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Majority

L.D. 1487

Date: 3/11/14

(Filing No. S- 419)

HEALTH AND HUMAN SERVICES

Reproduced and distributed under the direction of the Secretary of the Senate.

STATE OF MAINE

SENATE

126TH LEGISLATURE

SECOND REGULAR SESSION

COMMITTEE AMENDMENT "B" to S.P. 552, L.D. 1487, Bill, "An Act To Implement Managed Care in the MaineCare Program"

Amend the bill by striking out the title and substituting the following:

'An Act To Provide Fiscal Predictability to the MaineCare Program and Health Security to Maine People'

Amend the bill by striking out everything after the enacting clause and before the summary and inserting the following:

'PART A

Sec. A-1. 22 MRSA §3174-WW is enacted to read:

§3174-WW. Patient-centered MaineCare reform

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Managed care plan" means an entity that contracts with the department to provide managed care in the MaineCare program, through a health insurer or health maintenance organization authorized under Title 24-A that bears full risk under a capitated payment.

B. "Managed care program" means the program of integrated managed care for all covered MaineCare services implemented in accordance with this section.

2. Managed care program. The department shall implement a managed care program for all covered MaineCare services. The department shall include in the requests for proposals and in the contract with each managed care plan the requirement that the provision of services to members of the MaineCare program must be managed on a phased-in schedule over 3 years as provided in this subsection.

A. The following members must be enrolled in the first year of the implementation of managed care and in each year thereafter:

(1) Persons who are eligible for MaineCare under section 3174-G, subsection 1, paragraphs A, E, G, H and I; and

(2) Nondisabled children who are eligible under section 3174-G, subsection 1, paragraph B or D.

B. All of the eligibility groups under section 3174-G not included in paragraph A must be required to enroll in the managed care program after the first year of implementation and in subsequent years on a schedule as required by the department after the department has sought stakeholder input and approval from the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services and after the department adopts rules.

C. A member who is not in an enrollment group required to be enrolled under paragraph A or B may voluntarily enroll in a managed care plan that provides services in the region of the State in which the member lives.

D. A member may not be required to enroll in a managed care plan unless there are at least 3 unrelated issuers of statewide managed care plans that can each meet all the requirements in this section.

3. Managed care plans. The following requirements apply to contracts with managed care plans.

A. The department shall require services in the managed care program to be provided by managed care plans that are capable of coordinating and delivering all MaineCare covered services on a statewide basis to all enrollees.

B. The department shall select managed care plans using requests for proposals. The procurement method must give the department broad flexibility and power to negotiate value and must provide potential bidders the broad flexibility to innovate.

C. The department shall use a procurement method that results in a minimum of 3 and a maximum of 4 plans that the department authorizes to enroll MaineCare members upon negotiation of rates consistent with this section and applicable requirements of the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services.

D. At least one of the managed care plans must be operated by a nonprofit organization that may be controlled by a health care provider or providers or an affiliate of a provider or providers, unless no organization meeting this description meets the minimum criteria for selection established in the request for proposals.

E. The department shall consider quality factors in the selection of managed care plans, including, but not limited to:

(1) Accreditation by a nationally recognized accrediting body;

(2) Documented policies and procedures for preventing fraud and abuse;

(3) Experience in serving enrollees and achieving quality standards;

(4) Availability and accessibility of primary and specialty care physicians in the relevant network;

(5) Provision of nonmandatory benefits, particularly dental care and disease management, and other initiatives that improve health outcomes; and

(6) An office or a commitment to establishing an office for the managed care plan in the State.

F. After negotiations are conducted, the department shall select managed care plans that the department determines to be responsive, to have signed contracts with providers of covered services in sufficient numbers to meet access standards established in this section and by rule and to provide the best value to the department.

G. All contracts with managed care plans entered into under this section are contingent upon the appropriation and allocation by the Legislature for the managed care program of sufficient funding to pay for the managed care program.

H. All contracts with managed care plans entered into under this section are contingent upon the plan having signed provider contracts as required in paragraph F.

4. Plan accountability. The following provisions on managed care plan accountability apply to all managed care plan contracts entered into under this section and provide standards for plan accountability.

A. The term of a contract with a managed care plan under this section is 5 years or less, with an option for the department to renew for a period or periods of 2 years. At the end of a contract period the department may authorize a short-term extension of the contract if needed to provide for a transition to a new managed care plan with minimal disruption of services and care provided to MaineCare members.

B. The department shall establish contract requirements that are necessary for the operation of the managed care program and consistent with the requirements of this section. In addition to any other provisions the department may determine to be necessary, the contract must contain the following contractual obligations.

(1) The managed care plan shall participate in and coordinate with departmental efforts in health care payment reform including value-based purchasing; quality improvement; delivery system improvement; improvement in patients' experience of care; participation in other departmental initiatives, including the state innovation model grant initiative under the federal Patient Protection and Affordable Care Act; and participation in the patient-centered medical home initiative, including the financial support of qualifying primary care medical homes. The department may require the managed care plan to participate in initiatives regarding compensation for physicians for coordination of care, management of chronic disease and avoidance of the need for more costly services.

(2) Each managed care plan shall meet the large group minimum medical loss ratio of at least 85% as defined in 42 United States Code, Section 300gg-18. The department, with advice from any stakeholder or advisory group formed to advise the department on managed care and after finally adopting major substantive rules may adjust the components of the medical loss ratio if necessary to account for factors unique to MaineCare and not applicable to the large group minimum

medical loss ratio as defined in 42 United States Code, Section 300gg-18, except that the medical loss ratio may not be reduced to less than 85%.

(3) The managed care plan shall meet established access standards that are specific, population-based standards for the number, type and regional distribution of providers in managed care plan networks. The access standards must ensure access to care for both adult members and child members that is equal to or greater than available access to care that nonmembers have in the same geographic area. The access standards must ensure that payments to providers of MaineCare services and benefits reflect mutually acceptable rates, methods and terms of payment, are consistent with efficiency, economy and quality of care and are sufficient to enlist an adequate number of providers throughout the State. The access standards must require the managed care plan to pay for out-of-network care at a generally applicable rate when the plan is not able to deliver medically necessary services covered under the contract due to lack of network availability or lack of timely access to necessary care as defined through rulemaking.

(4) The managed care plan shall maintain an accurate and complete electronic database, available on the publicly accessible website of the managed care plan or other accessible site that is updated periodically, and that contains but is not limited to the following information:

(a) A list of contracted providers, including necessary information to assist enrollees and participants in plan selection and ongoing access to providers, as determined by the department through rulemaking; and

(b) A preferred drug list that is searchable by members and providers, that is updated within 24 hours after any change is made and that includes prior authorization information and a prior authorization process for prescribed drugs that is readily accessible to providers, displays appropriate contact information and provides timely responses to providers that meet or exceed the standards prescribed by 42 United States Code, Section 1396r-8(d)(1)(A).

(5) The managed care plan shall maintain and submit encounter and claims data for all services provided to MaineCare members in a manner and format and in accordance with a time schedule specified by the department. Claims data for each encounter submitted under this subparagraph must include the amount paid by the managed care plan to all providers of services attributable to the encounter.

(6) The managed care plan shall meet specific performance standards and benchmarks or timelines for improving performance over the term of the contract.

(a) A managed care plan shall establish an internal health care quality improvement system, including member satisfaction surveys as measured by a nationally recognized assessment tool and disenrollment surveys.

(b) A managed care plan must be accredited by a nationally recognized accrediting body, or have initiated the accreditation process, within one year

after the contract with the department is executed and must meet the requirements for external quality review.

(7) The managed care plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum, a provider credentialing system and ongoing provider monitoring, procedures for reporting instances of fraud and abuse and designation of a program integrity compliance officer.

(8) The managed care plan shall establish an internal process for reviewing and responding to grievances from enrollees and providers and submit quarterly reports including the number, description and outcome of grievances filed by enrollees. The grievance procedure must provide for oral or written appeal of actions taken by the managed care plan. The grievance procedure must permit members or their authorized representatives access to the department's administrative fair hearing process prior to exhausting the internal grievance appeal process of the managed care plan. The grievance procedure must provide for publication and access for the public to all final decisions of the department and the managed care plan except that all information that could directly or indirectly identify the member must be redacted prior to the publication or the provision of public access to the information.

(9) A managed care plan shall comply with requirements established by the department for enrollment reduction and withdrawal and for reporting encounter data. The requirements must provide for penalties or termination of a contract as a consequence of failure to meet the requirements.

(10) A managed care plan and the plan's fiscal agent or intermediary shall comply with the prompt payment requirements applicable to health carriers and health plans pursuant to Title 24-A.

(11) A managed care plan shall apply nationally endorsed quality standards that are coordinated and consistent with department quality initiatives and shall at least include population improvement goals, improved health outcomes and improvement in early periodic screening, diagnosis and treatment periodicity compliance. The managed care plan shall regularly track, monitor and publicly report on health plan performance in a format approved by the department pursuant to rulemaking.

(12) During a transition period to be determined by the department with stakeholder input, a managed care plan shall contract with any existing and qualified provider willing to accept the terms, conditions and rates associated with the managed care plan. After the transition period, the standards must allow managed care plans to limit providers in their networks based on credentials, quality indicators and price, but any limitation permitted by this subparagraph may not be construed to modify or excuse noncompliance with the access standards established pursuant to paragraph B, subparagraph (3), including without limitation access to family planning and family planning related services. In addition, after the transition period, the managed care plan shall contract with any willing and qualified provider who is a federally qualified health center, a

rural health clinic or a school-based health clinic or a provider who serves high-risk populations or specialize in conditions that require costly treatment.

(13) A managed care plan shall provide for continuation of health care benefits and services at prior authorized levels when a member files a grievance or appeal of a denial of a renewed prior authorization request. The managed care plan shall provide that the member may not be charged for services provided during the grievance or appeal process.

(14) A managed care plan shall provide that the commissioner and the medical director of the MaineCare program have the authority to override any denial of care by the managed care plan on the basis of medical necessity.

(15) A managed care plan shall provide that MaineCare members enrolled in the plan and providers are 3rd-party beneficiaries under any contract between the managed care plan and the department.

(16) A managed care plan must be subject to financial consequences, backed by a performance bond or similar guarantee, for failure to meet quality standards, access standards, patient satisfaction standards or other requirements of law or rule or of the contract between the department and the managed care plan.

(17) A managed care plan is subject to the jurisdiction and oversight of the Department of Professional and Financial Regulation, Bureau of Insurance and shall comply with provisions of Title 24-A, including chapter 56-A.

(18) A managed care plan when providing to members and prospective members written communications, including but not limited to notices, decisions and explanations of benefits, shall provide those communications in a manner that is readable at or near a 6th-grade reading level and offer translated versions of materials, as required by the department.

(19) A managed care plan may allow for cost sharing in accordance with the provisions of 42 United States Code, Section 1396o.

(20) A managed care plan shall provide a reasonable contribution to pay for the funding of the ombudsman program under subsection 7.

5. Payments to managed care plans. The following provisions apply to payments to managed care plans by the department.

A. The department shall pay managed care plans on the basis of per member, per month payments negotiated pursuant to this subsection. Payments must be at risk-adjusted rates based on historical utilization and spending data, projected and adjusted to reflect the eligibility category, geographic area and clinical risk profile of the members with the provision for subsequent adjustment based on actual enrollments and encounter data when available. In negotiating rates with the plans, the department shall consider any adjustments necessary to encourage plans to use the most cost-effective means of improving outcomes and providing specialized management of particular subgroups of populations with complex or high-cost needs.

B. For that portion of the MaineCare enrolled population covered by managed care plans in the 4th fiscal year of the provision of managed care coverage, the total amount expended by the department in that fiscal year to cover services to that portion of the population may not exceed 95% of the amount that would have been expended to cover the same number of enrollees for the same services in the same fiscal period in the absence of a managed care plan. This limitation must be calculated on the basis of historical experience, adjusted for actual increases in health care costs and reasonable projections of the trend in those costs. The method of calculation of the limitation must be established in rules adopted by the department.

6. Enrollment; choice counseling; eligibility. Except as otherwise provided by law, the following provisions apply to enrollment of MaineCare members in and choice counseling and eligibility for managed care plans.

A. A MaineCare member must be provided a choice of plans and may select any available plan unless that plan is restricted by contract with the department to a specific population that does not include the member. A MaineCare member must be provided at least 30 days in which to make a choice of plans. The department and managed care plans must provide notices about enrollment rules that current and potential enrollees can easily understand.

B. The department shall implement a choice counseling system to ensure that a MaineCare member has timely access to accurate information on the available managed care plans. Counselors providing enrollment support must reflect the ethnic, linguistic and cultural demographics of the population served. The counseling system must include plan-to-plan comparative information on benefits, provider networks, preferred drug lists, quality measures and other data points as determined by the department. Choice counseling must be made available through face-to-face interaction, through the publicly accessible website of the department, by telephone and in writing and through other forms of relevant media. Materials must be provided in a culturally appropriate manner, readable at or below a 6th-grade reading level and consistent with federal requirements. The department shall implement a competitive bidding process for procurement of choice counseling functions. The choice counseling system may not be administered by a managed care plan.

C. After a MaineCare member has enrolled in a managed care plan, the member must have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for good cause or during the annual open enrollment period. Good cause for disenrollment must include at a minimum:

(1) The plan does not cover a service the member seeks based on religious or moral beliefs;

(2) The member needs related services that are not available in the plan's network and the member's provider determines that receipt of the services separately would subject the member to unnecessary risk; and

(3) Other reasons, including but not limited to poor quality of care or lack of access to covered services and experienced providers.

D. The department shall automatically enroll in a managed care plan those MaineCare members who do not choose a plan. Except as otherwise described in this section, the department may not engage in practices that are designed to favor one managed care plan over another.

E. A member eligible for coverage pursuant to section 3174-G, subsection 1, paragraphs H and I must be required to participate in the Private Health Insurance Premium Program in accordance with section 18. The department shall identify all members who have access to group health plan coverage and shall inform the member that participation is mandatory for that member.

7. Ombudsman program. The department shall ensure the establishment of an external and independent ombudsman who is not within the control of a managed care plan. The ombudsman shall identify and report to the department and the committee of jurisdiction within the Legislature on systemic issues and possible solutions to those issues and assist MaineCare members and providers with grievances and appeals either within the ombudsman program or under contract with an external entity. The department and any plan that provides services to MaineCare members must provide data, from which personally identifying information has been removed, to the ombudsman as necessary for the ombudsman to carry out the functions of the position required by this subsection. The ombudsman program required by this subsection must operate and be funded completely independently from and must not interfere with the authority or operation of any ombudsman program established under state or federal law, including but not limited to sections 4087-A and 5107-A.

8. MaineCare benefits under managed care plans. The following provisions govern benefits under managed care plans.

A. A managed care plan shall provide coverage for all services and benefits required by the department for the applicable category of eligible members.

B. As approved by the department, a managed care plan may customize benefit packages for nonpregnant adults and provide coverage for additional services. Customized benefit packages must provide all services and benefits that were provided to nonpregnant adults on April 1, 2014. The department shall evaluate the proposed benefit packages to ensure services are sufficient to meet the needs of the plan's enrollees and to verify actuarial equivalence.

9. Rulemaking. The department shall adopt rules as necessary to implement this section. Rules adopted pursuant to this subsection are major substantive rules as described in Title 5, chapter 375, subchapter 2-A.

Sec. A-2. Stakeholder group on capitated managed care in the MaineCare program. By August 1, 2014 the Commissioner of Health and Human Services shall convene a stakeholder group to design and plan for the implementation of a capitated managed care program for MaineCare members. The stakeholder group shall make recommendations to the department regarding the implementation of the Maine Revised Statutes, Title 22, section 3174-WW, including, but not limited to, the following issues: the development of the selection and phase-in process; consumer choice and access to providers and network adequacy; accountability and transparency; incentives to encourage and reward healthy behaviors; alignment with existing efforts related to

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payment reform and care coordination; establishment of clear quality metrics and quality improvements; comprehensive and coordinated data analytics and access to data; usage and payment of emergency department services; and consumer protections. The membership of the stakeholder group must include, but is not limited to, representatives of the following: MaineCare members and advocates representing MaineCare members; consumer advocates; health insurance carriers; primary health care providers; acute care and critical access hospitals; behavioral health providers, including substance abuse providers; academics with a concentration in health care policy; pharmacies; pharmacy benefits managers; nursing facilities; the Department of Health and Human Services; the Department of Professional and Financial Regulation, Bureau of Insurance; and representatives of the state innovation model grant process. The stakeholder group shall work until the managed care program under Title 22, section 3174-WW is implemented and the phase-in of all mandatory populations is fully complete. The stakeholder group shall provide input to the department on the implementation of Title 22, section 3174-WW.

Sec. A-3. Issuance of request for information. By October 1, 2014, the Department of Health and Human Services shall issue a request for information based upon the provisions of the Maine Revised Statutes, Title 22, section 3174-WW and the criteria developed through the stakeholder process established pursuant to section 2 of this Part. The purpose of the request for information process is to determine whether there is sufficient interest among managed care companies to provide full-risk capitated managed care to all or part of the MaineCare program in a manner that is consistent with and compatible with the goals and structure of the value-based purchasing initiatives being undertaken by the department, including but not limited to health homes, patient-centered medical homes, accountable communities, peer support organizations and other issues that are identified in the responsibilities to the managed care stakeholder group.

Sec. A-4. Report to the Legislature. By March 1, 2015, the Department of Health and Human Services shall report to the joint standing committee of the 127th Legislature having jurisdiction over health and human services matters on the status of implementation of the managed care program pursuant to the Maine Revised Statutes, Title 22, section 3174-WW, each of the areas addressed by the stakeholder group established pursuant to section 2 of this Part, the specific recommendations of the stakeholder group and the department's value-based purchasing initiative, including accountable care. The report must include actual and projected cost savings and the structure of the managed care program. Beginning April 1, 2015 the department shall provide a report every month to the joint standing committee of the Legislature having jurisdiction over health and human services matters on the implementation of the managed care program.

Sec. A-5. Rulemaking required. The following rulemaking requirements apply to the implementation of the managed care program in the MaineCare program by the Department of Health and Human Services pursuant to the Maine Revised Statutes, Title 22, section 3174-WW.

1. By May 1, 2015, the department shall propose major substantive rules to implement managed care based on the recommendations of the stakeholder group established pursuant to section 2 of this Part.

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2. By September 1, 2015, the department shall provisionally adopt a managed care rule and provide copies of the rule to the Executive Director of the Legislative Council and the joint standing committee of the Legislature having jurisdiction over health and human services matters in accordance with the provisions of Title 5, section 8072, subsections 3 and 4.

3. By January 15, 2016, the joint standing committee of the Legislature having jurisdiction over health and human services matters shall make its recommendation to the full Legislature on the managed care major substantive rule in accordance with Title 5, section 8072, subsection 5.

4. The department shall issue a request for proposals to prospective bidders no later than 30 days following final legislative action on the provisional managed care rule.

5. Within 6 months of awarding contracts for managed care in the MaineCare program the department shall start implementation of managed care.

Sec. A-6. State plan amendment and waivers; contingent effective date. The Department of Health and Human Services shall apply to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services for approval of a state plan amendment under the United States Social Security Act, Section 1932(a) to implement the provisions of this Part and for all necessary waivers. The provisions of this Part take effect upon notification from the Department of Health and Human Services to the Revisor of Statutes that all necessary approvals under this section have been granted.

Sec. A-7. Appropriations and allocations. The following appropriations and allocations are made.

HEALTH AND HUMAN SERVICES, DEPARTMENT OF (FORMERLY DHS)

Office of MaineCare Services 0129

Initiative: Provides funds for the initial implementation of the managed care program for MaineCare services including convening and supporting the stakeholder group, preparing and issuing a request for information and preparing a report to the Legislature on the status of implementation and for required rulemaking.

GENERAL FUND	**2013-14**	**2014-15**
All Other	$0	$250,000
GENERAL FUND TOTAL	$0	$250,000

FEDERAL EXPENDITURES FUND	**2013-14**	**2014-15**
All Other	$0	$250,000
FEDERAL EXPENDITURES FUND TOTAL	$0	$250,000

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HEALTH AND HUMAN SERVICES, DEPARTMENT OF (FORMERLY DHS) DEPARTMENT TOTALS	2013-14	2014-15
GENERAL FUND	$0	$250,000
FEDERAL EXPENDITURES FUND	$0	$250,000
DEPARTMENT TOTAL - ALL FUNDS	$0	$500,000

PART B

Sec. B-1. 22 MRSA §3174-G, sub-§1, ¶F, as amended by PL 2011, c. 380, Pt. KK, §2, is further amended to read:

F. A person 20 to 64 years of age who is not otherwise covered under paragraphs A to E when the person's family income is below or equal to 125% of the nonfarm income official poverty line, provided that the commissioner shall adjust the maximum eligibility level in accordance with the requirements of the paragraph.

(2) If the commissioner reasonably anticipates the cost of the program to exceed the budget of the population described in this paragraph, the commissioner shall lower the maximum eligibility level to the extent necessary to provide coverage to as many persons as possible within the program budget.

(3) The commissioner shall give at least 30 days' notice of the proposed change in maximum eligibility level to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters; ~~and~~

Sec. B-2. 22 MRSA §3174-G, sub-§1, ¶G, as enacted by PL 2011, c. 380, Pt. KK, §3, is amended to read:

G. A person who is a noncitizen legally admitted to the United States to the extent that coverage is allowable by federal law if the person is:

(1) A woman during her pregnancy and up to 60 days following delivery; or

(2) A child under 21 years of age~~.~~;

Sec. B-3. 22 MRSA §3174-G, sub-§1, ¶¶H and I are enacted to read:

H. Beginning July 1, 2014, a person 21 to 64 years of age who is not otherwise eligible for medical assistance under this section, who qualifies for medical assistance pursuant to 42 United States Code, Section 1396a(a)(10)(A)(i)(VIII) and whose income is equal to or below 133% of the nonfarm income official poverty line plus 5% for the applicable family size as required by federal law. A person eligible for medical assistance under this paragraph must receive the same coverage as is provided to a person eligible under paragraph E; and

I. Beginning October 1, 2019, a person 19 or 20 years of age who is not otherwise eligible for medical assistance under this section, who qualifies for medical assistance pursuant to 42 United States Code, Section 1396a(a)(10)(A)(i)(VIII) and whose income is equal to or below 133% of the nonfarm income official poverty line plus 5% for the applicable family size as required by federal law. A person eligible for medical assistance under this paragraph must receive the same coverage as is provided to a person eligible under paragraph E.

Sec. B-4. Contingent repeal. The Maine Revised Statutes, Title 22, section 3174-G, subsection 1, paragraphs H and I are repealed upon the earlier of the following:

1. The meeting of all of the following conditions:

A. The enhanced Federal Medical Assistance Percentage with respect to amounts expended for medical assistance for newly eligible Medicaid individuals described in 42 United States Code, Section 1396a(a)(10)(A)(i)(VIII) is reduced below 100% for any calendar quarter in 2014, 2015 or 2016;

B. The reduction in the enhanced Federal Medical Assistance Percentage described in paragraph A has taken effect; and

C. After the reduction of the enhanced Federal Medical Assistance Percentage as described in paragraphs A and B, the Legislature has convened and conducted a session of at least 30 calendar days; and

2. December 31, 2016.

PART C

Sec. C-1. Research organization evaluation. The Office of Fiscal and Program Review shall contract with a nonpartisan research organization, referred to in this section as "the research organization," to study the impact of the MaineCare expansion authorized in the Maine Revised Statutes, Title 22, section 3174-G, subsection 1, paragraphs H and I on programs and services under this Part that do not currently receive Federal Medical Assistance Percentage matching funds or do not qualify for enhanced Federal Medical Assistance Percentage matching funds under the federal Patient Protection and Affordable Care Act, 42 United States Code, Section 18001, et seq., with the goal of identifying and maximizing General Fund savings. The Commissioner of Health and Human Services, the Commissioner of Corrections and the Executive Director of the State Board of Corrections shall provide to the research organization information and assistance requested for preparation of the evaluation. In evaluating the programs and services under this Part, the research organization shall at a minimum evaluate the impact on the following programs and services: the state-funded Mental Health Services - Community, Office of Substance Abuse and General Assistance - Reimbursement to Cities and Towns programs; the elderly low-cost drug program under Title 22, section 254-D; services provided for individuals 21 to 64 years of age who are currently eligible for MaineCare under the medically needy program; services provided under the State's demonstration project waiver under Section 1115 of the United States Social Security Act, 42 United States Code, Section 301, et seq., for individuals with HIV/AIDS; services provided for parents participating in family reunification activities; services provided for disabled individuals 21 to 64 years of age with incomes below

139% of the federal poverty level as defined by the federal Department of Health and Human Services and updated annually in the Federal Register under authority of 42 United States Code, Section 9902(2); services provided to individuals awaiting a MaineCare disability determination who are subsequently determined disabled; services provided to individuals who would have been considered eligible on the basis of a disability but for whom the full determination process was not completed; and medical services provided to persons in the care and custody of the Department of Corrections or a county correctional facility. The research organization also shall examine the amount of payment for services that hospitals received during fiscal years 2014-15 and 2015-16 as a result of the expansion of MaineCare eligibility pursuant to Title 22, section 3174-G, subsection 1, paragraphs H and I. In addition, the research organization shall evaluate any savings and the impact on health outcomes achieved through initiatives implemented pursuant to the state innovation models initiative grant.

The research organization shall report twice, no later than February 15, 2015 and February 15, 2016, respectively, to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over criminal justice and public safety matters on the amount of General Fund savings resulting from the MaineCare expansion authorized in Title 22, section 3174-G, subsection 1, paragraphs H and I and by the research organization pursuant to this section. The reports must include the amount of savings expected and realized during fiscal years 2014-15 and 2015-16 by service area or program, the amount deposited in the MaineCare Stabilization Fund pursuant to section 3 of this Part and the amount of savings projected to be achieved through fiscal year 2020-21 by service area or program.

Sec. C-2. Health insurance marketplace report. The Office of Fiscal and Program Review shall contract with a nonpartisan research organization to examine the financial feasibility of providing health care coverage to newly eligible MaineCare members through a health insurance marketplace in a manner similar to that of Medicaid expansion coverage in Arkansas or Iowa and the feasibility of establishing a state basic health program similar to Washington's basic health plan. The Office of Fiscal and Program Review shall report by February 15, 2015 to the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding the feasibility of providing health care coverage to newly eligible MaineCare members through a health insurance marketplace in a manner similar to that of Medicaid expansion coverage in Arkansas or Iowa and the feasibility of establishing a state basic health program similar to Washington's basic health plan.

Sec. C-3. Calculation and transfer. Notwithstanding any other provision of law, the State Budget Officer shall calculate the amount of savings identified in this Part that applies against each General Fund account statewide as a result of the expansion of MaineCare eligibility authorized in the Maine Revised Statutes, Title 22, section 3174-G, subsection 1, paragraphs H and I and shall transfer the amounts up to the amounts specified in section 5 of this Part by financial order upon the approval of the Governor. These transfers are considered adjustments to appropriations in fiscal year 2014-15. The State Controller shall transfer any amounts identified under this Part greater than the amounts specified in section 5 of this Part to the MaineCare Stabilization Fund

established under Title 22, section 3174-KK. The State Budget Officer shall provide a report of the transferred amounts to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs no later than April 30, 2015 for fiscal year 2014-15 and shall submit adjustments to baseline budget requests totaling no less than $11,800,000 per year to reflect the continuation of the identified savings in the 2016-2017 biennium.

Sec. C-4. Review and responsibility. Following receipt of the reports from the research organization as required under section 1 of this Part, the joint standing committee of the Legislature having jurisdiction over health and human services matters shall review the information provided in the reports and shall determine if the net cost to the General Fund of providing coverage under the MaineCare program to individuals pursuant to the Maine Revised Statutes, Title 22, section 3174-G, subsection 1, paragraphs H and I exceeds the savings to the General Fund, including any amount deposited in the MaineCare Stabilization Fund pursuant to section 3 of this Part, due to the expansion of coverage for those individuals. Following its review of the report received on February 15, 2016 pursuant to section 2 of this Part the joint standing committee may report out a bill to the Second Regular Session of the 127th Legislature regarding determinations and conclusions of the report.

Sec. C-5. Appropriations and allocations. The following appropriations and allocations are made.

ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF

Executive Branch Departments and Independent Agencies - Statewide 0017

Initiative: Deappropriates funds on a statewide basis for initial savings to be identified under this Part in existing state programs that result from the expansion of MaineCare eligibility.

GENERAL FUND	**2013-14**	**2014-15**
Unallocated	$0	($5,900,000)
GENERAL FUND TOTAL	$0	($5,900,000)

ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF DEPARTMENT TOTALS	**2013-14**	**2014-15**
GENERAL FUND	**$0**	**($5,900,000)**
DEPARTMENT TOTAL - ALL FUNDS	**$0**	**($5,900,000)**

LEGISLATURE

Legislature 0081

Initiative: Provides one-time funding for the Office of Fiscal and Program Review to contract with a nonpartisan research organization to evaluate the impact of the expansion of MaineCare eligibility.

GENERAL FUND	2013-14	2014-15
All Other	$0	$100,000
GENERAL FUND TOTAL	$0	$100,000

LEGISLATURE DEPARTMENT TOTALS	2013-14	2014-15
GENERAL FUND	$0	$100,000
DEPARTMENT TOTAL - ALL FUNDS	$0	$100,000

SECTION TOTALS	2013-14	2014-15
GENERAL FUND	$0	($5,800,000)
SECTION TOTAL - ALL FUNDS	$0	($5,800,000)

PART D

Sec. D-1. Appropriations and allocations. The following appropriations and allocations are made.

HEALTH AND HUMAN SERVICES, DEPARTMENT OF (FORMERLY DHS)

Medical Care - Payments to Providers 0147

Initiative: Provides funds for the costs of MaineCare coverage through December 31, 2016, for childless adults at or below 133% of the nonfarm income official poverty line plus 5% for the applicable family size as required by federal law.

FEDERAL EXPENDITURES FUND	2013-14	2014-15
All Other	$0	$327,657,166
FEDERAL EXPENDITURES FUND TOTAL	$0	$327,657,166

Office of Family Independence - District 0453

Initiative: Provides funding for 6 Family Independence Unit Supervisor positions, 13 Office Assistant II positions and 64 Eligibility Specialist positions in the Office of Family

Independence - District program and for related All Other costs necessary to implement and administer the MaineCare eligibility changes. This assumes the Eligibility Specialist positions are funded 25% General Fund and 75% Other Special Revenue Funds and the other positions are funded 50% General Fund and 50% Other Special Revenue Funds.

GENERAL FUND	**2013-14**	**2014-15**
POSITIONS - LEGISLATIVE COUNT	0.000	83.000
Personal Services	$0	$1,909,557
All Other	$0	$95,105
GENERAL FUND TOTAL	$0	$2,004,662

OTHER SPECIAL REVENUE FUNDS	**2013-14**	**2014-15**
Personal Services	$0	$4,325,301
All Other	$0	$381,651
OTHER SPECIAL REVENUE FUNDS TOTAL	$0	$4,706,952

Office of MaineCare Services 0129

Initiative: Provides funding for the one-time costs of changes to the Maine Integrated Health Management Solution and the Automated Client Eligibility System as a result of expanding MaineCare eligibility.

GENERAL FUND	**2013-14**	**2014-15**
All Other	$0	$110,539
GENERAL FUND TOTAL	$0	$110,539

FEDERAL EXPENDITURES FUND	**2013-14**	**2014-15**
All Other	$0	$994,852
FEDERAL EXPENDITURES FUND TOTAL	$0	$994,852

HEALTH AND HUMAN SERVICES, DEPARTMENT OF (FORMERLY DHS) DEPARTMENT TOTALS	**2013-14**	**2014-15**
GENERAL FUND	**$0**	**$2,115,201**
FEDERAL EXPENDITURES FUND	**$0**	**$328,652,018**
OTHER SPECIAL REVENUE FUNDS	**$0**	**$4,706,952**

DEPARTMENT TOTAL - ALL FUNDS		**$0**	**$335,474,172**

PART E

Sec. E-1. Written notices required regarding MaineCare coverage. At the time of enrolling in the MaineCare program a member who is eligible under the Maine Revised Statutes, Title 22, section 3174-G, subsection 1, paragraph H or I, the Department of Health and Human Services shall provide written notice that is readable at the 6th-grade reading level to the member:

1. Primary care provider. That the member is required to sign up as a patient with a primary care provider promptly after enrolling in the MaineCare program; and

2. Benefit termination. That the member's MaineCare coverage will end no later than December 31, 2016 unless a law is passed to extend coverage past that date.

PART F

Sec. F-1. Task Force to Create Opportunities for Stable Employment for MaineCare Members. The Task Force to Create Opportunities for Stable Employment for MaineCare Members, referred to in this Part as "the task force," is established.

1. Task force membership. The task force consists of 8 members appointed as follows:

A. Three members of the Senate appointed by the President of the Senate; 2 must be members of the party holding the largest number of seats in the Senate and one must be a member of the party holding the 2nd largest number of seats in the Senate; and

B. Five members of the House of Representatives appointed by the Speaker of the House; 3 must be members of the party holding the largest number of seats in the House and 2 must be members of the party holding the 2nd largest number of seats in the House.

2. Chairs. The first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the task force.

3. Appointments; convening of task force. All appointments must be made no later than 30 days following the effective date of this Part. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the task force. If 30 days or more after the effective date of this Part a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the task force to meet and conduct its business.

4. Duties. The task force shall meet up to 4 times in order to identify any policies in MaineCare that penalize or create a disincentive for members' increasing hours of

employment or earnings. The task force shall make recommendations to eliminate any such barriers and shall propose new policies that support and promote stable and lasting employment. In performing its work, the task force shall examine current rules related to MaineCare transitional assistance and any opportunities to further reduce the adverse effects on working families that lose eligibility for MaineCare due to increased employment. The task force shall consider solutions that provide continuity of care and minimize persons' moving on and off the MaineCare program.

5. Staff assistance. The Legislative Council shall provide necessary staffing services to the task force.

6. Report. The task force shall submit a report that includes its findings and recommendations for presentation to the joint standing committee of the Legislature having jurisdiction over health and human services matters by December 8, 2014.

PART G

Sec. G-1. Implement reforms in programs for adults with intellectual disabilities. The Department of Health and Human Services, referred to in this Part as "the department," shall implement the reforms identified in this section and shall transfer all savings resulting from those reforms and adjust reimbursement rates for providers of services as necessary to develop the funds that will reduce waiting lists for services under the MaineCare Benefits Manual, Chapter 101, Chapter II, Section 21, Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder and Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Disorder to less than 6 months by January 15, 2015.

1. The department shall implement the following reforms specified in Public Law 2013, chapter 368, Part SS, section 4, including implementing the plan for services called for by that law:

A. Each individual will receive a strength-based standardized assessment of that individual's strengths or needs to inform a person-centered plan;

B. Each individual will be assessed for the natural family and community support networks potentially available to that individual;

C. The State will establish a broad menu option model designed to match the amount and kind of paid support services needed by each individual;

D. Each individual will have a designated community resource assistant whose job it is to help individuals at any age navigate the local array of services;

E. The State will develop a thorough and accessible information repository;

F. The State will establish early support and planning for steps to transition individuals from childhood services to adult services;

G. The State will undertake educational efforts in each neighborhood to educate and foster inclusiveness and awareness of the community;

H. The State's developmental services will deliver only the paid services needed; and

I. Formal services will be based on individual and realistic needs.

ROFS

2. The department shall carry out the directives and proceed to implement the directives contained in the following laws:

A. In Resolve 2013, chapter 24, the directive to the department to add home support as a covered service permitting a member to live as independently as possible in the member's own home;

B. In Public Law 2013, chapter 368, Part NN, the directive to the department to review rate methodology to reduce costs for those with extraordinarily high medical needs; and

C. In Public Law 2013, chapter 368, Part SS, section 1, the directive to the department to pursue waivers to use electronic technology to lessen dependence, reduce the need for overnight support and eliminate unnecessary staffing costs.

3. The department shall consider the following reforms:

A. Decreasing the cost of health care to persons with intellectual disabilities by implementing care management for long-term support service providers;

B. Increasing the number of occupants from one or 2 to 3 or 4 in small home support residential programs in all cases where it can be done without encountering behavioral impediments;

C. Expediting the filling of residential beds by ensuring that vacancies are prioritized for individuals needing residential services;

D. Substituting foster homes for hourly staff care in those situations where individuals require long-term or permanent living arrangements for daily support; and

E. Accelerating the teaching of independent living skills with a focus on populations transitioning from school to adult living.

Sec. G-2. Savings from reforms. The savings generated by reforming the MaineCare services for adults with intellectual disabilities and autism pursuant to section 1 of this Part must be used to serve those on the waiting list for services under the MaineCare Benefits Manual, Chapter 101, Chapter II, Section 21, Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder and Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Disorder. The department shall develop a plan with clear steps and a timeline to ensure that waiting lists for services under Sections 21 and 29 do not exceed 6 months by January 15, 2015, and shall present its plan to the Legislature by October 1, 2014.

Sec. G-3. Emergency rule-making authority. The department is authorized to adopt emergency rules under the Maine Revised Statutes, Title 5, sections 8054 and 8073 to implement the provisions of this Part over which the department has subject matter jurisdiction without having to show that immediate adoption is necessary to avoid a threat to public health, safety or general welfare.

PART H

Sec. H-1. Fraud investigation. The Department of the Attorney General shall undertake an initiative to strengthen fraud investigation in the MaineCare program. The Department of the Attorney General shall establish 2 new positions within the Health

Care Crimes Unit to investigate allegations of misuse of public funds in the MaineCare program and to aid the Attorney General in the prosecution of crimes and other legal actions related to misuse of public funds.

Sec. H-2. Appropriations and allocations. The following appropriations and allocations are made.

ATTORNEY GENERAL, DEPARTMENT OF THE

Administration - Attorney General 0310

Initiative: Provides funds for 2 Attorney General Detective positions in the Health Care Crimes Unit.

FEDERAL EXPENDITURES FUND	**2013-14**	**2014-15**
POSITIONS - LEGISLATIVE COUNT	0.000	2.000
Personal Services	$0	$176,638
All Other	$0	$30,380
FEDERAL EXPENDITURES FUND TOTAL	$0	$207,018

SUMMARY

This amendment replaces the bill. The amendment contains the following provisions.

Part A establishes managed care in the MaineCare program. It includes requirements for managed care plans and for contracting by the Department of Health and Human Services for managed care services. It specifies how MaineCare members enroll in managed care plans, provides opportunities for disenrollment, provides for capitated payments to managed care plans, establishes a minimum loss ratio for managed care plans, provides a choice of plans and a choice counseling system that ensures the consumer has access to accurate information, establishes an ombudsman funded by the managed care plans to identify and report on systemic issues and to assist MaineCare members and providers with grievances and appeals, sets the minimum benefit package and authorizes major substantive rulemaking by the department. It establishes a managed care stakeholder group on capitated managed care in the MaineCare program to design and plan for implementation and make recommendations for implementation of managed care to the department. It requires the department to issue a request for information to determine whether there is sufficient interest among managed care companies to provide managed care as set forth in the law and in a manner that is consistent with and compatible with the goals and structure of the value-based purchasing initiatives being undertaken by the department, including but not limited to health homes, patient-centered medical homes, accountable communities, peer support organizations and other issues that are identified in the responsibilities of the stakeholder group. It requires the department to report by March 1, 2015 to the joint standing committee of the Legislature having jurisdiction over health and human services matters on the status of implementation of managed care pursuant to the Maine Revised Statutes, Title 22, section 3174-WW, each of the areas addressed by the managed care stakeholder group, the specific recommendations of the stakeholder group and the department's value-based

purchasing initiative, including accountable care. The report must also include actual and projected cost savings and the structure of the managed care program. Beginning April 1, 2015, the department is required to provide a report every month to the joint standing committee of the Legislature having jurisdiction over health and human services matters on the implementation of managed care. It imposes a schedule of required rulemaking to ensure prompt implementation of managed care. It requires the department to apply to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services for approval of a state plan amendment under the United States Social Security Act, Section 1932(a) to implement the provisions of this amendment and to apply for all necessary waivers. It provides a contingent effective date that requires notification from the department to the Revisor of Statutes that all necessary approvals have been granted.

Part B expands medical coverage under the MaineCare program to adults who qualify under federal law with incomes up to 133% of the nonfarm income official poverty line, with the 5% federal income adjustment for family size, and qualifies Maine to receive federal funding for 100% of the cost of coverage for members who enroll under the expansion. Adults eligible are those 21 to 64 years of age, effective July 1, 2014, and, if the expansion of MaineCare coverage is not repealed, adults 19 and 20 years of age, beginning October 1, 2019. The expansion of Medicaid eligibility contained in this Part is repealed the earlier of either December 31, 2016 or 3 circumstances occuring: the enhanced Federal Medical Assistance Percentage for calendar years 2014 to 2016 is reduced below certain stated levels; the reduced enhanced Federal Medical Assistance Percentage has taken effect; and after the occurrence of the reduction of the enhanced Federal Medical Assistance Percentage the Legislature has convened and conducted a session of at least 30 calendar days.

Part C requires the Office of Fiscal and Program Review to contract with a nonpartisan research organization to evaluate the financial feasibility of providing health care coverage to newly eligible MaineCare members through the health insurance marketplace, modeled after Medicaid expansion coverage in Arkansas or Iowa, and the feasibility of establishing a state basic health program similar to Washington's basic health plan and to report the findings of the evaluation to the joint standing committee of the Legislature having jurisdiction over health and human services matters by February 15, 2015. It directs the Office of Fiscal and Program Review to contract for an examination of the impact of the MaineCare expansion on programs and services that do not currently receive Federal Medical Assistance Percentage matching funds or do not qualify for enhanced Federal Medical Assistance Percentage matching funds under the federal Patient Protection and Affordable Care Act, 42 United States Code, Section 18001 et seq., with the goal of identifying and maximizing General Fund savings. It requires that the research organization report by February 15, 2015 and February 15, 2016 to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over criminal justice and public safety matters on the amount of General Fund savings resulting from the MaineCare expansion. The reports must include the amount of savings expected and realized during fiscal years 2014-15 and 2015-16 by service area or program. It requires the State Budget Officer to calculate the amount of savings that applies against each General Fund account for all departments and agencies

from savings associated with the MaineCare expansion and to transfer the amounts by financial order upon the approval of the Governor. It requires the State Controller to transfer any remaining savings to the MaineCare Stabilization Fund. It requires the State Budget Officer to provide a report of the transferred amounts to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs no later than April 30, 2015 for fiscal year 2014-15 and to submit adjustments to baseline budget requests totaling no less than $11,800,000 per year to reflect the continuation of the identified savings in the 2016-2017 biennium.

Part D provides funding for positions in the Department of Health and Human Services, Office of Family Independence - District program.

Part E requires the department, when enrolling a MaineCare member who is eligible under Title 22, section 3174-G, subsection 1, paragraph H or I, to provide written notice that is readable at the 6th-grade reading level to the member of the requirement to sign up as a patient with a primary care provider promptly after enrolling in the MaineCare program and that the member's MaineCare coverage will end no later than December 31, 2016 unless a law is passed to extend coverage past that date.

Part F establishes the Task Force to Create Opportunities for Stable Employment for MaineCare Members. The task force is directed to meet up to 4 times in order to identify any policies in MaineCare that penalize or create a disincentive for members' increasing hours of employment or earnings, to make recommendations to eliminate barriers to and to propose new policies that support and promote stable and lasting employment, to examine rules related to MaineCare transitional assistance and any opportunities to further reduce the adverse effects on working families that lose eligibility for MaineCare and to consider solutions that provide continuity of care and minimize persons' moving on and off the MaineCare program. The task force is directed to submit a report to the joint standing committee of the Legislature having jurisdiction over health and human services matters by December 8, 2014.

Part G directs the department to implement reforms specified in Public Law 2013, chapter 368, Part SS, section 4, to carry out the directives and implement the initiatives contained in Resolve 2013, chapter 24 and Public Law 2013, chapter 368, Part NN and Part SS, section 1 and to consider 5 reforms. This Part requires that savings resulting from accomplishing the required reforms in programs for adults with intellectual disabilities and autism be used to serve persons on the waiting lists for benefits under the MaineCare Benefits Manual, Chapter 101, Chapter II, Section 21, Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder and Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Disorder. This Part directs the department to develop a plan with clear steps and a timeline to ensure that waiting lists for services under Sections 21 and 29 do not exceed 6 months by January 15, 2015, and to present the plan to the Legislature by October 1, 2014. This Part authorizes the department to adopt emergency rules to accomplish the duties contained in law.

Part H directs the Department of the Attorney General to undertake an initiative to strengthen fraud investigation in the MaineCare program. The Department of the Attorney General is directed to establish 2 new positions within the Health Care Crimes Unit to investigate allegations of misuse of public funds in the MaineCare program and to

aid the Attorney General in the prosecution of crimes and other legal actions related to misuse of public funds.

FISCAL NOTE REQUIRED

(See attached)

Approved: 03/10/14 mac

126th MAINE LEGISLATURE

LD 1487 **LR 1044(03)**

An Act To Implement Managed Care in the MaineCare Program

Fiscal Note for Bill as Amended by Committee Amendment "B" (S-419)
Committee: Health and Human Services
Fiscal Note Required: Yes

Fiscal Note

Legislative Cost/Study

	FY 2013-14	FY 2014-15	Projections FY 2015-16	Projections FY 2016-17
Net Cost (Savings)				
General Fund	$0	($3,434,799)	($1,418,768)	$3,542,400
Appropriations/Allocations				
General Fund	$0	($3,434,799)	($1,418,768)	$3,542,400
Federal Expenditures Fund	$0	$329,109,036	$357,091,833	$279,926,385
Other Special Revenue Funds	$0	$4,706,952	$4,836,712	$4,970,364
Revenue				
Other Special Revenue Funds	$0	$4,706,952	$4,836,712	$4,970,364

Legislative Cost/Study

The general operating expenses of the task force in Part F are projected to be $5,250 in fiscal year 2014-15 and $750 in fiscal year 2015-16. The Legislature's proposed budget includes $10,000 in fiscal year 2014-15 for legislative studies. Whether this amount is sufficient to fund all studies will depend on the number of studies authorized by the Legislative Council and the Legislature. The additional costs of providing staffing assistance to the study during the interim can be absorbed utilizing existing budgeted staff resources.

Fiscal Detail and Notes

This bill implements and adjusts funding related to the expansion of MaineCare eligibility and makes other changes to the MaineCare program.

Part A establishes a managed care program for all covered MaineCare services and provides an appropriation of $250,000 in fiscal year 2014-15 for the Office of MaineCare Services in the Department of Health and Human Services for the initial implementation including: convening and supporting the stakeholder group; preparing and issuing a request for information; preparing a report to the Legislature on the status of implementation and for required rulemaking.

Part C requires an evaluation of current state programs to identify savings that would result from the MaineCare expansion, identifies programs and populations that may realize savings and deappropriates funds statewide. The specific programs and amount of savings that will be realized and distributed to each program cannot by determined at this time. As a benchmark, the implementation of the MaineCare childless adults waiver effective October 2002 enrolled approximately 15,000 persons by the end of the first year and resulted in savings of $1,800,000 that was subsequently deappropriated from the Mental Health Services - Community program in fiscal year 2002-03 (PL 2001 c.714). Part C includes a deappropriation of $5,900,000 in 2014-15 in the Executive Branch Departments and Independent Agencies -Statewide program in the Department of Administrative and Financial Services for the initial savings to be identified in existing programs as a result of the expansion of MaineCare eligibility.

Part C includes an appropriation of $100,000 in fiscal year 2014-15 for the Office of Fiscal and Program Review to contract with a nonpartisan research organization to evaluate the impact of the MaineCare expansion on state programs and to examine the financial feasibility of providing coverage through a Health Insurance Marketplace model. This level of contract funding will likely be insufficient to fund any detailed analysis of both the impact of MaineCare expansion and the financial feasibility of a Health Insurance Marketplace model. This level would not be sufficient to fund any actuarial analysis.

Part D of the bill includes General Fund appropriations of $2,004,662 in 2014-15 for the Office of Family Independence - District program in the Department of Health and Human Services for the State share of the costs of 83 new positions to administer the MaineCare eligibility expansion. Funding for the new positions included in Part D reflect a 75% federal match for the 64 Eligibility Specialist positions and a 50% federal match for the other new positions. The funding for the Eligibility Specialist positions assumes a 700 person caseload for each new position. This is the target caseload the Department of Health and Human Services has identified for the Eligibility Specialist positions.

Part D also includes Federal Expenditures Fund allocations totaling $327,657,166 in 2014-15 as shown below. The estimated federal allocations assume 100 percent federal matching funds through December 31, 2016 for childless adult waiver population with incomes less than 134% of the federal poverty line. The fiscal note also assumes funding for the payment of three months of claims for this population after December 31, 2016 at the 95% enhanced federal match rate.

		FY 2013-14	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**
Childless Adults @ or below 133% of FPL					
Estimated Population	55,965				
Est. Annual Cost Per Person	$5,855	$0	$327,657,166	$343,712,367	$180,277,137
Assumed Federal Match		100.0%	100.0%	100.0%	100.0%
State Share of Costs		$0	$0	$0	$0
Childless Adults - CY 2017 Costs					
Estimated Cost		$0	$0	$0	$90,138,568
Assumed Federal Match		100.0%	100.0%	100.0%	95.0%
State Share of Costs		$0	$0	$0	$4,506,928

The bill does not include appropriations for the MaineCare costs of coverage for the parents population from 101% to 133% of the federal poverty line. Funding for coverage for this population through December 31, 2013 and for continued transitional MaineCare coverage was included in PL 2013, c. 368, the 2014-2015 Biennial Budget bill (LD 1509) at a General Fund funding level estimated at the time to be $8,825,036 for fiscal year 2013-14 and $9,319,22? for fiscal year 2014-15. PL 2011 c. 657 had originally eliminated coverage for this population effective September 30, 2012 contingent on federal approval of a waiver of federal Patient Protection and Affordable Care Act maintenance of effort requirements. Because the federal waiver was not granted, restoring the PL 2011, c. 657 deappropriation of $5,866,833 ($7,822,444 annualized) for this initiative was included in the adjustments to the MaineCare baseline in the 2014-2015 Biennial Budget.

The Department of Health and Human Services now estimates this population has a General Fund cost of approximately $17 million per year, even though there have been no substantive program changes that would definitively explain a change in estimate of this magnitude. This fiscal note reflects the difference between the baseline adjustment used to prepare the 2014-2015 Biennial Budget and the Department's latest estimate - see table below. If there are no subsequent MaineCare appropriations or deappropriations affecting this population during the 126th Legislature, continued funding for this population will be included in the 2016-2017 MaineCare biennial budget baseline. Any biennial 2016-2017 MaineCare budget savings to that baseline will be based on enacted adjustments made by the 127th Legislature.

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17
Parents (Between 101 and 133% of the Federal Poverty Line)				
Estimated Population 15,000				
2014-2015 Budget Baseline Adjustment	$0	$0	$25,424,935	$26,670,757
Assumed Federal Match	61.8%	61.6%	61.6%	61.6%
State Share of Costs	$0	$0	$9,775,887	$10,254,90?
Updated DHHS Estimates	$0	$0	$46,411,365	$48,685,1?
Assumed Federal Match	61.8%	61.6%	61.6%	61.6%
State Share of Costs	$0	$0	$17,845,170	$18,719,423
2016-2017 GF Baseline Adjustment	$0	$0	$8,069,283	$8,464,517

The fiscal note assumes any secondary impact on the numbers of persons participating in MaineCare as a result of this bill's expansion of MaineCare eligibility would be minimal based on the fact that most of the populations affected by the bill have been covered by MaineCare or on a MaineCare waitlist within the last year. The secondary impact on MaineCare participation as a result of implementation of the federal Patient Protection and Affordable Care Act (ACA) on MaineCare eligibility groups not addressed by the bill is not a result of this bill and therefore not included in this fiscal note. Any secondary ACA impact on the childless adult expansion population is assumed to have a minimal impact on General Fund costs given the 100% federal match. The secondary ACA impact on the parents expansion population could be significant and if it exceeds the growth assumptions for this population may result in additional General Fund costs beginning in fiscal year 2014-15. While the bill in aggregate assumes savings that could offset these General Fund costs, it does not include a mechanism to return savings to the MaineCare program until savings exceed the assumed statewide deappropriation included in this bill.

Additional costs and/or savings resulting from Part G requirements related to programs for adults with intellectual disabilities and autism are assumed to be absorbed within existing resources for existing programs.

Part H provides a Federal Expenditures Fund allocation of $207,018 in fiscal year 2014-15 for the Department of the Attorney General for 2 Attorney General Detective positions in the Healthcare Crimes Unit.