public Health Insurance Programs Eligibility Limits Expressed as a Percentage of the Federal Poverty Level: New England States

	Pregnant Women	Infants	Children	Parents	Aged, Blind and Disabled	Other Adult (Non-Categoricals)
Maine	200%	200%	200%	200%	100%	100%
Connecticut	185%	300%	300%	150%	69%	State General Assistance Medical Program (SAGA). Similar coverage and eligibility as aged/disabled Medicaid group
Massachusetts[2]	200%; 300%	200%; 300%	150%; 300%	133%; 300%	100%	100% 300%
New Hampshire	185%	300%	300%	76%	76%	Individuals referred to their city or town for direct relief
Rhode Island	250%	250%	250%	185%	100%	--
Vermont[3]	200%; 300%	300%	300%	185%; 300%	74%	150%; 300%

[1] SCHIP means the State Children's Health Insurance Program which is a federal program operating in partnership with Medicaid to provide coverage for children.

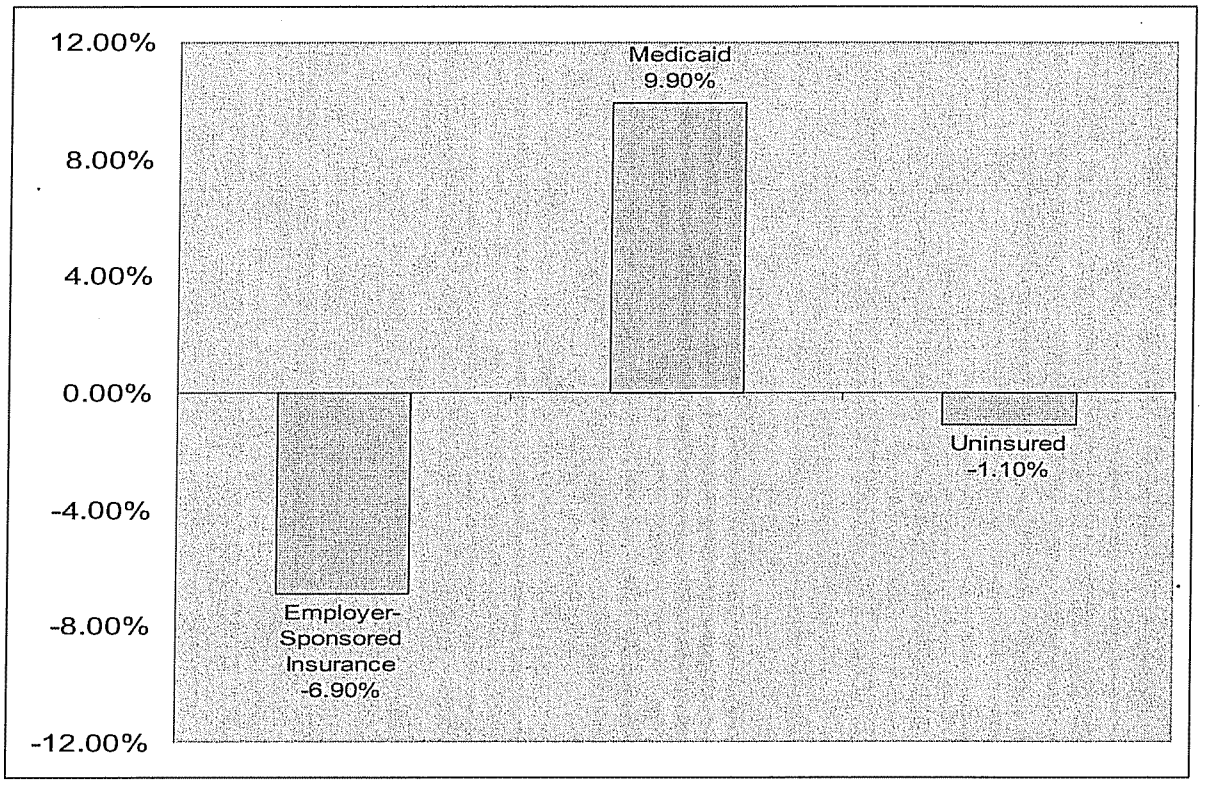
[2] Massachusetts recently implemented a new comprehensive health care reform program referred to as Commonwealth Care. This new program builds on current Medicaid coverage and fills in the remaining gaps for MA. residents who are uninsured up to 300% of the federal poverty level through a subsidized managed care health plan. The first number in the chart above reflects the Medicaid eligibility limits and the second the eligibility limit for the new Commonwealth Care Program for individuals eligible for that program, which itself is built upon a Medicaid 1115 waiver.

[3] Vermont recently implemented a comprehensive new health care reform program referred to as Catamount Health that builds on current Medicaid coverage and fills in some of the remaining gaps for uninsured adults up to 300% of the federal poverty level through a subsidized private coverage program. The first number in the chart above reflects the Medicaid eligibility limits and the second the eligibility limit for the new Catamount Health Program for individuals eligible for that program, which in itself is built upon a Medicaid 1115 waiver.

Prepared 1/23/07

Percentage Point Change Among Nonelderly (ages 0 – 64)

by Health Coverage Type 2000 – 2004[1]



This chart shows that between 2000 and 2004 the number of people receiving health coverage through their employers dropped by 6.9 percentage points. MaineCare filled the gap left by this drop in coverage. The increased coverage provided through MaineCare meant that the state experienced an actual decrease in our overall uninsured rate, even at a time when employer based coverage dropped significantly.

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[1] Kaiser Family Foundation. *Percentage Point Change Among Nonelderly 0-64 by Coverage Type, 2000 – 2004.* www.statehealthfacts.org.

Medicaid Matters
at the Beginning and at the End of Life

- **Births:** MaineCare pays for nearly one-third (31.7%) of all births in Maine.[1]
- **Nursing Home Services:** MaineCare pays for nearly three-quarters (72%) of all nursing home care and two-thirds (67%) of residential care in Maine.[2]

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[1] Kaiser State Health Facts: Births Financed by Medicaid as a Percentage of Total Births, 2002 (most recent state-by-state data available).

[2] An Opportunity to Respect our Elders," Maine Health Care Association, Augusta, Maine.

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The MaineCare Non-categorical Program

Who receives services through MaineCare non-categorical program?

"Non-categorical" MaineCare members are adults, aged 21 – 64, who do not have minor children at home, who are not disabled and whose income is below the federal poverty level ($10,210 per year for a single person). Individuals enrolled range in age with approximately one-third of recipients under age 30 and one quarter are over the age of 50. 45% of non-categorical recipients are women. This program serves a wide range of individuals including many who use it temporarily until to recover their health and return to work. Please see the collection of interviews with current and former program enrollees attached.

Enrollment by County as of Jan. 4, 2007

County	Number of Enrollees
Androscoggin	1,890
Aroostook	1,441
Cumberland	3,783
Franklin	484
Hancock	635
Kennebec	1,892
Knox	552
Lincoln	411
Oxford	1,103
Penobscot	2,655
Piscataquis	338
Sagadahoc	260
Somerset	1,315
Waldo	634
Washington	1,134
York	1,810
Total	**20,337**

What is the MaineCare non-categorical waiver?

In the fall of 2002, Maine was granted a section 1115 waiver from the federal Centers for Medicare and Medicaid Services to open eligibility for MaineCare to this population. Because childless adults do not fit into an existing Medicaid category (such as "disabled", "parent with child," "child" or "aged"), a federal waiver is required in order for states to cover them through the Medicaid program with the benefit of federal matching funds. All expenditures under a section 1115 waiver must be "budget neutral" to the federal government. A cap on federal spending is established by the waiver.

Maine's total spending cap (state and federal dollars) for this waiver was set at $105,348,286 in FFY '06 and $104,732,214 in FFY'07. Current projections indicate that Maine has spent approximately $38,080,575 less than the federally authorized cap over the last five years, and will spend $21M less than authorized under the cap for FFY '07

What have been the outcomes of the implementation of the non-categorical program?

- Uninsured rates for childless adults living below poverty have declined. Prior to this waiver, there was no comprehensive public health insurance program available to this population. The uninsured rate among this group was more than three times higher than that of their non-poor counterparts. The non-categorical waiver has helped to reduce the uninsured rate for this group by nearly 8 percentage points—in effect by over 20%.

Years	Uninsured rate for childless adults below poverty
2001-2002	38%
2002-2003	34.2%
2003-2004	31.3%
2004-2005	27.5%
2005-2006	30.3%*

* This increase in the uninsured rate was likely caused by the freeze in enrollment in the non-categorical program during this period. Enrollment dropped from 24,925 in February 2005 to 10,872 in July 2006.

- Maine had the lowest uninsured rate for poor adults in the nation from 2004-2005 according to the Kaiser Family Foundation.1

- Access to care has reduced cost and improved health. The per member per month (PMPM) cost during the first year of the waiver was $525 reflecting the higher cost of beginning to serve a population that had been without access to medical care on a regular basis. By FFY '05—three years into the waiver, the PMPM cost had declined

[1] Kaiser Family Foundation, "Health Insurance Coverage of Adults 19-64 Living in Poverty (under 100% FPL), states (2004-2005)", www.statehealthfacts.org (most recent period for which comparative data is available).

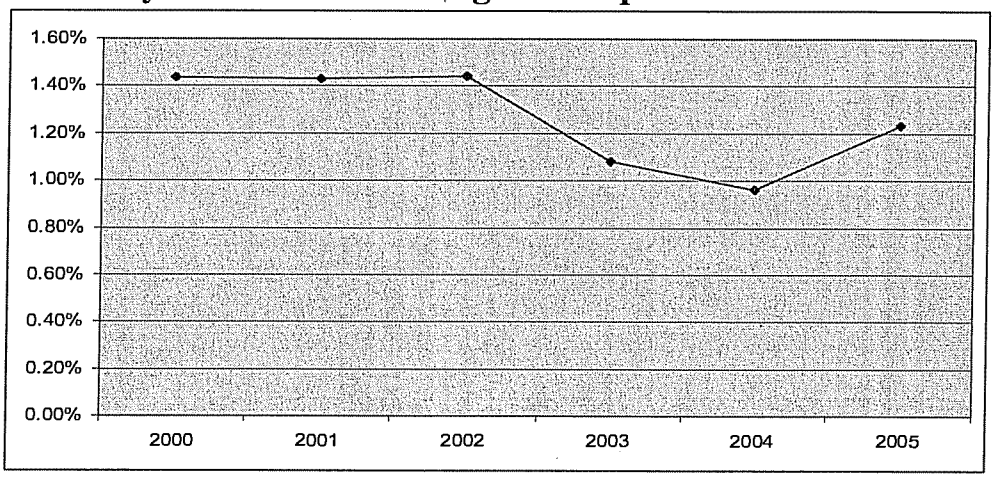
to $417 providing evidence that health care costs can be lowered when individuals have reliable access to medical care. Approximately 25% of non-categorical enrollees have chronic lung disease or diabetes. It costs more than $50,000 annually to treat a patient suffering from diabetes-related complications. Access to regular care can help reduce these higher costs as we have seen in this waiver group.

Three-quarters of this group report that they now have a "medical home"—one place where they can go to get on-going regular care; that they have had a relatively recent physical exam and that their shots are up to date.

The PMPM cost for this group continues to decline, but now reflects both the effect of access to care and reductions in the benefit package that began in December 2005.

- The rate of charity care at hospitals has declined since the non-categorical MaineCare Program was implemented in 2002. As the chart below shows, rates of charity care at hospitals declined in 2003 and 2004. The overall rate increased in 2005, but remained below 2000 – 2002 levels. There are two explanations for this increase: 1) the freeze in enrollment in the non-categorical program began in March 2005 and by the end of that year, enrollment in the program had dropped by more than 11,000 enrollees; and 2) many hospitals across the state raised their eligibility levels between 2004 and 2005 (see appendix 1).

Charity Care as a Percentage of Hospital Gross Revenues[2]



- In FFY 04, MaineCare paid hospitals $51,588,885 (federal and state dollars) for inpatient and outpatient services for members of the non-categorical program. These expenditures for inpatient and outpatient services at hospitals represented 45% of the overall expenditures for this program.3

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[2] Analysis of Hospital Audited Financial Statements. This data was filed by hospitals with the Maine Health Data Organization. Dr. Nancy Kane created a methodology for presenting this data, which was adopted by the MHDO. In this chart 2000 to 2003 is the work of Dr. Nancy Kane. The 2004 and 2005 data was submitted by the hospitals using Dr. Kane's methodology. The Institutions for Mental Disease were removed from the overall calculation because Medicaid does not pay for inpatient services at these institution.

[3] Data included in draft report prepared by the Muskie School of Public Service, University of Southern Maine, 2/07.

- **Payments for prescription drugs made through municipal general assistance programs (local welfare programs) dropped by 90% within three years of implementation of the non-categorical waiver program.** This represents a savings of nearly a ¼ million dollars for towns and cities throughout Maine. When enrollment in the non-categorical program was frozen in 2005-6, general assistance costs for prescription drugs quadrupled over the pre-freeze levels. [4]

What has the State done to manage cost under the non-categorical MaineCare Program?

- March, 2005—Enrollment Frozen. Early enrollment in this program occurred more rapidly than originally anticipated. This was attributed to pent-up demand for health coverage and high medical needs among this previously uninsured group. Additionally, implementation of this program occurred during an economic downturn when demand for public services typically increases and during an ongoing period of turmoil in the private insurance market marked by rising premium costs, reductions in employer-based coverage and contraction in the private insurance market. By early 2005, enrollment in the waiver grew to over 24,000. In March 2005, the Department froze enrollment and established a waiting list for program services.

- December 2005—Reduction in Benefits. In accordance with legislative direction, the Department made a significant cut in services for non-categorical members beginning in December 2005. The following services were eliminated: ambulance services, community support services, day treatment services, developmental and behavioral clinic services, home health services, hospice services, laboratory services, medical imaging services, medical supplies and durable medical equipment, occupational therapy, physical therapy, podiatric services, rehabilitative services, speech and hearing services, targeted case management services, and vision services. Mental health services were limited to 16 visits per year (in subsequent legislation this limit was extended to 24 visits with prior authorization).

- July 2006—Enrollment re-opened as a result of legislative action. As a result of the freeze, enrollment had dropped from nearly 25,000 to just below 10,000. People left the program for a variety of reasons. For some, their earnings increased above the federal poverty level, while others did not recertify at their annual review for the program. Meanwhile, the number of eligible applicants on the waiting list grew to over 8,000 people by April 2006. In the spring of 2006 with enrollment at such a low level, the Department reported that spending on the program was far below the cap. In the supplemental budget, the legislature directed DHHS to open enrollment on July 1st, 2006 but to keep spending under the expenditure cap.

- December 2006—Freeze in enrollment to ensure that costs stay below the cap. On December 15, DHHS determined that enrollment would soon reach the cap. Before

[4] Data provided by the Office of Integrated Access and Services, Maine Department of Human Services, 2/07.

this happened, it froze program enrollment at just over 20,000 and started a waiting list for eligible applicants again. As of mid-February, the waiting list had 2,887 people on it.

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Should MaineCare Members Pay *More* for their Care?

What is "cost-sharing"?

Cost sharing in the Medicaid program means shifting a share of the cost of health care services from the state and federal government to Medicaid recipients. Cost sharing takes several different forms including co-payments for services and monthly premiums for coverage. For example, in Maine if a low-income beneficiary pays a $20 premium, the State would net $7.36 but would also send $12.64 back to the federal government.[1]

Middle-income families pay co-payments and premiums—why can't MaineCare recipients pay something for their care?

In most cases MaineCare families *do* pay something for their care. In fact, the attached charts show that co-payments are applied to many more health care services in Maine than in the rest of New England. Moreover, families eligible for the former "Cub Care" program pay monthly premiums, which are among the highest in New England. In addition, low-income families actually pay a higher percentage of their income than those with higher incomes for over-the-counter medications, and other services, like dental care, eyeglasses and certain therapies that MaineCare simply doesn't cover for adults. For example, while a $150 pair of glasses represents 20% of the weekly wage of a family earning $40,000 a year, it represents nearly double that, or 40%, for a family earning $20,000.

Medicaid beneficiaries include low-income children and their parents, seniors and people with disabilities. By definition, they have little, if any, disposable income and must use what they do have for other basic needs like food and housing. An elderly or disabled SSI recipient receives a monthly check of $623 plus a $10 State supplement for a total of $633. The maximum TANF benefit for a

[1] Medicaid is a federal-state matching program. In State fiscal year '07 the State's share is .3682 and the federal share is .6318.

family of 3 is $485 per month. Typical rents in many parts of the State often exceed $600 a month before considering the cost of heat and electricity.

Low-income working families with costs for transportation and other work-related expenses find it difficult to make ends meet even with relatively higher annual incomes of $23-30,000. For example, a single parent with two children living in Franklin County earning $23,180 per year (or $1932 per month—or 135% of the poverty level) can barely pay for the family's most basic needs. According to analysis by the Maine Center for Economic Policy[2], this family would spend at least $1600 per month on a combination of the most basic needs -- food, rent, telephone, transportation to and from work, and clothing and household goods.[3] While this family would be eligible for a child care subsidy, they would have to pay $173 per month as their share of the cost. In addition, this family would have around $100 removed from their pay stub for federal and state taxes. This leaves the family $59 available on a monthly basis for other necessities such as school supplies, car repairs, or any other unexpected expenses.

What does the research show about cost sharing?

A large body of research shows that increasing cost sharing tends to: (1) reduce access to health care; and (2) create the need for more expensive forms of care such as emergency room care or hospitalization. These problems are particularly acute for the elderly and people with chronic medical conditions who use the most health care services—a person with five prescription drugs monthly will pay five times more than a person with one prescription.

There is now a substantial body of research that demonstrates the extreme caution that must be used in adopting such policies to avoid harm to beneficiaries and additional public expense.

Co-payments have lead to reduction in use of essential drugs with resulting adverse health conditions:

- When prescription drug co-payments were imposed on older adults receiving welfare these individuals filled fewer prescriptions for essential medications. This reduction in the use of essential drugs led to a 78% increase in adverse events including death, hospitalization, and nursing home admissions.[4]

---

[2] This analysis is based on 2004 data with expenses increased at the Consumer Price Index or inflation. This is a very conservative increase, especially given the increased cost in housing prices.

[3] Costs in Cumberland and York County would be significantly higher.

[4] Tamblyn, Robyn, et al., "Adverse Events Associated with Prescription Drug Cost-Sharing among Poor and Elderly Persons," Journal of the American Medical Association, 285(4):421-429, Jan. 2001.

- A study looking at the differential impact of plans with and without cost-sharing on low income individuals in poor health showed clear difference in health outcomes. Low-income individuals with high blood pressure saw large declines in their blood pressure on the free care plan relative to the cost-sharing plans. However those in cost -sharing plans saw a 14% rise in their predicted odds of death from higher blood pressure as compared to a 6% rise in odds for higher income individuals.[5]

- The imposition of $2 and $3 co-payments on Medicaid beneficiaries under the poverty level resulted in significant reduction in access and utilization. Even though many would think of these as small co-payments, 40% of those affected reported that they put stress on family budgets causing them to spend less on food or housing or take less than the prescribed amount of their medications.[6]

- Higher co-payments for substance abuse treatment make treatment reoccurrence more likely. While co-payments produce and an initial reduction in treatment cost, they lead to higher rates of relapse with increased costs in the long term.[7]

Premiums have lead to a loss of coverage for many low-income families.

- A multi-state study of health examining the impact of differing levels of premiums on low income working families found higher premiums associated with lower participation. Premiums set at 1% of a family's income lead to a 15% drop in enrollment, while premiums set at 3% reduced enrollment by as much as half.[8]

- In 2003 under a Medicaid waiver, Oregon implemented premiums for poor adults, including those living under the poverty level, to $6-$20, based on income. Following these changes, enrollment dropped by nearly half, or roughly 50,000 people. There were enrollment losses among all those subject to the increased premiums, but losses were steepest among those with the lowest incomes.[9]

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[5] Gruber, Jonathan, "The Role of Consumer Co-payments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond," Prepared for the Kaiser Family Foundation, October 2006.
[6] Ku, Leighton et al, "The Effects of Co-payments in the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program," Center on Budget and Policy Priorities, November, 2004.
[7] LoSasso, Anthony, et al., "The Effects of Co-payments on Substance Abuse Treatment Expenditures and Treatment Reoccurence," Psychiatric Services, 55(12): 1605-11, December 2002.
[8] Ku, Leighton, et al, "Sliding Scale Premium Health Insurance Programs: Four States' Experiences," Inquiry 36:471-480 (Winter 1999-2000).
[9] Artiga, Samantha and Molly O'Malley. "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences", Kaiser Commission on Medicaid and the Uninsured, May 2005

- Even those with relatively higher incomes lose coverage when premiums are unaffordable. When Rhode Island began charging families with incomes above 150% of poverty premiums ranging from $43-$58 a month nearly one in five families lost their coverage. When Maryland implemented monthly premiums of $37 for families between 185%-200% of poverty in their SCHIP Program 28% of enrolled children lost their coverage causing the Maryland legislature to eliminate these premiums.[10] Similarly when Virginia premiums imposed for children in families above 150% of the poverty level more than 3,000 children faced the loss coverage. Virginia first established a moratorium then subsequently canceled these premiums because, as expressed by Governor Warner, "Our premiums were actually costing more to administer than the dollars we were receiving, so...[eliminating the premiums] was both the morally right and the fiscally right thing to do."[11]

[10] ibid

[11] Ku, Leighton et al, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities; July 7, 2005.

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State Children's Health Insurance Program

Annual Premium Payments for Two Children in a Family of Three Selected Income Levels—

New England States July 2006[1]

In Maine, and most other New England states, families at certain income levels pay a monthly premium for public health care coverage. The table below shows the annual amount paid by families in all of the New England states for this health care coverage.

	Effective Annual Premium at 151% of the Federal Poverty Level– $25,927	Effective Annual Premium at 200% of the Federal Poverty Level– $34,344
Maine	$192	$786
Connecticut	$0	$0
Massachusetts	$288	$288
New Hampshire	$0	$600
Rhode Island[2]	$732	$924
Vermont	$0	$360

[1] Source: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. 2006

[2] The premium payments for Rhode Island may include coverage for certain parents in these households.

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Co-Payment Requirements
for Selected Medicaid Services for Adults: New England States—October 2004[1]

Within prescribed limits established by federal law states have the flexibility to establish cost-sharing for certain Medicaid services. This chart shows co-payments required by New England States for typical Medicaid services.

	Maine	Conn.	Mass.	N.H.	R.I.	Vt.[2]
Inpatient Hospital	$3/day up to $30/month	$0	$3/admission	$0	$0	$0
Outpatient Hospital Services	$.50-$3/day, depending on payment, up to $30/mo.	$0	$3/non-emergency visit in ER	$0	$3/non-emergency visit in ER	Group B - $25/medically necessary emergency visit in ER
Laboratory and x-ray services	$.50-$1/day, depending on payment up to $10/mo. for each service	$0	$0	$0	$0	$0
Ambulance Services	$.50-$2/day, depending on payment, up to $30/mo.	$0	$0	$0	$0	$0
Physician	$0	$0	$0	$0	$0	$0
Prescription Drugs	$2.50 per drug up to $25/mo. no co-pay for mail order Rx	$0	$1/generic Rx or OTC product, $3/brand Rx	$1/generic Rx, $2/brand or compound Rx	$0	Group A - $1-$3 depending on drug cost
Hearing Aids	$0	$0	$0	$0	$0	$0
Optometrist Services	$.50-$3/day, depending on payment, up to $30/mo.	$0	$0	$0	$0	$0
Medical Equipment and supplies	.50-$3/day, depending on payment, up to $30/mo	$0	$0	$0	$0	$0
Prosthetic and Orthotic Devices	$.50-$2/day, depending on payment, up to $30/mo.	$0	$0	$0	$0	$0
Home Health Services	$.50-$3/day, to $30/mo.	$0	$0	$0	$0	$0

[1] **Source:** Data produced by the Kaiser Commission on Medicaid and the Uninsured. This is the most current data source that provides a comprehensive look at co-payments in all states. http://www.kff.org/medicaid/benefits/index.jsp?CFID=9660749&CFTOKEN=49747174

[2] **Notes:** Vermont has an approved Section 1115 waiver from CMS under which it created the "Vermont Health Access Plan" (VHAP). Under the provisions of this waiver, the State has extended coverage to children in families with incomes below 300 percent of the federal poverty level and to parents and caretaker relatives with incomes below 185 percent of the federal poverty level. These beneficiaries receive care through a primary care case management program. Coverage under this waiver is identified on the tables as "B" and the State's traditional Medicaid coverages are identified as "A." Provisions of the waiver were amended in 2004 to eliminate most copayment requirements and require instead payment of an income-based monthly premium ranging from zero to $70/household.

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Testimony of Christine Hastedt on behalf of the Maine Association of Interdependent Neighborhoods in Opposition to the Expenditure Cap Limitation for the MaineCare "Childless Adult" Waiver Group Proposed in LD 499

Senator Rotundo, Representative Fisher, members of the Joint Standing Committee on Appropriations and Financial Affairs; Senator Brannigan, Representative Perry and members of the Health and Human Services Committee, my name is Christine Hastedt. I work for Maine Equal Justice and am speaking today on behalf of the low-income coalition, the Maine Association of Interdependent Neighborhoods, in opposition to the reduction of the expenditure cap for the "childless adult" waiver group proposed in LD 499.

By reducing the expenditure cap for this group from the federally approved level of $104 M, to $90 M, this budget would leave more than 3,000 Maine people uninsured with all of the resulting negative consequences to them, to our health care system, and to our economy. Nearly 1/3rd of those who won't be covered will be under 30; another third will be older—in their mid-forties, fifties and early sixties; roughly half will be women, the rest men. But all of them will be very poor—their incomes will be below the federal poverty level or $10,210 for a single individual. They have little or no disposable income to purchase health care or health insurance assuming it was even available to them. And largely it is not. A recent study by the Kaiser Family Foundation found that *less* than 10% of low-income working adults have access to any insurance options in the absence of public coverage.

One of the greatest sources of insecurity in our country today is the fear of becoming uninsured. And there is good reason for that fear. Mortality rates increase by 10-15% for the uninsured. The chance of surviving cancer is far less when that disease is diagnosed late in its progression. And we know that the uninsured have higher cancer mortality rates precisely because they are much more likely diagnosed with late stage cancer—they are

70% more likely to be diagnosed with late-stage colon cancer than those who are insured; 50% more likely to be diagnosed later with prostate cancer; and 160% more likely to be diagnosed with late stage Melanoma. A similar pattern exists for cardiovascular disease.

Lack of access to health insurance has economic consequences as well. Better health improves annual earnings by as much as 10-30%. And, as we all know, when people without health insurance are hospitalized, the cost of their care is shifted to all other payers in the health care system contributing to the crisis of rising health insurance costs that we all face.

These are the reasons that increasingly as we turn on the radio or pick up a newspaper we hear that one or another State is coming up with a plan to provide health insurance coverage for all of their citizens. Maine has been a leader in this effort. Despite rising national rates of uninsurance, Maine has increased the number of its citizens with health care coverage over the last five years and now has the lowest percentage of low-income non-elderly citizens without health insurance in the nation. This is the goal of many other states. Yet, as there is a growing national consensus that we must cover the uninsured, this budget takes an unfortunate step backwards, giving up the chance to cover more than 3,000 uninsured Maine people with the federal government paying two-thirds of the cost.

This federal waiver has achieved some remarkable results in Maine. It has had a direct and dramatic effect in offsetting the amount of hospital charity care in Maine hospitals. The most recent data available shows annualized expenditures for hospital services of $51.5M. representing nearly 45% of total program costs.

The cost of prescription drugs in the Municipal General Assistance Program dropped by 90%--nearly a quarter of a million dollars—during the first three years of the program. When program enrollment was frozen in 2005-6, general assistance prescription costs quadrupled over their pre-freeze levels.

Finally, there is evidence that it has improved the health of thousands of Maine people. More than three-quarters of those enrolled now have a medical home with a primary care

provider. The monthly cost of care for these individuals decreased from $525 when the program began in 2002, to $417 just three years later—a drop over more than 20%--showing that costs can be lowered with access to regular care.

The program has helped a 52 year old woman from central Maine overcome a debilitating case of Hepatitis C and return to her job caring for others where she anticipates having access to private insurance soon. Another young woman lost her job and had to give up plans for college when she became ill and experienced numerous hospitalizations. Through coverage under this program she was diagnosed with a particularly complicated form of diabetes which took many months to stabilize. But she won this battle and is now back at work, and back on track to go to college.

Since this program began it has received considerable attention largely in the form of concerns about cost. But the people served by this waiver, and the cost of serving them are *not* new to the State budget or the health care system or the economy. This program has simply made this group of individuals more visible and brought the costs of their lack of health insurance into sharper focus.

Among the 20,000 people who now have health insurance under this waiver are those no longer getting care too late in hospital emergency rooms; no longer getting prescription assistance from local municipalities; no longer are they falling into the criminal justice system for lack of mental health or substance abuse treatment; no longer too ill to go to work. Today, we can see the cost of providing insurance to these individuals in one line of the budget, rather paying for the consequences of *not insuring* them spread out over many others. And, most importantly, it has allowed us to address their lack of health insurance in a more rationale, less costly and far more humane manner.

Thank you for the opportunity to offer this testimony today.

Fund for a Healthy Maine (FHM) Allocations
FY 2006-07 to FY 2008-09

		Baseline		Gov. Budget Proposed Adjustments		Republican Caucus Proposed Adjustments		Difference	
	2006-07	2007-08	2008-09	2007-08	2008-09	2007-08	2008-09	2007-08	2008-09
DEPARTMENT OF THE ATTORNEY GENERAL									
011-26A-0947-01 FHM - ATTORNEY GENERAL									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(1.500)	(1.500)	(1.500)	(1.500)	(0.000)	(0.000)
Pers. Serv.	66,054	74,037	78,459	85,579	90,656	85,579	90,656	0	0
All Other	6,553	6,699	6,707	22,730	22,862	22,730	22,862	0	0
Program Total	72,607	80,736	85,166	108,309	113,518	108,309	113,518	0	0
Annual % Increase	5.92%	11.20%	5.49%						
DEPARTMENT OF HEALTH AND HUMAN SERVICES (formerly BDS)									
011-14G-0948-01 FHM - SUBSTANCE ABUSE									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	5,657,240	5,657,240	5,657,240	808,839	908,581	282,862	297,005	(525,977)	(611,576)
Program Total	5,657,240	5,657,240	5,657,240	808,839	908,581	282,862	297,005	(525,977)	(611,576)
Annual % Increase	0.24%	0.00%	0.00%						
DEPARTMENT OF EDUCATION									
011-05A-0949-01 FHM - SCHOOL NURSE CONSULTANT									
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	82,069	90,633	92,238	0	0	0	0	0	0
All Other	8,206	8,206	8,206	928	817	410	431	(518)	(386)
Program Total	90,275	98,839	100,444	928	817	410	431	(518)	(386)
Annual % Increase	1.51%	9.49%	1.62%						
FINANCE AUTHORITY OF MAINE									
011-05A-0950-02 FHM - HEALTH EDUCATION CENTERS									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	103,235	103,235	103,235	14,000	14,000	5,162	5,420	(8,838)	(8,580)
Program Total	103,235	103,235	103,235	14,000	14,000	5,162	5,420	(8,838)	(8,580)
Annual % Increase	1.61%	0.00%	0.00%						
011-05A-0951-02 FHM - DENTAL EDUCATION									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	243,235	243,235	243,235	34,500	34,500	12,162	12,770	(22,338)	(21,730)
Program Total	243,235	243,235	243,235	34,500	34,500	12,162	12,770	(22,338)	(21,730)
Annual % Increase	0.68%	0.00%	0.00%						
011-05A-0952-02 FHM - QUALITY CHILD CARE									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	148,592	148,592	148,592	19,200	19,200	7,430	7,801	(11,770)	(11,399)
Program Total	148,592	148,592	148,592	19,200	19,200	7,430	7,801	(11,770)	(11,399)
Annual % Increase	1.11%	0.00%	0.00%						
DEPARTMENT OF HEALTH AND HUMAN SERVICES (formerly DHS)									
011-10A-0953-01 FHM - BUREAU OF HEALTH - ORAL HEALTH									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	973,897	973,897	973,897	139,900	139,900	48,695	51,130	(91,205)	(88,770)
Program Total	973,897	973,897	973,897	139,900	139,900	48,695	51,130	(91,205)	(88,770)
Annual % Increase	2.71%	0.00%	0.00%						
011-10A-0953-02 FHM - BUREAU OF HEALTH - TOBACCO PREVENTION AND CONTROL									
Pos. - Leg.	(4.000)	(4.000)	(4.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	269,111	282,364	291,596	0	0	0	0	0	0
All Other	6,539,145	6,439,145	6,439,145	1,939,200	2,039,200	326,957	343,305	(1,612,243)	(1,695,895)
Program Total	6,808,256	6,721,509	6,730,741	1,939,200	2,039,200	326,957	343,305	(1,612,243)	(1,695,895)
Annual % Increase	0.55%	-1.27%	0.14%						
011-10A-0953-06 FHM - BUREAU OF HEALTH - HOME VISITS									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	4,715,713	4,715,713	4,715,713	667,000	717,000	235,786	247,575	(431,214)	(469,425)
Program Total	4,715,713	4,715,713	4,715,713	667,000	717,000	235,786	247,575	(431,214)	(469,425)
Annual % Increase	2.72%	0.00%	0.00%						

Fund for a Healthy Maine (FHM) Allocations
FY 2006-07 to FY 2008-09

		Baseline		Gov. Budget Proposed Adjustments		Republican Caucus Proposed Adjustments		Difference	
	2006-07	2007-08	2008-09	2007-08	2008-09	2007-08	2008-09	2007-08	2008-09
011-10A-Z015-01 FHM - DRUGS FOR THE ELDERLY & DISABLED									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	8,088,741	8,898,741	8,898,741	2,159,154	3,909,695	2,159,154	3,909,695	0	0
Program Total	8,088,741	8,898,741	8,898,741	2,159,154	3,909,695	2,159,154	3,909,695	0	0
Annual % Increase	-16.30%	10.01%	0.00%						
011-10A-Z048-01 FHM - IMMUNIZATION									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	0	0	0	1,258,000	1,258,000	1,155,000	1,212,750	(103,000)	(45,250)
Program Total	0	0	0	1,258,000	1,258,000	1,155,000	1,212,750	(103,000)	(45,250)
Annual % Increase									
DEPARTMENT OF HEALTH AND HUMAN SERVICES (formerly DHS)									
Pos. - Leg.	**(16.000)**	**(16.000)**	**(16.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**
Pers. Serv.	**990,932**	**1,029,884**	**1,060,637**	**0**	**0**	**0**	**0**	**0**	**0**
All Other	**41,245,237**	**41,957,267**	**41,957,267**	**9,678,863**	**11,877,610**	**4,290,950**	**6,427,339**	**(5,387,913)**	**(5,450,271)**
Dept. Total	**42,236,169**	**42,987,151**	**43,017,904**	**9,678,863**	**11,877,610**	**4,290,950**	**6,427,339**	**(5,387,913)**	**(5,450,271)**
Annual % Increase	**-2.13%**	**1.78%**	**0.07%**						
JUDICIAL DEPARTMENT									
011-40A-0963-01 FHM - JUDICIAL DEPARTMENT									
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	100,849	94,808	100,025	0	0	0	0	0	0
All Other	2,726	2,726	2,726	0	0	0	0	0	0
Program Total	103,575	97,534	102,751	0	0	0	0	0	0
Annual % Increase	5.42%	-5.83%	5.35%						
DEPARTMENT OF PUBLIC SAFETY									
011-16A-0964-01 FHM - FIRE MARSHAL									
Pos. - Leg.	(3.500)	(3.500)	(3.500)	(-0.500)	(-0.500)	(-0.500)	(-0.500)	(0.000)	(0.000)
Pers. Serv.	188,327	195,611	203,195	5,659	7,003	5,659	7,003	0	0
All Other	20,310	12,120	12,120	0	0	0	0	0	0
Program Total	208,637	207,731	215,315	5,659	7,003	5,659	7,003	0	0
Annual % Increase	6.16%	-0.43%	3.65%						
GRAND TOTALS - ALL DEPARTMENTS									
Pos. - Leg.	**(21.500)**	**(21.500)**	**(21.500)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(0.000)**	**(0.000)**
Pos. - Other	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**
Pers. Serv.	**1,428,231**	**1,484,973**	**1,534,554**	**91,238**	**97,659**	**91,238**	**97,659**	**0**	**0**
All Other	**47,435,334**	**48,139,320**	**48,139,328**	**10,579,060**	**12,877,570**	**4,621,705**	**6,773,627**	**(5,957,355)**	**(6,103,943)**
Grand Total	**48,863,565**	**49,624,293**	**49,673,882**	**10,670,298**	**12,975,229**	**4,712,943**	**6,871,286**	**(5,957,355)**	**(6,103,943)**
Annual % Increase	**-1.77%**	**1.56%**	**0.10%**						

Fund for a Healthy Maine (FHM) Allocations
FY 2006-07 to FY 2008-09

		Baseline		Gov. Budget Proposed Adjustments		Republican Caucus Proposed Adjustments		Difference	
	2006-07	2007-08	2008-09	2007-08	2008-09	2007-08	2008-09	2007-08	2008-09
011-10A-0953-07 FHM - BUREAU OF HEALTH - COMMUNITY SCHOOL GRANTS									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	7,883,443	7,883,443	7,883,443	1,132,300	1,282,300	394,172	413,881	(738,128)	(868,419)
Program Total	7,883,443	7,883,443	7,883,443	1,132,300	1,282,300	394,172	413,881	(738,128)	(868,419)
Annual % Increase	2.72%	0.00%	0.00%						
011-10A-0953-08 FHM - PUBLIC HEALTH INFRASTRUCTURE									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	0	0	0	1,800,000	1,800,000	500,000	750,000	(1,300,000)	(1,050,000)
Program Total	0	0	0	1,800,000	1,800,000	500,000	750,000	(1,300,000)	(1,050,000)
Annual % Increase									
011-10A-0954-01 FHM - BFI - CENTRAL									
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	44,416	51,051	54,052	0	0	0	0	0	0
All Other	4,450	1,480	1,480	6,246	6,366	223	234	(6,024)	(6,132)
Program Total	48,866	52,531	55,532	6,246	6,366	223	234	(6,024)	(6,132)
Annual % Increase	11.07%	7.50%	5.71%						
011-10A-0955-01 FHM - BUREAU OF MEDICAL SERVICES									
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	43,021	66,075	69,863	0	0	0	0	0	0
All Other	51,837	56,837	56,837	0	0	0	0	0	0
Program Total	94,858	122,912	126,700	0	0	0	0	0	0
Annual % Increase	-21.05%	29.57%	3.08%						
011-10A-0956-01 FHM - FAMILY PLANNING									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	410,062	410,062	410,062	58,900	58,900	20,503	21,528	(38,397)	(37,372)
Program Total	410,062	410,062	410,062	58,900	58,900	20,503	21,528	(38,397)	(37,372)
Annual % Increase	2.72%	0.00%	0.00%						
011-10A-0957-01 FHM - SERVICE CENTER									
Pos. - Leg.	(10.000)	(10.000)	(10.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	634,384	630,394	645,126	0	0	0	0	0	0
All Other	46,235	46,235	46,235	0	0	2,312	2,427	2,312	2,427
Program Total	680,619	676,629	691,361	0	0	2,312	2,427	2,312	2,427
Annual % Increase	6.71%	-0.59%	2.18%						
011-10A-0958-01 FHM - DONATED DENTAL									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	37,162	37,162	37,162	5,400	5,400	1,858	1,951	(3,542)	(3,449)
Program Total	37,162	37,162	37,162	5,400	5,400	1,858	1,951	(3,542)	(3,449)
Annual % Increase	2.71%	0.00%	0.00%						
011-10A-0959-01 FHM - HEAD START									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	1,383,960	1,383,960	1,383,960	198,500	198,500	69,198	72,658	(129,302)	(125,842)
Program Total	1,383,960	1,383,960	1,383,960	198,500	198,500	69,198	72,658	(129,302)	(125,842)
Annual % Increase	2.72%	0.00%	0.00%						
011-10A-0960-01 FHM - MEDICAL CARE									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	7,045,145	7,045,145	7,045,145	(269,437)	(171,351)	(826,180)	(813,231)	(556,743)	(641,880)
Program Total	7,045,145	7,045,145	7,045,145	(269,437)	(171,351)	(826,180)	(813,231)	(556,743)	(641,880)
Annual % Increase	1.16%	0.00%	0.00%						
011-10A-0961-01 FHM - PURCHASED SOCIAL SERVICES									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	3,983,435	3,983,435	3,983,435	572,000	622,000	199,172	209,130	(372,828)	(412,870)
Program Total	3,983,435	3,983,435	3,983,435	572,000	622,000	199,172	209,130	(372,828)	(412,870)
Annual % Increase	2.72%	0.00%	0.00%						
011-10A-0962-01 FHM - HUMAN LEUKOCYTE									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	0	0	0	0	0	0	0	0	0
All Other	82,012	82,012	82,012	11,700	11,700	4,101	4,306	(7,599)	(7,394)
Program Total	82,012	82,012	82,012	11,700	11,700	4,101	4,306	(7,599)	(7,394)
Annual % Increase	2.71%	0.00%	0.00%						

SENATE

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LISA T. MARRACHÉ, DISTRICT 25
KEVIN L. RAYE, DISTRICT 29

JANE ORBETON, LEGISLATIVE ANALYST
ELIZABETH COOPER, LEGISLATIVE ANALYST
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STATE OF MAINE

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DONALD G. SOCTOMAH,
PASSAMAQUODDY TRIBE

ONE HUNDRED AND TWENTY-THIRD LEGISLATURE

COMMITTEE ON HEALTH AND HUMAN SERVICES

MEMORANDUM

Date: March 30, 2007

To: Senator Margaret Rotundo, Senate Chair
Representative Jeremy R. Fischer, House Chair
Joint Standing Committee on Appropriations and Financial Affairs

From: Joseph C. Brannigan, Senate Chair
Anne C. Perry, House Chair
Joint Standing Committee on Health and Human Services

Re: Recommendations on the change package to LD 499, An Act Making Unified 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 Years Ending June 30, 2008 and June 30, 2009

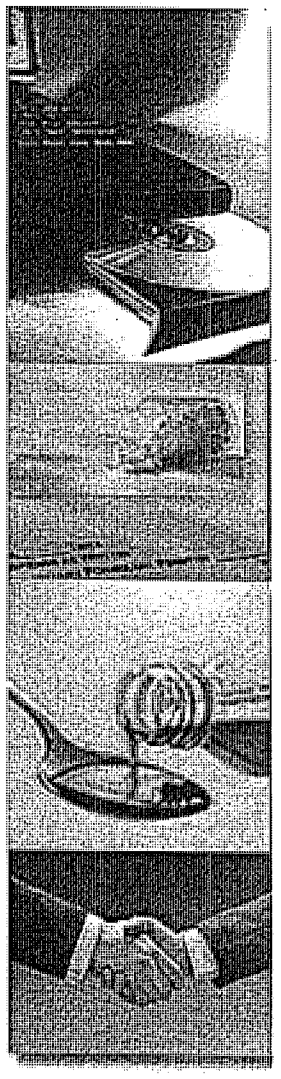
The Health and Human Services Committee is pleased to provide their report on the change package to LD 499, the 2008-2009 biennial budget. The Health and Human Services Committee, although somewhat hurried to conduct its review and report back, discussed the change package items, reviewed the preliminary votes of the Appropriations Committee on the contents of the change package and agreed to support the change package as presented.

Committee members are aware of the most recent revenue reprojections and are concerned about their impact on the remainder of the FY07 budget and the biennial budget. With regard to agencies and programs under the jurisdiction of the HHS Committee, committee members expressed serious concern that in finalizing budget packages the Appropriations Committee might make adjustments or cuts without input from the HHS Committee. We request that the HHS Committee be consulted first and given an opportunity to identify appropriate cuts in collaboration with the Department of Health and Human Services.

Thank you for your consideration.

c: Members, Health and Human Services Committee
Christopher Nolan, OFPR

Governor's Office of Health
Policy and Finance



MaineCare
Pharmacy Initiatives

PDL

- Preferred Drugs:
  - By definition are usually Cost-Effective
  - Provide the best clinical outcome for the least amount of money

PDL
What it's not

- A PDL is not a Formulary
- Formulary is a limited list of drugs that are covered
- In a PDL all Drugs continue to be covered
- Members have access to Non-Preferred Drugs in a variety of ways:
  - By Prior Authorization
  - By Step Therapy
  - By Grandfathering in certain Drug Classes
  - By Special Medical Conditions (Cancer)

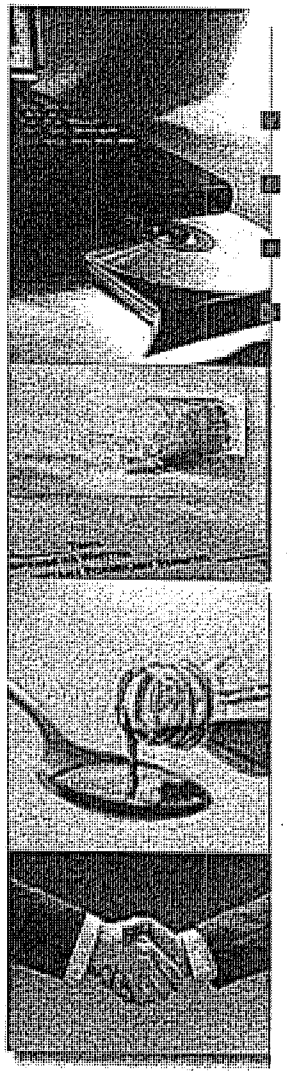
Antipsychotics

- Nearly $20 million (state + federal) spent annually
- 11% of drug budget
- Over 12,000 users
- Presently, PDL only addresses high doses and duplicate therapy
- Can save over $1 million (state) by selecting first-line drugs that won't need PA
- 15 States currently PA in this Category

PA for Some Atypicals

- Follow National Association of State Mental Health Directors Guidelines (see next 2 slides)
- Many choices in first line medications
- Established users not affected (about 50% over course of the year)
- Only affects new starters

Antipsychotic PDL: Ensuring Appropriate Access and Efficient Utilization (NASMHD)



All medications should be available.

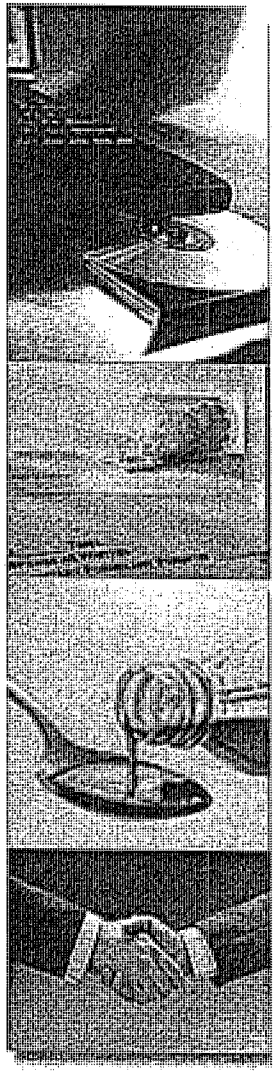
Not all medications need be available on a first-line basis.

PA should be simple and flexible.

Choices of first-line medications at a minimum must include:

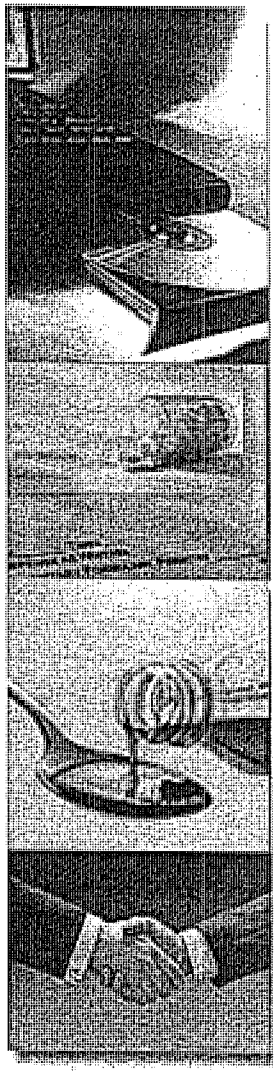
- Clozapine (any approved formulation) [Treatment-resistance]
- Risperidone or paliperidone [Atypical with long-acting formulation]
- Ziprasidone or aripiprazole [Weight-neutral atypical]
- Olanzapine or quetiapine [Sedating atypical]
- Haloperidol or fluphenazine [high potency typical and long-acting formulation]
- Perphenazine or thiothixene or other medium-potency typical
- Chlorpromazine or other low-potency typical.

Appropriate Access and Efficient Utilization (NASMHD)



- Helps ensure that medications are prescribed according to manufacturer indications
- A prescription drug may be selected for prior authorization if one of the following characteristics apply:
  - Clinically appropriate
  - High ingredient cost
  - Use is within a narrow member population
  - Drugs with a high potential for inappropriate use or abuse
  - Agents that are best reserved for second or third line therapies

What happens when a PA is needed?



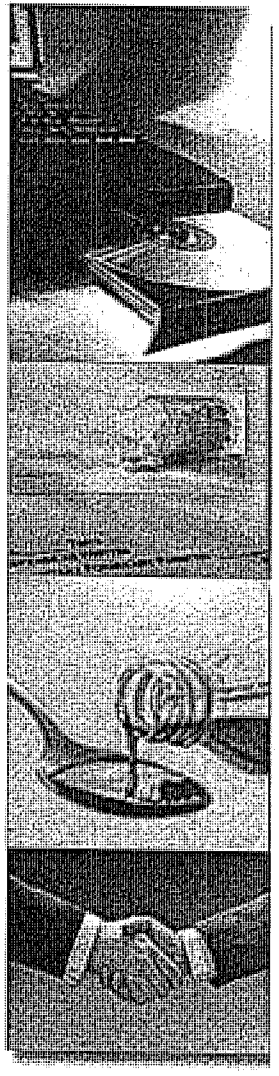
- But the doctor has not completed the PA request
  - There was a one time override the pharmacist could use to dispense a one month supply during the PDL implementation phase.
  - The member always has access to a 96 hour emergency supply.
- Nearly 80% of PA's submitted are approved
- Completed PA receive a decision on average within 3 hours of submission

What happens when a PA is not approved?

- Additional information documenting medical necessity for a re-determination may be submitted.

- A member can appeal the decision by requesting a Fair Hearing.

4 Brand Name Per Month Limit



- $1 Million savings (State)
- Only for MaineCare members who are:
  - Not a dual eligible
  - Over 18 years of age
- Will not apply to:
  - Cancer medications
  - HIV medications
  - Antipsychotics
- Currently have 5 Brand limit for MaineCare members living in certain settings
- 17 States currently have limits in place

DHHS

NAMI Maine
1 Bangor Street
Augusta, ME 04330

May 29, 2007

Hon. John Nutting
Maine State Senate
State House Station #3
Augusta, Maine 04333

Dear Senator Nutting:

At your request, I am sending this letter regarding the budget language which creates both prior authorization and step therapy for atypical antipsychotics. Step therapy is "fail first" policy – all people are required to take the same medication at first, fail on that medication, take the second tier medication, fail on that...and so on, until eventually they have failed enough and can take the medication that will work. These new restrictions on access to medications are an additional $6 million dollars in reductions to mental health services in Maine. As I know you are painfully aware, limiting access to treatment, especially medication can lead to tragedy – for the person who is ill and their family. Here are my comments:

1. L.D. 1677, the budget enacted in 2005 was amended by HHS-1, sponsored by Representative Dudley. That language said: "22MRSA section 3174, sub-1A, paragraph c is enacted to read: "Ensure that atypical anti-psychotic drugs remain available in the same manner as they were on July 1, 2005 including adopting any clinical edits approved thereafter by the Department's Psychiatric Work Group and conform to national standards for the prescribing of atypical anti-psychotic drugs." I am a member of this Work Group and we have NOT called for these changes.

2. Fail first policies conflict with most clinical treatment guidelines and force people with serious mental illness to delay the start of effective treatment, exposing them to increased risks including relapse, hospitalization, arrest, or death. Most private health plans have discontinued fail first policies because they did not control costs. The Kaiser Family Foundation released research several years ago noting that step therapy and prior authorization did not work with psychiatric medications.

3. The state references best practices from the national Association of State Mental Health Program Directors' as the guide for these changes and claims that these medications are all, really, the same. According to a recent report by NASMHPD, entitled *Comparative Effectiveness of Antipsycotics: Critical reassessment and recommendations, Circa 2007* forcing people to switch medications or limiting access to medications because "they are all the same" is dangerous. They say, quote: "there are modest differences in efficacy and SIGNIFICANT differences in side-effects among the available antipsychotic medications. Individuals have different vulnerabilities and preferences and show variable patterns of response to different antipsychotic medications...There is enormous individual variability in antipsychotic response and vulnerability to adverse effects. Antipsychotic treatment needs to be individualized. **There is no best agent or best dose of agent for all patients.** The choice of initial antipsychotic agent and dose and issues of continuation or changes require careful monitoring and joint consumer-clinician decision making." They recommend:
   - An open formulary with unrestricted access to all mediations";
   - If a medication is found to be safe and effective, its continuation should be guaranteed.
   - Prior authorization should be used for unproven higher risk practices such as concurrent use of three antipsychotics or ultra high doses of antipsychotic agents.

4. A recent large, national study carried out by NIMH, the CATIE study found: (l) "Even when patient and clinician were not completely satisfied with their original agent and agreed to switch antipsychotic, those who DID NOT SWITCH, did better than those who did. SWITCHING ANTIPSYCHOTIC AGENTS WAS FOUND TO BE RISKY AND COSTLY."; and (2) second generation anti-psychotic agents have been considered to be more effective in improving negative and cognitive symptoms."

NAMI Maine believes these changes will cause harm and hopes they will be reconsidered. Thank you for this opportunity to provide additional information.

Sincerely,

Carol Carothers

Carol Carothers
Executive Director

cc. Senator Mills
Members of the Appropriations Committee

Jude Walsh

STATE	ATYPICAL ANTIPSYCHOTICS				
	Require PA?	PA Criteria	On PDL?	PDL Website (if atypicals on PDL)	Special Provider Education?
ALABAMA	No	None	No	n/a	No
ALASKA					
ARIZONA					
ARKANSAS					
CALIFORNIA					
COLORADO					
CONNECTICUT					
D.C.					
DELAWARE					
FLORIDA					
GEORGIA	Yes. At website, click on 'what am I' - Provider, then Pharmacy, then PA Criteria.	http://www.dch.georgia.gov/	Yes	http://www.dch.georgia.gov/	
HAWAII					
IDAHO	No	None			
ILLINOIS	Yes	http://www.hfs.illinois.gov/pharmacy/a_pdl.html	Yes	http://www.hfs.illinois.gov/preferred/	
INDIANA					
IOWA	No	None	No	n/a	No
KANSAS	No	None	No	n/a	No
KENTUCKY	Yes	http://chfs.ky.gov/NR/rdonlyres/EA289599-8FC5-43DF-A8CD-A3DCCED9C84B/0/A472021805.pdf			
LOUISIANA	Yes	http://www.lamedicaid.com/provweb1/forms/rxpa/RxPAFaxForm.pdf	Yes	http://www.lamedicaid.com/provweb1/Pharmacy/preferredoct05.htm#antipsychotic	
MAINE	Yes	http://www.mainecarepdl.org/uploads/4S/S5/4SS5qCpZM86bfuCwmA2VqA/MaineCare-PDL-w.criteria.01.06.2006.pdf	Yes	http://www.mainecarepdl.org/index.pl/pdlfiles	http://www.mainecarepdl.org/uploads/TqA8/TqA84HkDbCwpalynjpQRMA/Misc-Non-Pref-20420-7.doc
MARYLAND					
MASSACHUSETTS	Yes	www.mass.gov/masshealth/pharmacy	Yes	http://www.mass.gov/?pageID=eohhs2terminal&L=6&L0=Home&L1=Provider&L2=Insurance+(including+MassHealth)&L3=MassHealth&L4=MassHealth+drug+List&Lf=Therapeutic+Class+Tables&sid=Eeohhs2&b=terminalcontent&f=masshealth_provider_pharmacy_therapeutic_table_24&csid=Eeohhs2	
MICHIGAN	No	None	No	n/a	
MINNESOTA	No	None			
MISSISSIPPI	No	None	Yes*	http://www.medicaid.state.ms.us/Provider/Provider_Manuals/pharmacy.pdf	*Scheduled for PDL inclusion 10/06
MISSOURI	No	None	No	n/a	No
MONTANA	Yes		Yes. See page 15 at hyperlink ->	http://www.dphhs.mt.gov/medicaid/pdf/pharmacy.pdf#xml=http://search2.discoveringmontana.com/cgi-bin/texis.cgi/webinator/search/xml.txt?query=ability&pr=DPHHS&prox=page&rorder=500&rprox=500&rdfreq=500&rwfreq=500&rlead=500&sufs=0&order=r&cq=&id=43fd6eca1	
NEBRASKA	No	None		http://www.hhs.state.ne.us/med/pharm/covered.asp	
NEVADA	No	None	No	n/a	No
NEW HAMPSHIRE	Yes	http://www.dhhs.state.nh.us/NR/rdonlyres/eenpjx5ovw5xenxiv65oe5fdha56vob2enswz2bsmpvihcqzmcdmzxacx6m4kbcmbhlzq6sn3lh3mywotlmdehy27cd/PDL+01-23-06.pdf	Yes	http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/LIBRARY/Policy-Guideline/preferred-drug.htm	http://www.dhhs.state.nh.us/NR/rdonlyres/e7jxfzz6k5abxl5fqtx24e2vuswxw3wc457ccyj2fx5ek2s234f2ezdwwojbox7kvmbk4tsj5oa6qmb7uf5vwlf65eb/Non-preffered+Brand+5-1.pdf
NEW JERSEY					
NEW MEXICO	Yes	http://www.phs.org/resources/documents/exception.pdf	Yes	http://www.phs.org/resources/documents/nmrx2.pdf	
NEW YORK					
NORTH CAROLINA	No	None			
NORTH DAKOTA	No	None	No	n/a	No
OHIO	Yes		Yes	http://medlist.odjfs.state.oh.us/	
OKLAHOMA					
OREGON					
PENNSYLVANIA	Yes	http://www.dpw.state.pa.us/General/Bulletins/003673169.aspx?AttachmentId=1058	Yes	http://providersynergies.com/services/medicaid/documents/PAM_PDL_Phase_1-4_Combined_122205.pdf	
RHODE ISLAND	No	None		n/a	No
SOUTH CAROLINA	No	None	Voluntary PDL	n/a	No
SOUTH DAKOTA					
TENNESSEE (TennCARE)	Yes	https://tennessee.fhsc.com/Downloads/provider/TNRx_PDL_CC_ST_QLL.pdf	Yes	https://tennessee.fhsc.com/Downloads/provider/TNRx_PDLquicklist_20051201.pdf	No
TEXAS	Yes	http://www.hhsc.state.tx.us/HCF/vdp/PT/PDL_Program.html	Yes	http://www.hhsc.state.tx.us/HCF/vdp/PT/PDL_Program.html	
UTAH	Quantity Limits	http://health.utah.gov/medicaid/pdfs/PHARMACY/attachmnts/druglimits1-06.pdf			
VERMONT	http://www.ovha.state.vt.us/docs/2005-12-15-SPMI_Prescriber_Final.pdf	http://www.ovha.state.vt.us/docs/2006-02-01-VT_Clinical_Criteria.pdf	http://www.ovha.state.vt.us/legislative.cfm	http://www.ovha.state.vt.us/docs/2006-02-01-PDL_QuickList_(VT).pdf	http://www.ovha.state.vt.us/docs/2005-12-15-SPMI_Description.pdf
VIRGINIA	No	None			
WASHINGTON					
WEST VIRGINIA	Yes	http://www.wvdhhr.org/bms/sPharmacy/PDL/bms_pdl_PreferredDrugListTOP.pdf	Yes	http://www.wvdhhr.org/bms/sPharmacy/PDL/bms_pdl_PreferredDrugListTOP.pdf	
WISCONSIN	Review w/ PA Committee 3/29/06	Review with Mental Health Advisory Grp 4/12/06			
WYOMING	No	None	No	n/a	No

Revised February 23, 2006

15 States have PA

Sen. Nutting

Snippy Response - Computer System Better

Date	Issue
8/7/2003	Why is DHS classifying strattera as a stimulant. It is the
	only non-stimul.ant for ADGD and is a norepinephrine uptake
	inhibitor. It is the one drug that has been found to be effective
	with adults. Harmful to classify it in this manner.
3-Aug	Her 15 year old son was removed from his lithobid to a
	generic version of lithium because of the new rules. Past
	experience witth generics had caused pronounced tics
	and she asked the pharmacist not to do this. The prescribing
	psychiatrist was not aware of the new rules, so, 2 weeks
	later, when her son was experiencing pronounced tics
	(involuntary throat clering and quick jerky movements of
	his head) she called and asked that he be put back on the
	original medication, which had worked fine. Given her sons
	age (adolescence) this could have resulted in his refusal to
	take his medications. This is not a GAME.
9/17/2003	Reports that requests for prior authorization were denied
	as follows: prozac x 2 patients, sarafem x 2, neurontin x 3,
	Trileptal x 3, Abillify x 3, Effexor x 2, Ambien x 2, Sonata x 2.
	The patient on Trileptal was only given 3 tabs, so missed a
	couple of doses and ended up in the ER with a seizure.
	Even so, the prior authorizatin request was denied. 24
	prior authorizations were approved, but 12 had to be deferred
	and took lots of time to collect and send data. Although
	MDs were told some medications were grandfathered, they
	are now told no one is grandfathered. Some of the prior
	authorizations were allowed only through October 1st, so, what
	will happen then? In addition, they have some patients
	who are on four medications, but two will no longer be
	allowed, so they will need to change everything, possibly
	causing deterioration to a person now stable, and also
	costing more as more office visits will be needed to start
	a new regimen.
9/30/2003	One 34 year old female was rehospitalized. She had been
	stabilized on effexor, but they insisted she switch to zoloft
	even though she had failed on that before. She was
	switched to zoloft, decompensated, and was rehospitalized.

	One 24 year old male was stabilized on seroquel, but the						
	pharmacy rejected his re-fill when he went in because						
	it hadn't been prior authorized. The patient didn't know						
	what to do, so left without his meds, and didn't tell anyone,						
	after 10 days with no medications, he was rehospitalized.						
	He is now homeless and a member of the AMHI class.						
10/5/2003	Male resident, long time amhi client with history of violence.						
	stabilized on zyprexa, but it's not approved, so they want						
	to switch him to risperdol. M.D. asked for prior authorization						
	mutiple contacts and appeals went unheeded. Finally, M.D.						
	phoned the public guardian, who phoned DHS and the						
	drug was prior authorized.						
10/7/2003	client of hers was told she couldn't have her current						
	medication, and that she had to take one that she is						
	alergic to. The M.D. told the Medicaid people that she was						
	alergic to the other medicine, but they were told she would						
	have to take it for a week anyway. The medication she is						
	alergic to is morphine, she had a fenatyl patch. So, she						
	took the morphine (she has soriatic arthritis) and it gave						
	her asthma symptoms and she was hospitalized.						
10/14/2003	patient with PTSD and history of homicide has had						
	to switch from topamax, which had stabilized him, to 10						
	other medications, none of which has done what topamax						
	did.						
10/9/2003	Fax from DHS denied topamax for a patient stabilized						
	on that medication. The fax said "please provide studies						
	showing topamax is effective with patients w/affective instability						
	"This is going to be a disaster for this patient and is glaringly						
	irresponsible.						
10/15/2003	Patient was stabilized on topamax for PTSD and panic.						
	Denied 3 times, doctor is increasking lexapro to compensate.						
	patient has decompensated greatly.						
10/16/2003	Has beendenied effexor, lamictal, and seroquel. Is 48 years						
	old with bipolar and PTSD. Was stable on the meds. Is						
	now experiencing sleeplessness, withdrawal symptpoms,						
	amd decompensating.						

10/7/2003	Parent of 11 year old boy with several psychiatric diagnoses.						
	End of August was started on topamax. They paid 50/month						
	for it at 25 mg. But the increase to 50 mg. Cost double, and						
	because husband lost job last spring, they haven't money						
	Her son will be switching to anothre med.						
10/10/2003	Child ws on zentec for allergies and ws made to switch to						
	clariton, an dthen switched to clarenex. Both meds failled						
	but they will not allow return to zentec, which was working.						
10/10/2003	Has been taking brand name, lexopril. And the pharmacist						
	wouldn't fill her prescription. Gave her some samples.						
10/14/2003	Was on topamax since 2-03. Working well. Has been told she						
	must drop this medicatin and start on another that costs						
	less. She is mad.						
10/16/2003	Is on medicaiton for M.S. and is being denied these meds.						
10/16/2003	3 people deferred on their medications one is an 80 year old						
	who was taking ativan the generic doesn't work for him)						
	so he is being asked to try 2 others instead. He is frail and						
	elderly and stable, so this doesn't make sense. Also reports						
	an elderly man taking flomax for cancer, has been denied						
	that med, and will be asked to take something.						
10/23/2003	patient with depression, name brand prozac in past, tried						
	generic but didn't work. Had reaction. Forced to switch to						
	effexor. No sense. Clinically not the right med. Was stable						
	before.						
10/23/2003	Client was doing well on zyprexa for 2 years plus. Made to						
	switch and this has failed.						
10/23/2003	Seroquil worked for this patient. Risperdol trial caused						
	decompensation. Patient had to decompensate for 30 days						
	before could be tried on seroquil.						
10/23/2003	Number of patients with schizophrenia wre placed on meds.						
	in hospital and stabilized. They come to him, he hasn't got						
	the hospial records, so without those to prove grandfather,						
	they are removed from those medications.						
10/24/2003	Has been denied ambien. Is 57 years old and has depress.						
	anxiety, insomnia, and hep. B. Has been stable on his meds.						
	now, without the ambien, he is short of breath, problems						

	with kidneys, hung over feeling, irritable, and feels cold. Is						
	trying to get the doctor to appeal.						
10/24/2003	Client was denied seroguel at 100 mgs. Qhs. Has been						
	doing well on that medication and sleeping well. DHS has						
	denied continuation of seroquel until the MD produces						
	documentation showing that the client had a prior trial on						
	risperdol.						
10/24/2003	Neurontin is deined. Clinet has SAD,. Major depression, and						
	PTSD. The doctor is appealing the denial.						
10/23/2003	Denials this week were: abilify x 1, ambien x 1, Geodon x 1						
	Lamictal x 4, Neurontin x 4, Seroquel x 5, Straterra x 1,						
	Topamax x 11, Trileptal x 4, zyprexa x 2. Inconsistent						
	feedback from DHS. I.e., some say if there is a dose change						
	a new PA is needed, others say not. Instead of 1 year						
	approvals, they are giving 6 mos. Approvals.						
	One patient is still being denied topamax and they have						
	asked for a hearing, but not received a reply. There used to						
	be a 30 day supply while waiting for PA, but now it is only 4						
	days, stressing out patients. Phone calls have gone up by						
	25%, costing more, and involve calling DHS, the pharmacy,						
	and the patient. Local pharmacy has had to hire more help to						
	assist with Pas and DHS the same.						
10/24/2003	Denied abilify. Has bipolar 28 years old. Has failed on						
	lithium in the past. Also failed on depakote and trileptal. Dr.						
	is giving samples this past week. Appeal was denied						
10/21/2003	Topamax denied. 48 year old woman with bipolar living in						
	group home. Client was stable on this medication. The						
	medicaiton should have been grandfathered, but that was						
	denied, then deferred, then denied, then decision was reversed						
	again. Dr. had to defend the medicaiton 4 times. Dr. reports						
	numerous instances of denials and cumbersome appeals						
	processes.						
10/21/2003	4l year old woman, new to maine, came here on zoloft. As						
	part of a three med. Combination to treat bipolar. Was						
	stable on the 3 meds: zoloft, topomax and depakote.						
	zoloft was denied, and topamax approved for just 3 mos.						
	Client became depressed without the zoloft and Dr. appealed.						

	Then the issue became justifying the topamax.						
10/21/2003	is bipolar and adhd. Was stabilized on xuyprexa and ambien.						
	both denied. Now is not sleeping, "going through living hell".						
	"I finally had my life together, and now I can't function"						
10/17/2003	Denials: Abilify x 3, ambien x 2, geodon x 2, remeron x 2,						
	seroquel x 3, sonata x 2, straterra 2, trileptal x 9, topamax x 11,						
	zyprexa x 6. One patient had multiple medical problems and						
	was only given 30 days supply. A breast cancer patient was						
	denied sonata, as she had not been trialed on ambien. Her						
	present meds. Keep her comfortable. A woman with mental						
	illness was denied topamax and had been table and out of						
	the hospital for 4 years. She is now decompensating. A						
	patient in his 40s with a long history of multiple psyc. Treatment						
	all ofer the country and nmultiple hospital admissions and						
	paranoia is being denied zyprexa even though this med. Has						
	kept him out of the hospital. Many of the patients they treat						
	are living in group homes and cannot read or write, and they						
	call on th day they have no medicaitons, and the paperwork						
	makes it impossible to get the medications on time.						
10/22/2003	Son has been taking straterra. He is age 7. The med.						
	worked well for him. But, when she went to the pharmacy to						
	fill the script, she was told he couldn't get it because it is no						
	longer covered. So, she couldn't afford to pay the $90. So a						
	new drug was prescribed - concerta. The concerta doesn't						
	work as well and he is now depressed and has trouble sleeping.						
	Mom was told that if he continues to be depressed, they will give						
	him another pill for anxiety and will mean he takes 2 meds						
	instead of the one that he took before that was working.						
	will this be more expensive than the one he took before?						
10/29/2003	being denied serequil and lomictal. Has been denied twice.						
	is 48, bipolar and ptsd. Was stabilized. Worries about						
	hospitalization because meds. Aren't working now.						
10/28/2003	patient is major depression recurrent. Was stabilized after						
	3 hospitalizations. Took depakote, clonazepam in the past						
	and is allergic to lithium. Also has hypothrydoidism, hyper-						
	tension, mighraines, and arthritis. Side effects connected						
	to the other conditions also argue for continuation of topamax.						

10/29/2003	denied abilify. Schizoaffective and just been stabilized on this						
	medicaiton. This is the first denial and has been told it						
	doesn't meet maine care criteria. Is on the ACT team and						
	is fighting to get the denial overturned.						
10/29/2003	group home staffperson in presque isle. The medication						
	denied is ambien. The client is schizoaffective and severe						
	has been stable. Was allowed 10 mill./day, but now is allowed						
	only 10 mill/month. Has precipitated mood swings, angry						
	outbursts and needed crisis services last night. Maybe will						
	need hospitalization. The crisis worker suggested taking						
	client to the ER to get the medication.						
10/30/2003	zyprexa and seroquel being denied for 50 year old bipolar						
	since age 16. Stable and no hospital or crisis use for over						
	5 years. Past use of risperidol was unsuccessful. MD						
	requested zyprexa and was denied. Requested seroquel						
	and was denied too. Client went to crisis unit for the first						
	time in 5 years.						
10/31/2003	clinet has been doing well onseroquel, helps her sleep.						
	3rd request sent in asking for use of seroquel, and the						
	DHS wants proof that risperdal as been tried. Because it						
	hadn't been tried, they denied the seroquel and the patient						
	will be forced to change to risperdal. Diagnosis is traumatic						
	brain injury.						
10/31/2003	patient who had spinal cord surgery and brain surgery was						
	taking oxycontin. Was denied and forced to use morphine.						
	broke out in rash and was ill. Now they are requiring lab						
	work to prove morphine doesn't work.						
11/4/2003	Finally got approved for topamax, which had been denied.						
	suffers from migranes and was stabilized on this drug for						
	10 years. Had been denied and MD gave samples in the						
	interim.						
11/6/2003	adhd, odd, reactive attachment disorder. Took cylert and						
	ritilin without success. Was doing well on strattera, but						
	was denied access today. They have an appeal in the						
	works bnut not until december. The issue was times and						
	dosage. So, was doing better in school on this medication						
	and not cannot have it.						

11/13/2003	ptsd and personality disorder. Stress and agoraphobia. Was						
	on samples of gabitril. 8mg a day, tapering off to 4, then none						
	due to denial. Has been much better on this medication.						
10/30/2003	denied blood pressure medication for this paranoid schiz.						
10/28/2003	was on neurontin. Was denied her medication at rite aid.						
	"I don't know where I would be without my medication"						
10/9/2003	was stable on his medications. Dr. requested prior auth.						
	how he feels overwhelmed by the denial, and the copay of						
	25. Cannot afford the co-pay and is crying on the phone						
10/9/2003	has been denied zyprexa. Was stable on this medication.						
	has been told he will need to fail 3 times before he can						
	have the zyprexa. He is less stable because of this.						
10/9/2003	was denied topamax was stable on this medicaiton.						
	the doctor tried to get approval to prescribe.						
11/12/2003	denied lamictal and effexor. Patient is 25 years old and is						
	depressed, bipolar, and general anxiety disorder. Was stable.						
	Is now trying zoloft with little success and suffered some						
	withdrawal symptoms. Has been suicidal, is very depressed						
	was refused hospitalization, but has entered the partial						
	hospital program because of the increased depression.						
	was on 125 mg. Of lamictal for bipolar, but can only get 25 mg.						
10/4/2003	was stablized on ??, prior authorization at shalom was denied						
11/12/2003	was denied topamax. Has headaches and anxiety. Was stable						
11/4/2003	denied prozac for depression. Was stabilized for years on						
	this edication. Can't get the script filled. Unsure of the impact						
	yet.						
11/13/2003	was on seroquel for borderline personality disorder, depression						
	and ptsd. Is 33. Was stable. Now has migranes, stiff neck,						
	stomach problems, and has been hospitalized.						
	took a month but he finally got his meds. Spent days without						
	sleep.						
10/12/2003	was on lamictal, but wouldn't refill without prior authoriz.						
	delay caused her to be without meds. For 2 weeks while						
	waiting for paperwork.						
11/13/2003	Dr. told patient (24 year old) he would have to be suicidal						
	to get effexor. He has failed on welbutrin in the past. He is						
	developmentally challenged and the nurse calling felt he						

	wouldn't be able to advocte successfully for himself. She callled						
	nami to find out if suicidality was the criteria for overriding						
	prior authorization rules.						
12/8/2003	zanaflex for back injuries has been denied. She is also bipolar.						
	the request was denied. She was told to take baclofen 10 mg.						
	3x/day. But it didn't work. Doctor asked again, and they are						
	waiting. In the meantime, she is out of medicine, it was stopped						
	abruptly, she is agitated and in pain.						
12/4/2003	topamax was denied. Has major depression and anxiety						
	in middle 40s. Was doing well on topamax and the MD						
	sent multiple requests and the med. Has been denied						
	multiple times because it is only approved fro seizures and						
	bipolar. Has been hospitalized many, many times in the past,						
	but has been stable on topamax.						
12/4/2003	chronic back pain and diabetes. Was denied pain meds and						
	went without them for several days and went into crisis.						
11/21/2003	is an adult with borderline and depression. Was taking						
	medication (consumer couldn't name it) and it seemed to						
	help. However, was taken off of it and the pharmacy denied						
	him and wouldn't let him get his script. He is unable to pay						
	on his own. He needs the meds. And fears blood pressure						
	problems, and health problems.						
11/26/2003	was taking ability, paxil, and viox. Was stable. Has been without these medications for over a week. Has gone to the drug store						
	3 times because the doctor resubmitted the info 3 times,						
	but hasn't been given a refill.						
11/26/2003	has been denied topamax for her bipolar disorder.						
	was stable on this medication. Doctor is pursuing prior						
	authorization, but she was just stabilized on this new medication						
12/4/2003	client was on neurontin for 3 years for an agression disorder.						
	was doing well, but hs been deferred and then denied. Script						
	is running out tomorrow. Was told the diagnosis wasn't on						
	the list. Fears the agression will reappear.						
11/14/2003	is leaving practice because can't work with maine care						
	had 500 patients. Gave her resignation to spring harbor						
	can't practice under these rules. A second md there plans						
	to do the same.						
11/21/2003	daughter wass finaly approved for abilify. Note original call was						

	on 10-29.						
11/17/2003	this case manager called about a client taking abilify. The						
	client is 19 yrs. Old and a class member. Schizoaffective						
	is the diagnosis and experienced vomiting and dystonia on						
	geodone. Had a neurological exam and endoscopy and						
	was taken off geodone and put on ability. Was doing well on						
	abilify. Vomiting stopped, trempors decreased. Request						
	to continue on abilify was denied, noting that geodone, risperdal						
	or seroquel needed to be tried instead. MD is pursuing the						
	issue. Consumer is very concerned about having to go back						
	to medicaitons that cause tremors and vomiting.						
11/14/2003	denias this week: abilify x 2, ambien x 2, effexor x 2, lamictal						
	x 3, neurontin x 2, seroquel x 3, sonata x 3, strattera x 1,						
	topamax x 9, trileptal x 17, xanax x 2, aonogram x 1, zyprexa						
	x 6. Two cases are goinf for a hearing, both on topamax for						
	bipolar. One pt. Went to ER because of no meds; another						
	went to the ER for an MVA. Exra office visits have been needed						
	because of the need to change meds.						
11/14/2003	psychiatric nurse practitioner has 2 full time employees doing						
	Pas. Hours have been spent sending journal articles.						
	one patient who has not been hospitalized since taking trileptal,						
	has been stable on that med. Since 2001. This is just not						
	working and placing our patients at risk.						
11/18/2003	son was taking ability. He is 16 and schizophrenic. He was						
	stablized. The MD is truying to get this medicaiton. But						
	it seems his son will need to be hospitalized to get this						
	medication. His son is a student in high school.						
11/18/2003	was denied metazapine. Is 22 with szhicophrenia and						
	depression. Was stable, but was denied and placed on trazadel						
	and zoloft. Feels he cannot function and is having trouble						
	looking for work.						
11/19/2003	daughter jennifer who has depression and was stable on						
	abilify was hospitalized and placed back on abilify/ family is						
	concerned that once discharged, the abilify will again be						
	denied. This is a second call as information was missing						
	in the earlier call.						
11/20/2003	son is age 5. Was taking straterra and has been stable						

	since august. MD is workingon th epaperwork, but has						
	been denied. She is going to attend the hearing but						
	wants us to know that her son needs thismedication.						
12/10/2003	client was denied seroquil and risperdol. The doctor						
	prescribed zuprexa, but was denied because mainecare						
	insists that geodone needs to be prescribed. This client						
	was recently hospitalized. This MD feels overwhelmed by						
	the number of denials.						
12/3/2003	Letter sent to mainecare regardng clarification of policy.						
	is pa needed for doseage changes? Titrating medicaitons						
	is needed, and is there a need for a PA when doing so. Two						
	lettres sent without adequate response.						
12/18/2003	son is 21 year old schizophrenic who was denied risperdol						
	im, it has been tried and seemed to work. Has tried all						
	oral meds. Without success and unable to handle them.						
	Dr. has called, but the decision was not reversed.						
11/25/2003	is 55 had has 2 deteriorating disks, ptsd, self mutiliation						
	issues. Was denied skelaxin and oxycontin. Has been						
	vomiting, has pain, is depressed, wants to hurt self.						
12/19/2003	denied ambien. Is bipolar and has been stabilized. Dr.						
	has asked for reconsideration. Only gets 10 days per						
	month for sleep and only sleeps those days. Still gets his						
	risperdol for now.						
12/22/2003	denied zyprexa. Is 30 depressed, anxiety, schiophrenic, ptsd.						
	bipolar. Was stabilized. Doctor has appeaed. Was without						
	zyprexa for 4 days. Trashed house, abused finacee.						
12/22/2003	welbutrin. Has major depression. Ws stabliized.						
	the issue is needing to take the excel version, because						
	never can remember to take the second pill. Hasn't done						
	anything yet to appeal.						
1/17/2004	daughter was approved for lotrel. Stopped this, and switched						
	her to analapril maleate and norvasc. The eventual cost of the						
	switch ws a higher cost (only about a buck), but double the						
	co-pay for his daughter...so, what's the point?						
1/12/2004	client ws denied zyprexa which she used succesfully in the past						
	now there is a new psychiatrist, who has refused to do the						
	prior authorizatin steps. So, the client hasn't got the zyprexa						

	and she is very depressed, and not sleeping and no appetite.						
1/12/2004	age 41. Denied welbutrin, ativan, and effexor. Has						
	depression, and is very sleepy. Has seizures. Has migraines						
	needs to have these meds.						
1/14/2004	age 63. Has major depression, ADD, chronic fatigue,						
	and bipolar. Was stabilized on ambien. Now denied.						
	had to show that he had already tried xanax, trazadone,						
	an dover the counter sleep products. Now has insomnia.						
	Finally got 10 pills. As interim						
1/3/2004	denied prozac and buspar. Is bipolar. Was stabilized.						
	has times during the request period for a prior auth. Where						
	he han't got the medications and he becomes symptomatic						
1/5/2004	denied seroquel. Age 13, bipolar, narcissim, odd. Has						
	been taking these medicaitons for 3 years and doing well						
	untyil they moved to maine. PCP is trying to help with						
	samples, but when mes are gone (2-3 weeks without)						
	his behavior escalates and he gets homocidal and						
	suicidal thoughts.						
12/31/2003	denied ambien. 43 year old with bipolar. Now he cant						
	sleep and his sleep pattern is all messed up.						
1/7/2004	denied meds for arthritis, allergies, pain, and bi0olar. Is						
	48, bipolar, ptsd, agoraphobia, panic attacks. Appealed						
	the denial, but it was denied. New side effects appeared						
	and he had to have a new medicaiton added to counter						
	those, caused by the cheaper med. This caller was not						
	able to remember the names of the meds denied when he						
	called us.						
1/8/2004	denied solactin and changed to backofin also switched						
	from ditripan to detrol. Age 51 and bipolar. Was stable						
	on these meds. Has been really sick with stroke-like						
	suymptoms. Went to neurologists was determined that						
	reactions to backtofin.						
4-Jan	denied topamax, zuyprexa and zidix(?). Was stable on that med.						
	now the client can't stay awake. Is sicker.						
1/15/2004	43 year old with depression and ptsd. Denied seroquil. Was						
	finally allowed this med, but not at the right dose. Has been						
	stable on this for 2 years. Now feels moody and depressed.						

6/1/2005	This woman, stable on medications: lithobid, seroquel,						
	clozapine, risperdol, was refused all meds this am at Miller						
	Drug. Went to CH&CS and got samples. Told the MD needs						
	to clear this before she can have any of her meds.						

Nolan, Christopher

From: Wyke, Rebecca
Sent: Monday, May 07, 2007 1:07 PM
To: Nolan, Christopher
Cc: Schneiter, Ellen
Subject: FW: PHIP
Importance: High

Chris, here's the plan. Numbers are just slightly higher than yours. B.

From: Figueroa, Kirsten
Sent: Monday, May 07, 2007 12:01 PM
To: Wyke, Rebecca; Schneiter, Ellen
Cc: Harvey, Brenda
Subject: RE: PHIP
Importance: High

Hi,

Okay, the admin below can be changed to $285,000 for FY07, which breaks out as 4 new staff (1 Social Services Prog Specialist II and 3 Reimbursement Specialists) for $260,000 PS and $25,000 all other. The SSPSII would manage contract, program, and supervise staff. The staff would take referrals and investigate whether paying the insurance premium is less than what MaineCare would have spent by reviewing individual's income on quarterly basis as well as quarterly medical bills. The $285,000 is total state/fed. It is 50/50, so state expense is $142,500.

For FY08, admin is $820,000, which continues the 4 staff above, plus adding 2 more Reimbursement Specialists for $420,000 (total state/fed) to expand program. Would also add $400,000 (total state/fed) for contract, which would assist in Recertification of people already on program. This is also 50/50, so state expense is $210,000 for personnel and all other, and $200,000 for contract.

This means savings go up slightly. Net savings are $1,850,000 and $3,950,000.
See below for specifics. Thanks, Kirsten

	FY08 Total	FY09 Total	FY08 GF	FY09 GF
Admin	$285,000	$820,000	$130,000 4 staff $12,500 for all other (mailings)	$190,000 6 staff $20,000 all other (mailings) $200,000 contract
Net Savings	5,069,699	11,058,454	1,850,000	3,950,000
Gross Savings	5,354,699	11,878,454	1,992,500	4,360,000

LD 499
HHS

Pruett, Diane

From: Harvey, Brenda

Sent: Thursday, May 03, 2007 8:44 PM

To: Cain, RepEmily; Craven, RepMargaret; Dionne, James K.; Fischer, RepJeremy; Flood, RepPatrick; Giles, RepJayne; Martin, SenJohn; Millett, RepSawin; Mills, RepJanet; Nolan, Christopher; Pruett, Diane; Robinson, RepJohn; Rotundo, SenMargaret; Turner, SenKarl; Valentino, RepLinda; Webster, RepDavid

Cc: Wyke, Rebecca; Ende, Patrick; Hollander, Lucky; Figueroa, Kirsten

Subject: A response to all the MH email you are receiving

Importance: High

Attachments: Mental Health Expenditures from 2002 to 2006 grew by 90 (3).doc

To all...

I am planning to hand this out tomorrow but given how much email you are receiving on this issue, I thought this might be helpful. The charts will come tomorrow--- Providers are claiming that over $100MM of reductions are being made to $300MM plus of services.

1. $ 100MM is a combination of ASO and Rate reductions for two years—GF and federal match.
2. The $300MM is '06 (one year) expenditure in community services that have rate variability— they are comparing apples to oranges-- total expenditures are much higher.
3. I have tried to give you an accurate picture of the dollars to help you in your deliberations. I hope it's helpful. I'll be happy to answer questions...

Take care,

Brenda

Brenda M. Harvey
Commissioner
Tel: (207) 287-4223
Fax: (207) 287-3005

MAINE EQUAL JUSTICE PARTNERS

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The MaineCare Non-categorical Program

Who receives services through MaineCare non-categorical program?

"Non-categorical" MaineCare members are adults, aged 21 - 64, who do not have minor children at home, who are not disabled and whose income is below the federal poverty level ($10,210 per year for a single person). Individuals enrolled range in age with approximately one-third of recipients under age 30 and one quarter are over the age of 50. 45% of non-categorical recipients are women. This program serves a wide range of individuals including many who use it temporarily until to recover their health and return to work. Please see the collection of interviews with current and former program enrollees attached.

Enrollment by County as of Jan. 4, 2007

County	Number of Enrollees
Androscoggin	1,890
Aroostook	1,441
Cumberland	3,783
Franklin	484
Hancock	635
Kennebec	1,892
Knox	552
Lincoln	411
Oxford	1,103
Penobscot	2,655
Piscataquis	338
Sagadahoc	260
Somerset	1,315
Waldo	634
Washington	1,134
York	1,810
Total	**20,337**

- Maine had the lowest uninsured rate for poor adults in the nation from 2004-2005 according to the Kaiser Family Foundation.1

- Access to care has reduced cost and improved health. The per member per month (PMPM) cost during the first year of the waiver was $525 reflecting the higher cost of beginning to serve a population that had been without access to medical care on a regular basis. By FFY '05—three years into the waiver, the PMPM cost had declined to $417 providing evidence that health care costs can be lowered when individuals have reliable access to medical care. Approximately 25% of non-categorical enrollees have chronic lung disease or diabetes. It costs more than $50,000 annually to treat a patient suffering from diabetes-related complications. Access to regular care can help reduce these higher costs as we have seen in this waiver group.

  Three-quarters of this group report that they now have a "medical home"—one place where they can go to get on-going regular care; that they have had a relatively recent physical exam and that their shots are up to date.

  The PMPM cost for this group continues to decline, but now reflects both the effect of access to care and reductions in the benefit package that began in December 2005.

- The rate of charity care at hospitals has declined since the non-categorical MaineCare Program was implemented in 2002. As the chart below shows, rates of charity care at hospitals declined in 2003 and 2004. The overall rate increased in 2005, but remained below 2000 - 2002 levels. There are two explanations for this increase: 1) the freeze in enrollment in the non-categorical program began in March 2005 and by the end of that year, enrollment in the program had dropped by more than 11,000 enrollees; and 2) many hospitals across the state raised their eligibility levels between 2004 and 2005 (see appendix 1).

Charity Care as a Percentage of Hospital Gross Revenues[2]

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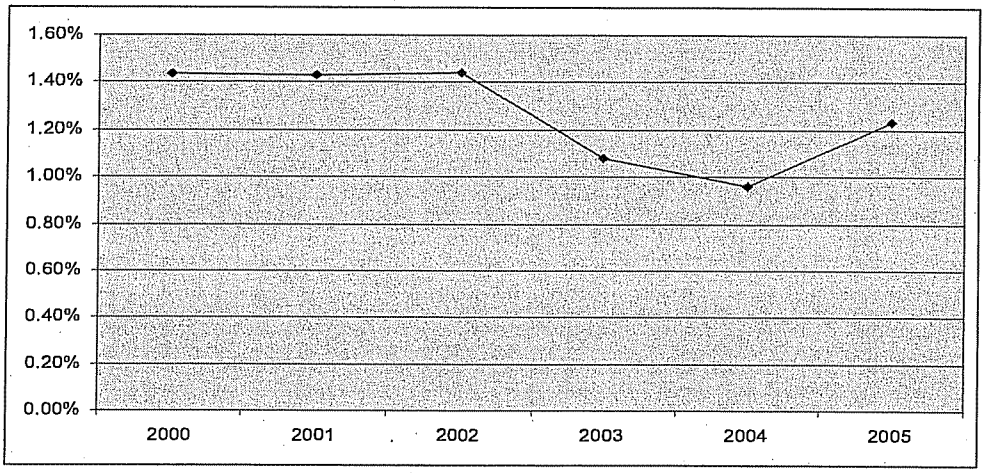
[1] Kaiser Family Foundation, "Health Insurance Coverage of Adults 19-64 Living in Poverty (under 100% FPL), states (2004-2005)", www.statehealthfacts.org (most recent period for which comparative data is available).

[2] Analysis of Hospital Audited Financial Statements. This data was filed by hospitals with the Maine Health Data Organization. Dr. Nancy Kane created a methodology for presenting this data, which was adopted by the MHDO. In this chart 2000 to 2003 is the work of Dr. Nancy Kane. The 2004 and 2005 data was submitted by the hospitals using Dr. Kane's methodology. The Institutions for Mental Disease were removed from the overall calculation because Medicaid does not pay for inpatient services at these institution.



- In FFY 04, MaineCare paid hospitals $51,588,885 (federal and state dollars) for inpatient and outpatient services for members of the non-categorical program. These expenditures for inpatient and outpatient services at hospitals represented 45% of the overall expenditures for this program.3

- Payments for prescription drugs made through municipal general assistance programs (local welfare programs) dropped by 90% within three years of implementation of the non-categorical waiver program. This represents a savings of nearly a ¼ million dollars for towns and cities throughout Maine. When enrollment in the non-categorical program was frozen in 2005-6, general assistance costs for prescription drugs quadrupled over the pre-freeze levels. [4]

What has the State done to manage cost under the non-categorical MaineCare Program?

- March, 2005—Enrollment Frozen. Early enrollment in this program occurred more rapidly than originally anticipated. This was attributed to pent-up demand for health coverage and high medical needs among this previously uninsured group. Additionally, implementation of this program occurred during an economic downturn when demand for public services typically increases and during an ongoing period of turmoil in the private insurance market marked by rising premium costs, reductions in employer-based coverage and contraction in the private insurance market. By early 2005, enrollment in the waiver grew to over 24,000. In March 2005, the Department froze enrollment and established a waiting list for program services.

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[3] Data included in draft report prepared by the Muskie School of Public Service, University of Southern Maine, 2/07.
[4] Data provided by the Office of Integrated Access and Services, Maine Department of Human Services, 2/07.

- December 2005—Reduction in Benefits. In accordance with legislative direction, the Department made a significant cut in services for non-categorical members beginning in December 2005. The following services were eliminated: ambulance services, community support services, day treatment services, developmental and behavioral clinic services, home health services, hospice services, laboratory services, medical imaging services, medical supplies and durable medical equipment, occupational therapy, physical therapy, podiatric services, rehabilitative services, speech and hearing services, targeted case management services, and vision services. Mental health services were limited to 16 visits per year (in subsequent legislation this limit was extended to 24 visits with prior authorization).

- July 2006—Enrollment re-opened as a result of legislative action. As a result of the freeze, enrollment had dropped from nearly 25,000 to just below 10,000. People left the program for a variety of reasons. For some, their earnings increased above the federal poverty level, while others did not recertify at their annual review for the program. Meanwhile, the number of eligible applicants on the waiting list grew to over 8,000 people by April 2006. In the spring of 2006 with enrollment at such a low level, the Department reported that spending on the program was far below the cap. In the supplemental budget, the legislature directed DHHS to open enrollment on July 1st, 2006 but to keep spending under the expenditure cap.

- December 2006—Freeze in enrollment to ensure that costs stay below the cap. On December 15, DHHS determined that enrollment would soon reach the cap. Before this happened, it froze program enrollment at just over 20,000 and started a waiting list for eligible applicants again. As of mid-February, the waiting list had 2,887 people on it.

Corrected
5/4/2007

MaineCare Third Party Liability (TPL) Initiative

Proposal: Recognizes savings as a result of enhanced TPL recovery efforts.

			Revised DHHS Proposal	
	CP II	**CP II Modified**	**2007-08**	**2008-09**
MaineCare Savings (per year)	$5,600,000	$6,900,000	$9,100,000	$9,100,000
Admin Costs (per year)	($500,000)	($500,000)	($700,000)	($700,000)
Net GF Impact	$5,100,000	$6,400,000	$8,400,000	$8,400,000

Admin Assumptions:

	GF	FEF	Total
Positions	7.5	7.5	15
Personal Services	$400,000	$400,000	$800,000
AO	$300,000	$300,000	$600,000
Total	$700,000	$700,000	$1,400,000

Maine Health Care Association

Maine's Nursing Homes Deserve Our Support

The long-term care community relies on MaineCare for about 70% of its funding. Without an increase to the MaineCare rate, providers cannot give raises and their ability to recruit and retain good qualified staff is compromised.

Maine was once a leader in supporting its system of long-term care - but as priorities shifted, nursing homes received a smaller share of MaineCare funding. According to the Kaiser Foundation, Maine ranks 47th in the percentage of Medicaid funds spent on nursing home care.

According to the most recently audited cost reports, Maine nursing homes were under-reimbursed by more than $27 million for MaineCare services in 2005.

Nursing home rates are still based on 1998 cost data. Cost of living adjustments, when received, have averaged less than 1% annually over the last five years. Facilities find it increasingly difficult to compete with hospitals and private sector health organizations that have private health insurance revenues to offset MaineCare losses.

Maine's long term care facilities have the third highest acuity levels and the highest staffing requirements in the nation. These complex medical needs and strict staff ratios require adequate MaineCare resources.

MaineCare budget issues also affect private pay residents who subsidize the program through increased private pay rates to make up for Maine Care losses.

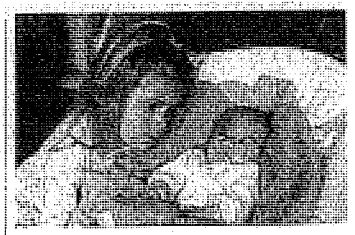
The only new funding for both nursing homes has come mostly from their own provider tax revenues. New revenues from the tax are simply not adequate to pay for increases in the costs of care. This is not a stable or adequate funding source for meeting the needs of our elderly and disabled citizens.

When MaineCare funding does not keep pace with our increasing operating costs – insurances, fuel and other items, the ongoing viability of facilities and the public's access to quality care is threatened.

317 State Street, Augusta, ME 04330 Tel: 207.623.1146 Fax: 207.623.4080 Website: www.mehca.org

Description	FY 08	FY09
The Jason Program ensures that children with potentially life limiting conditions and their families receive medical, emotional and spiritual support from the time of their diagnosis throughout their lives and bereavement support as needed. $75,000 for operational support is a State investment in a public/private partnership which will draw down a $300,000 foundation grant for a medical team to provide statewide services to families and most importantly, support to local medical teams to develop specific, often complicated medical treatment plans to avoid costly hospitalizations.	75,000	75,000

WE MAKE EVERY DAY COUNT FOR CHILDREN....



- The Jason Program has operated for the last seven years with no state support, 100% dependent upon philanthropy.
  - We currently serve approximately 100+ children each year and anticipate this to increase by 50 % in 07/08 because of increased awareness of our program by families and medical professionals
  - Consult with and provide education to approximately 3-400 professionals each year
  - provide ongoing bereavement support to an additional 50 families

- The Jason Program has received a two year grant to become financially self sufficient by hiring a full time physician, and adapting a fee for service structure for its current services. **The grantor has requested that this be a public private project and that the state provide matching support.**

In addition to providing necessary care, there is a major cost savings associated with The Jason Program preventing unnecessary hospitalizations and emergency care

A study conducted by The Jason Program and The Muskie Institute with data collected from the Maine Health Information Center (2005), revealed the following estimated costs for inpatient hospitalizations to third party payers for children with diagnoses considered to be potentially life threatening. The study estimated that there are approximately 5,000 children living in the state of Maine with potentially life threatening illnesses. According to the report, the hospitalization data for these children in 2002 indicates:

- There were **13,926 hospitalizations** for these identified children that potentially cost the state of Maine through MaineCare reimbursement : **$229,627,637.**
- The **average hospitalization was $16,489** for the average stay of: 5.76 days.
- The average number of **hospitalizations per child was 21.**

- If we add the additional costs of each child taking ambulance transport the costs would rise considerably as an **ambulance run** for an average of 22 miles can cost as much as **$1,584.18 per transport.**

CASE EXAMPLE 1: A child cared for in Raymond that was kept out of the hospital for five years by being cared for by The Jason Program in his community, potentially saved the state: $346,269 in hospitalization costs alone per year or $1,731,345 TOTAL or $28,855.75 per month.

CASE EXAMPLE 2: A child that has been cared for on Vinylhaven by The Jason Program has reduced his hospitalizations by 80% for the past 1.5 years for an estimated savings of $519,403 or $28,855.75 per month.

CASE EXAMPLE 3: A child that was cared for in Limerick was hospitalized only once in three years with an estimated savings of $1,022,318 or $28,855.75 per month.

1) In addition to the clear quality of care impact programs like The Jason Program have, there are cost savings projections which are supporting a national movement as well. The Jason Program is working with The Governor's Policy office and MaineCare to pursue the possibility of adapting a Medicaid Waiver to cover the costs of all of The Jason Program services. Other states who have pursued this have found the following:

1. The State of Colorado, in their CHI-PACC® based Medicaid Waiver, projected averted hospitalization costs of $20M annually for the 200 children they anticipate enrolling in the program.
2. For New York's CHI PACC®, Milliman USA's actuarial analysis projected the following based on 1997-2001 Medicaid experience.

- The average annual total medical costs for children with selected life-limiting diagnoses, was $11.5K per child per month, or $138K per child per year
- The average cost of terminal hospitalization for this cohort is just over $46K
- An estimated 15% reduction in total medical costs was anticipated from the program through avoided terminal hospitalizations, ambulatory sensitive admissions, and reduced outlier days (based on DRGs) for very long stays.

3) Further, claims analysis for the State of Utah's Medicaid Waiver based on the CHI PACC model (Promoting Hope for Utah Children) yielded the following information.

- The average annual monthly cost per child in the targeted cohort ranged from $4.9K to $6.0K in 1999, with perinatal cases at $23.6K or $283.2K annually.
- An estimated 40% reduction in the number of hospital and nursing facility days was projected from their pediatric palliative care program.

Description	FY 08	FY 09
Provides licensing for essential library resources which we need to bring back on line. These assist business and individual needs through public libraries and access to on-line public library resources. Funds "MARVEL" (a knowledge and research tool) that proves access to journals, magazines and newspapers focused upon technology, business, science and medicine as well as other database resources.	125,000	125,000

* MARVEL provides free access to over 50,000 journals, magazines, and newspapers.

* Over 2.9 million searches were recorded in 2006 – a 43% increase from 2005.

* The Maine State Library MARVEL databases are a knowledge and research tool essential to research and development initiatives as well as business growth.

* Investing in information is an economic growth strategy.

* Databases are the content piece of research and development and right now there are some serious gaps in access to high end biomedical resources as well as science, medicine, technology and business.

* Will help in meeting needs by allowing statewide licensing to bring these science resources back online for use by research and educational institutions, libraries, and for home use by the public.

DHHS Budget	FY 08	FY 09
Domestic Violence/Sexual Assault – purchased services. Contracted efforts will provide 24 hour direct service (hotline, emergency shelter) to crime victims statewide, education and prevention efforts (police, medical personnel, schools, business, etc.) as well as specific school based education programs – all statewide.	1,000,000	1,000,000

Domestic Violence Funding

- Domestic violence is a pervasive problem in Maine. In Maine, the crime of domestic assault occurs every 104 minutes, as reported to police. Many cases are never even reported. Half of Maine homicides from 1999 to 2005 are domestic murders.

- The $2 million request for domestic violence and sexual assault services is for needed programs. Funds would be provided to DHHS/Purchased Social Services, to make grants for **direct services to crime victims** as well as for **education and prevention** efforts. Examples of services include:
    - 24-hour hotline, referral services, temporary emergency shelter to victims of domestic violence
    - Community education, including training for law enforcement officers, schools, medical professionals, businesses and others
    - School-based education programs

- The $2 million request is much less than is being requested by a bill in the AFA Committee. **LD 1224**, An Act to Prevent Violence against Maine Families and to Provide Adequate Intervention in Cases of Domestic Violence and Sexual Assault requests **$4.6 million per year** for services and education.

    - LD 1224 is sponsored by **Senator Bill Diamond,** cosponsored by **Senators Benoit, Mitchell and Turner; and by Reps Fischer, Cain, Craven, Flood, Mills and Tibbetts.**

- Funding would be used by DHHS to make grants to **community-based agencies** to provide school-based and community-based DV and SA projects for education, prevention and provisions of direct services

- Community-based programs operated by the Maine Coalition to End Domestic Violence (MeCEDV) and the Maine Coalition Against Sexual Assault (Me CASA) are listed on the attached sheets;

- The types of programs and services that would be funded are listed on the attached sheets

VOLUNTEER MEDICAL RIDE NETWORK
PROVIDING ACCESS TO ESSENTIAL HEALTH CARE SERVICES.

THIS NETWORK PROVIDES TRANSPORTATION FOR SENIORS WHO HAVE NO OTHER RESOURCE TO TRAVEL TO ESSENTIAL MEDICAL APPOINTMENTS (E.G., KIDNEY DIALYSIS TREATMENT, RADIATION AND/OR CHEMO TREATMENT OR RELATED FOLLOW-UP FOR CANCER AND CARDIAC CARE).

THESE FUNDS WILL HELP ALL 5 OF MAINE'S AREA AGENCIES ON AGING SUPPORT THE VOLUNTEER MEDICAL RIDE NETWORK.

FOR EXAMPLE, THE AROOSTOOK AGENCY ON AGING CURRENTLY HAS 49 VOLUNTEER MEDICAL RIDE DRIVERS. MANY OF THESE VOLUNTEERS ARE OLDER PEOPLE RELYING ON A FIXED INCOME. IN 2005 THERE WERE 145 VOLUNTEER DRIVERS AND, IN THE AFTERMATH OF THE GASOLINE PRICE SPIKE FOLLOWING HURRICANE KATRINA, THE NUMBER REDUCED TO 72 DRIVERS BY THE END OF 2005.

UNFORTUNATELY, WITH CONTINUED HIGH MOTOR FUEL COSTS, THE NUMBER OF VOLUNTEER DRIVERS HAS DWINDLED.

ASSURING MILEAGE REIMBURSEMENT WOULD MAKE IT EASIER TO RECRUIT MUCH-NEEDED VOLUNTEER DRIVERS AND EXPAND THE NETWORK.

MEALS ON WHEELS
A VITAL SOURCE OF GOOD NUTRITION AND SOCIAL CONTACT.

VOLUNTEER DRIVERS FOR MEALS ON WHEELS PROVIDE VITAL FOOD AND SOCIAL CONTACT TO MAINE'S SENIORS AND DISABLED IN NEED.

THE DELIVERED FOOD PROVIDES GOOD NUTRITION AND, FOR MANY ISOLATED SENIORS, THE MEALS ON WHEELS DELIVERY PROVIDES THEIR ONLY SOCIAL CONTACT.

UNFORTUNATELY, RISING MOTOR FUEL PRICES HAVE INCREASED THE TRAVEL COST FOR THE VOLUNTEER DRIVERS.

TO ENSURE THE CONTINUED VIABILITY OF THE MEALS ON WHEELS PROGRAM, FUNDS ARE NEEDED TO REIMBURSE THE MEALS ON WHEELS VOLUNTEER DRIVERS FOR INCREASED TRAVEL EXPENSES RESULTING FROM INCREASED MOTOR FUEL COSTS.

HOMEMAKER PROGRAM

1. SERVES 3000 ELDERLY CONSUMERS THROUGHOUT THE STATE

2. 420 DIRECT CARE WORKERS PROVIDE HOMEMAKER SERVICES INCLUDING: MEAL PREPARATION, HOUSEKEEPING, LAUNDRY, GROCERY SHOPPING, PICKING UP PRESCRIPTIONS

3. CURRENTLY THERE ARE 350 CONSUMERS WHO ARE WAITING FOR SERVICES DUE TO THE UNAVAILABILITY OF STAFF.

4. THESE WORKERS RECEIVE LOW WAGES AND NO BENEFITS MAKING RECRUITMENT AND RETENTION DIFFICULT

5. A WAGE INCREASE FOR THESE DIRECT CARE WORKERS WOULD HELP ATTRACT MORE WORKERS INTO THIS WORKFORCE

EIM PROVIDES DIRECT SERVICES TO CONSUMERS THROUGH ITS CARE COORDINATION PROGRAM

EIM IS AN AWARD WINNING CARE COORDINATION PROGRAM. THESE FUNDS WOULD PREVENT A REDUCTION IN STAFF LEADING TO INCREASED CASELOADS AND A REDUCED ABILITY TO MONITOR PROVIDERS TO ASSURE QUALITY IN SERVICE DELIVERY

1. EIM MAKES IT POSSIBLE FOR ELDERLY AND DISABLED HOME CARE CONSUMERS THROUGHOUT THE STATE TO REMAIN IN THEIR HOMES AND AVOID HIGHER COST CARE.

2. EIM PROVIDES A PERSON CALLED A CARE COORDINATOR WHO HELPS ELDERLY OR DISABLED PERSONS IN THE FOLLOWING WAYS:

   THE CARE COORDINATOR HELPS SIMPLIFY A COMPLEX LONG TERM CARE SYSTEM BY DOING SUCH THINGS AS: MAKING A HOME VISIT AND LEARNING ABOUT THE PERSON'S CARE PLAN; MAKING CONTACT WITH HEALTH CARE PROVIDERS AND ARRANGING SERVICES; MONITORING SERVICES AND RESOLVING ANY PROBLEMS WITH PROVIDERS OF SERVICES; ADJUSTING THE CARE PLAN AS NECESSARY; PROVIDING REASSURANCE AND EMOTIONAL SUPPORT BY TELEPHONE.

3. EIM HAS BEEN NATIONALLY RECOGNIZED FOR THE QUALITY AND COST EFFECTIVENESS OF ITS CARE COORDINATION SERVICES.

4. EIM SERVES OVER 2940 ELDERLY AND DISABLED CONSUMERS OVER ONE-THIRD OF WHOM ARE MEDICALLY ELIGIBLE FOR NURSING FACILITY CARE BUT CHOOSE TO REMAIN AT HOME. WITHOUT THIS PROGRAM MANY MORE PEOPLE WOULD RESIDE IN NURSING FACILITIES.

HEALTH ◈ TRAVEL

AL JOURNAL.

What's Selling at Spring Art Sales
LEISURE & ARTS D5

Tapping your home's equity without selling it or taking out a loan — PERSONAL FINANCE D3

Noninvasive test for detecting Down syndrome early in pregnancy — ACHES & CLAIMS D2

New Tack on Copays: Cutting Them

Employers, Insurers Bet That Covering More of the Cost of Drugs Can Save Money Over the Long Term for Chronic Conditions

By VANESSA FUHRMANS

Gary Hovland

DESPERATE FOR WAYS to curb soaring health-care costs, a groundswell of employers and health insurers are turning to a radically different approach: motivate patients to take not just the cheapest medicines, but the ones they need the most.

Over the past decade, health plans have sought to save money by shifting costs onto workers and encouraging them to use lower-cost generics. But the new model—which involves lowering or eliminating copayments on medications for chronic illnesses—makes better medical sense. And it may save even more money by preventing costly health crises down the road. For instance, a heart-attack patient who no longer has to pay for a costly but essential blood thinner is more likely to take it regularly—and reduce the chances of a second attack or eventual surgery.

Employers such as **Marriott International** Inc., **Procter & Gamble** Co. and **Eastman Chemical** Co. have now reduced or eliminated copayments for drugs for certain chronic conditions, such as heart disease. **Pitney Bowes** Inc., which already gives away diabetes and asthma drugs, has lowered copays this year for osteoporosis treatments, anti-seizure medications and prenatal supplements. For diabetics and heart-attack patients, it has made cholesterol-lowering statins free. And at least one major insurer, **Aetna** Inc., is studying whether to implement the approach with certain drugs and patients across its health plans.

Behind the about-face is mounting evidence that higher copayments may not make long-term economic sense. While they've curbed drug spending in the short run, studies show they've also discouraged some people from taking essential medicines. A 2004 Rand Corp. study of more than 80 corporate and commercial health plans, for instance, showed that chronically ill people used to taking regular drugs cut their medications by between 8% and 23% when their copays were doubled.

In rethinking copays, employers and health plans have targeted conditions like diabetes and heart disease in part because chronic illnesses are major drivers of the overall rise in health-care costs. These patients are also

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Incentive Plans

Some experiments in improving access to critical drugs:

- **Marriott** cut copayments for drugs related to heart disease, diabetes and asthma.
- **University of Michigan** cut copays for diabetes patients.
- **Pitney Bowes** gives away diabetes and asthma drugs and has cut copays for osteoporosis treatments, anti-seizure drugs and others.
- **UnitedHealth** cut copays for a chlorofluorocarbon-free asthma inhaler.

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es' New Spending Means for Fliers

...Slash Cut Copays

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among the most vulnerable to costly medical complications—and, at the same time, it's relatively easy to monitor their drug regimens to help manage the illnesses.

Seeing Results

Early experiments with providing free drugs for chronic disease have produced results—reducing costs and helping people stay out of the hospital and emergency rooms. Pitney Bowes says it now spends 19% less annually for each asthma patient than it did six years ago, before it eliminated those copays.

"Cost shifting [onto employees] is the easiest way to attack cost. But it comes right back at you because you're not attacking the root cause," says Andrew Scibelli, manager of health-management programs at **Florida Power & Light Co.**, which is looking at cutting its copays for employees with conditions such as diabetes and coronary artery disease in 2008.

Marriott decided to slash copayments for patients with heart disease, diabetes and asthma in 2005 after worrisome signs that people with those illnesses were forgoing medications.

Affordability Issue

In the years prior to that, the hotel chain had stepped up drug copays to combat escalating health-care costs. But when its health-data and disease-management firm, ActiveHealth Management, would call on doctors to inquire why they hadn't, for instance, prescribed heart-attack patients a certain medication, "the doc would say, I want to, but the patient says they can't afford it because of the copay," says Lonny Reisman, ActiveHealth's chief executive.

Aetna plans to launch one the most ambitious studies of the tailored approach later this year.

So Marriott waived the copays on generics and halved the $25 and $45 copays it had required for branded drugs related to diabetes, asthma and heart disease

ActiveHealth, an Aetna unit, helps identify which Marriott workers or family members with chronic illnesses aren't taking potentially lifesaving drugs, informs their doctors and reminds the patients about the breaks. In the program's first year, Marriott executives say, they've made up in health savings what they lost in drug copays.

Vaccines and Screenings

"Over the next several years, we think we'll see even better results," says Jill Berger, Marriott's vice president of health and welfare plans. Encouraged by the initial results, the hotel chain began waiving copayments this year for other types of preventive care, such as childhood immunizations, mammograms and colonoscopies.

Bonita Kothe, an administrative assistant at the University of Michigan in Ann Arbor, says she has been more vigilant about taking the four medications she takes for her diabetes since the university reduced her copays nearly a year ago. Since all four are generics, she pays nothing. (Other diabetes-related drug copays have been cut by between 25% and 50%.)

Though the $60 she used to pay every three months for the drugs wasn't a tremendous financial barrier, Ms. Kothe says she used to miss the occasional pill. But between reducing the cost and explaining the strategy to employees, "they made me more aware of how important it is to take my medicines," she says.

Despite the initial successes, many employers are still reluctant to spend more upfront on health care, even with the promise of a longer-term payoff. Others are concerned that slashing copays will encourage people to take more costly brand-name drugs instead of generics.

"Employers tell us, I want to do something, but I have no new money to spend," says Mark Fendrick, a professor of medicine and director of a research center at the University of Michigan studying such health-insurance-plan designs.

Tailored Approach

That's why most health plans and employers that do this aren't just cutting copays indiscriminately but tailoring the breaks based on how much a given patient needs a set of drugs. The University of Michigan, for instance, provides its lower copays only for patients with diabetes. ActiveHealth also is helping employers design individualized copayment plans that would, for example, allow a heart-attack patient to pay much less for cholesterol-lowering drugs than someone simply with high cholesterol.

UnitedHealth Group Inc. has taken a slightly different tack, reducing copays for certain brand-name drugs to the lowest level in cases where a generic isn't available. Last month, for instance, it cut copays for Xopenex, a chlorofluorocarbon-free asthma inhaler, to between $5 and $10, down from between $45 and $50.

Aetna plans to launch one the most ambitious studies of the tailored approach later this year. For those who have suffered a heart attack, the health insurer plans to waive copays for four of the five essential classes of medicines that medical evidence shows heart-attack patients should take—statins, ace inhibitors, beta blockers and ARBs (the fifth is aspirin)—and study the effect on patients' health and cost over three years.

Avoided Complications

The experiment will cost Aetna and the participating employers for which it administers health and drug benefits money up front, but "we think we'll reduce costs very rapidly," says Troyen Brennan, Aetna's chief medical officer. Aetna points to one academic study that calculates savings of nearly $6,000 per patient by eliminating the heart-medication copays.

If the three-year study bears out such cost savings, Aetna says it plans to implement the approach across its health plans and expand it to more than a dozen other types of medications.