REPORT OF THE TASK FORCE TO EVALUATE AND REVISE THE MAINE HEALTH PROGRAM-PHASE 2

May 31, 1991

Report of the Task Force to Evaluate and Revise the Maine Health Program-Phase 2

To the Joint Standing Committee on Appropriations:

This report represents the unanimous findings and recommendations of the members of the task force. One member objects to one element of one recommendation which will be described in the body of the report but does not otherwise dissent from the full recommendations of the Task Force.

You have charged us to make specific recommendations for revising the Maine Health Program in order to ensure that the FY 1991-92 and 92-93 General Fund expenditures for the programs authorized by Public Law 1989, Chapter 588, including the Maine Health Program, do not exceed the amount of revenues projected pursuant to Public Law 1989, Chapter 588. These programs include both the Community Health Program and the Hospital Shortfall Fund. You have further charged us to examine whether there are sufficient controls, restrictions and requirements to ensure that expenditures do not exceed revenues, to compare the costs and services under the Maine Health Program with typical private programs, and to investigate all cost containment options including copayments, deductibles, managed care, discount programs, and changes in the scope and level of benefits provided. We have carried out this complex and difficult assignment to the extent possible given the tight timetable, absence of funds, and limited staff support available. Our task was complicated by the absence of a long history of experience because of the newness of the programs, and ever-changing projections on enrollment, utilization, and capitation as each week's data became available, and by uncertainty on the revenue side. The Task Force wishes to thank Fran Finnegan of the Department of Human Services for his hard work, often on his own time, his constant updating of data, his analysis of the meaning of the data, and his good humor in staffing our effort under great time pressure.

Our findings and recommendations are based on the most recent data, that of May 28, 1991 supplied by the Department of Human Services on enrollment, client age distribution, per capita costs for adults and for children, benefits provided by diagnostic category, in-patient-outpatient distribution, non-hospital benefits, payments by third parties, and shifts of clients to federally reimbursed programs. Because the Maine Health Program is still new, caution is required when making projections from the data. On the revenue

side, we have relied on the most recent estimates, as of May 17, 1991, supplied by the State Tax Assessor of applicable revenue under LD 1332; $13,704,000 for FY 91-92 and $14,665,000 for FY 92-93.

When we presented our Phase 1 report to you, we undertook to monitor the effectiveness of the modifications we recommended and the Legislature enacted in achieving a balance between revenues and expenditures for FY90-91. On the basis of our May 28, 1991 review, we conclude that the goal of balance will be achieved.

Findings

1. We find that, without modification, as of July 1, 1991, there will not be sufficient controls, restrictions, and requirements to ensure that expenditures under the Maine Health Program do not exceed available funds.

2. We find that certain cost containment options, including managed enrollment, managed care, discount programs for some products, and changes in eligibility, scope and level of some benefits are necessary to balance revenues and expenditures for the next biennium.

3. We find that, given the uncertainty of projections in enrollment and revenue, the Department of Human Services needs statutory flexibility to manage enrollment to stay within available funds for the next biennium.

4. We find that there is presently no significant cost and service advantage in private plans compared with the Maine Health Program given the profile of MHP's beneficiaries and the deep discounts from providers the Department of Human Services realizes.

Factors underlying recommendations

In reaching our recommendations, we reviewed the following factors:

our charge which limited the scope of our review to the programs and expenditures under Public Law 1989, Chapter 588.

the carryover impact of the Phase 1 changes on MHP costs for the next biennium and the appropriateness of continuing or modifying them;

significant recent declines in adult enrollment in the program not attributable to the freeze on new adult enrollment;

legislatively approved changes to the Medicaid program to determine their applicability to the Maine Health Program;

the state's plan to maximize federal payments to Medicaid. We structured alternative recommendations on the size of the Hospital Shortfall fund depending on the success or failure of this plan.

the costs of administering the Maine Health Program over the next biennium, $1,600,000, in determining total costs.

Recommendations–Benefits

1. Unless otherwise provided by statute, we recommend that the scope and amount of medical assistance received by enrollees of the Maine Health Program be the same as the medical assistance received by persons eligible for Medicaid, except that pregnancy-related services, nursing home benefits, case management services and day health services may not be offered as services under the program. In addition, DHS may by regulation exclude from the Maine Health Program those services or extensions of services for adults which are added to the Maine Medicaid program to maximize federal revenue for services previously funded with state dollars.

2. Approve the following cost reduction changes approved by the Legislature for the Medicaid program for the Maine Health Program:

outpatient radiology, drug rebates and utilization and the ability to adopt a formulary, third party utilization, and managed care without the requirement of a second opinion. Dr. Frederick Holler, a task force member, dissents from the managed care recommendation on the ground that it is administratively burdensome and will restrict access to care.

3. Establish the following limitations on inpatient treatment for alcohol and other substance abuse and for psychiatric treatment:

Limit admission for inpatient substance abuse treatment for detoxification in hospitals and licensed inpatient substance abuse treatment facilities to 3 days per episode with a maximum of 3 episodes a year. The limitation on number of days may be increased up to a total of 5 days per episode for cases with medical complications if allowed with prior authorization by the Department of Human Services.

Limit admission for inpatient alcohol abuse care at hospitals and licensed inpatient substance abuse treatment facilities to 3 days per episode. Up to 14 additional days limited to one episode per year for cases with medical complications may be allowed with prior authorization by the Department of Human Services.

Limit inpatient hospital psychiatric care to 3 days per episode. Up to 21 additional days may be allowed with prior authorization by the Department of Human Services.

It is our intent that for alcohol, substance abuse, and psychiatric inpatient admission and services, the Department of Human Services be given the authority to institute stringent pre–authorization procedures and managed care including during the initial 3 day inpatient period, that inpatient care be used only in those instances where other treatment has failed or no other alternative exists, or, in the case of a hospital, where the condition of the patient clearly requires 24–hour monitoring and care.

Recommendations–Eligibility

1. Lower the asset test for Maine Health Program enrollees under 65 years of age to the following Medicaid asset test: $2,000 for a single person, $3,000 for a couple and $100 for each child. In a two–earner household where a second car is needed to enable both earners to go to work, we recommend exempting the second car from the asset test to the same extent that the first car is exempted. These changes should become effective for enrollees on their regular recertification date.

2. Lower the asset test for Maine Health Program enrollees ~~over the~~ age ~~of~~ 65 to $10,000. This affects only a small number of people of whom most have no earned income. A small additional asset cushion seems reasonable for this group.

3. Reduce the transition period, the time during which enrollees whose income rises above 95% of poverty may stay on the program if they contribute to it on a defined scale, from 24 months to 12 months.

4. Eliminate the category called "work disregard allowance" in determining eligibility for adult enrollees over 95% of poverty. This change conforms the MHP work disregard criteria with that of AFDC Medicaid.

The changes just outlined together with ongoing savings from shifting medically needy enrollees to Medicaid and recovering retroactive payments from Medicaid should yield savings to the Maine Health Program in excess of 15% in each year of the biennium.

Recommendations-Enrollment Management and Related Statutory Changes

1. Adult enrollment in the program should remain closed except under the following conditions:

The Department of Human Services will set a cap on total adult enrollment which limits expenditures to revenues available for each fiscal year of the 1991-93 biennium. DHS shall track enrollment to determine the accuracy of the cap. To the extent that revenues exceed expenditures, enrollment shall be reopened quarterly with preference to be given and notice to be sent in the first quarter of reopened enrollment to those who were suspended because of the May and June 1991 temporary transition and work disregard rules and who might be eligible under the new transition rules. The Department should consult with its Advisory Committee on the Maine Health Program to develop criteria.

2. Under existing statute, if actual funds available fall short of expectations, the Department of Human Services must take five steps beginning with step 1, proceeding if needed in order through step 5. The Department must analyze and justify each step it chooses and give 60 day notice of analyses and changes. We believe this system is too rigid to allow reasonable responses to unanticipated circumstances, given the present uncertainty in the economy. We recommend the Department be given the flexibility to take any of the 5 steps in any order to stay within the revenues. The Department should consult with its Advisory Committee on the Maine Health Program to develop criteria.

Recommendation-Community Health Program
We recommend continued funding of the Community Health Program at $1.2 million for each fiscal year of the biennium. We believe that such community-based programs partially funded through competitive grants of up to $50,000 each, providing comprehensive 24-hour care and preventive and educational services can reduce dependence on higher cost alternatives.

Recommendation-Hospital Shortfall Fund
1. If the plan to maximize the federal contribution to Medicaid succeeds in eliminating the Medicaid shortfall to hospitals, we recommend that the statutory language establishing the Hospital Shortfall Fund be retained but that no appropriation be made to it, and that the funds released be used for the Maine Health Program. We reach this conclusion because we believe legislative intent in establishing the Hospital Shortfall Fund was to reduce the massive cost-shifting to private payers of governmental shortfalls, charity care and bad debt which raise the cost of insurance to unaffordable levels for many individuals and businesses. The same goal is achieved by the Maine Health Program which reduces the massive cost shift of charity care and bad debt to private payers,

2. If the Medicaid maximization fails, we recommend continued funding of the Hospital Shortfall Fund.

Under either alternative, the changes we recommend in eligibility and benefits for the Maine Health Program and the increased flexibility we recommend for the Department of Human Services to manage enrollment will result in a balance between revenues and expenditures for each fiscal year of the biennium 1991-93.

Recommendations-Other Statutory Changes
1. Roll the present SOBRA and High Risk Assessments and the assessment on hospitals for the Medicaid maximization plan into one assessment to relieve the administrative burden on both the Department of Human Services and hospitals.

2. Continue the controls and restrictions adopted for May and June, 1991 until no later than September 1, 1991 to give the Department of Human Services time to put in place the capacity to administer these recommendations.

3. Adopt emergency legislation to allow these recommendations to take effect as soon as possible.

The Task Force appreciates the confidence placed in us by Governor McKernan, Speaker Martin, and President Pray. We have met frequently, absorbing vast amounts of data in our attempt to understand all the variables and options available. At all times, we have worked toward consensus, accommodating and compromising our various viewpoints to achieve a result which is programmatically sound and fiscally responsible during difficult times.

Respectfully submitted,

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