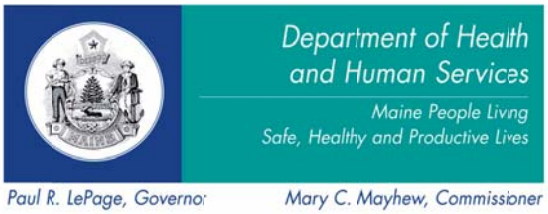

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MaineCare Redesign Task Force Recommendation Report

December, 2012

Submitted by:

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Contents

Executive Summary

The MaineCare Redesign Task Force was created in 2012 by State legislative mandate. The Task Force was charged with recommending strategies for redesign of the MaineCare program to realize $5.25 million in state savings in SFY '13. The committee was composed of nine members representing the interests of MaineCare members and providers and with expertise in health care and economic policy. Additionally, the Department of Health and Human Services contracted with SVC, Inc. and Milliman to staff the Task Force and provide a national perspective and expertise on healthcare reform and Medicaid cost containment strategies.

The Task Force undertook a comprehensive review of the current MaineCare program inclusive of coverage categories, covered benefits, cost-sharing requirements, enrollment and expenditures. Research on nationwide Medicaid cost-containment trends and initiatives was conducted in addition to an in depth review of nine states including Arizona, Arkansas, Florida, Idaho, Iowa, Louisiana, Maryland, Minnesota and Wisconsin.

This research and analysis informed the development of short-term, mid-term and long-term strategies for MaineCare reform. All strategies were considered with the long range goals of investing in primary care, producing coordinated, quality services for Maine's most vulnerable citizens, and fostering effective and efficient use of services. The committee also considered public testimony on the recommendations as part of their process. As outlined in Table 1, a total of eighteen recommendations were developed with projected total State savings in SFYs '13-'15 of $35.22 million.

Table 1: Summary of Task Force Recommendations

	Strategy	State Savings SFY '13	State Savings SFY '14	State Savings SFY '15
Prior Authorization	Implement concurrent review for psychiatric services for individuals under 21 in all settings	$0.02M	$0.05M	$0.05M
	Elective surgeries	$0.07M	$0.3M	$0.3M
	High cost imaging & radiology	$0.23M	$0.94M	$0.94M
	Elective inductions before 39 weeks	$0.08M	$0.32M	$0.32M
Hospital Acquired Conditions	• Expand list to include all of those listed for the State of MD • Payment adjustments made annually based on HACs	$0.16M	$0.66M	$0.66M
Readmissions	Increase time span from 72 hours to 14 days for which readmissions are not reimbursed.*	$0.38M	$1.53M	$1.53M
Leave Days	Eliminate reimbursement for hospital leave days	$0.16M	$0.64M	$0.64M
Pharmacy	Expand Medication Management Initiative/J Code PDL	$0.17M	$0.64M	$0.64M
	PA for antipsychotics	$0.075M	$0.3M	$0.3M
Total Savings for Short-Term Strategies		**$1.35M**	**$5.38M**	**$5.38M**
Pharmacy	Competitive Bid for Specialty Pharmacy	-	$0.39M	$0.79M

	Strategy	State Savings SFY '13	State Savings SFY '14	State Savings SFY '15
	Increase generic dispensing rate by 1%, Reduce use of specialty drugs	-	$1.01M	$1.35M
Program Integrity	• Develop operational policy and procedure to handle day to day Medicaid discretionary functions • Internal review of data collected • Utilize CMS's best practice annual summary report • Develop policy/procedure and mechanisms for reporting to the Medicaid and CHIP Payment and Access Commission	-	$1.83M	$2.44M
Total savings for Mid-term strategies		-	**$3.23M**	**$4.58M**
Increase Benefits*	Restore Smoking Cessation Benefits	-	($0.394M)	($0.394M)
	Allow dental benefits for individuals using the ER for dental services	-	($3.15M)	($3.15M)
Total savings for Mid-term strategies with additional benefits		-	**($0.45M)**	**$0.9M**
Value-Based Purchasing	Increase promotion of targeted initiatives o ED o Maternal & child health o Care Coordination to assist transition o Provider incentive program	-	$1.46M	$1.95M
Value-Based Purchasing with CMO	Care Management Organization	-	$0.51M	$0.68M
Improve Birth Outcomes	Healthy Babies Initiative	-	$0.7M	$1.39M
Targeted Care Management	Targeted Care Management for top 20%	-	-	$8.61M
Total Savings for Long-Term Strategies		-	**$2.67M**	**$12.63M**
TOTAL (without additional benefits)		**$1.35M**	**$11.28M**	**$22.59M**

* These initiatives require legislation and are referred to the Legislature for further study and review.

Overview

The MaineCare Redesign Task Force was established in 2012 by legislative mandate to "provide detailed information that will maintain high-quality, cost-effective services to populations in need of health care coverage, comply with the requirements of the federal Patient Protection and Affordable Care Act of 2010 for state Medicaid programs and realize General Fund savings in fiscal year 2012-13 of $5,250,000" (Public Law, Chapter 657, LD 1746, 125th Maine State Legislature). This report provides an overview of the Task Force findings and recommendations for MaineCare reform and cost containment strategies.

Background

Task Force membership was established pursuant to PL 2011, Chapter 657, Part T. Mary Mayhew, the Commissioner of Health & Human Services, served as the chair of the Task Force. Eight additional members were appointed to represent MaineCare members and providers and to provide expertise in public health, financing, state fiscal and economic policy. The Task Force convened nine times between August and December 2012. All meetings were open to the public and provided an opportunity for public input and comment. Additionally, the Department of Health and Human Services contracted with SVC, Inc. and Milliman to staff the Task Force and provide a national perspective and expertise on healthcare reform and Medicaid cost containment strategies. Meeting minutes are available in Appendix 3.

Table 2: Task Force Membership

Member	Role
Mary Mayhew	Commissioner, DHHS
Ana Hicks	Represents MaineCare members
Rose Strout	Represents MaineCare members
Mary Lou Dyer	Represents providers of MaineCare services
David Winslow	Represents providers of MaineCare services
Scott E. Kemmerer	Member of the public who has expertise in public health policy
Frank Johnson	Member of the public who has expertise in public health care financing
Jim Clair	Member of the public who has expertise in state fiscal policy
Ryan Low	Member of the public who has expertise in economic policy

Table 3: Task Force Meetings

Meeting Date	Agenda Items
August 28, 2012	• Welcome & Introductions • Guiding Principles • Review of Governing Statute • Meeting Framework • Medicaid Overview • Value-Based Purchasing Overview • Review of Statutory Duties • Future Topics/Agendas • Public Comment
September 12, 2012	• Welcome & Introductions • Review of Requested MaineCare Data • Presentation by Michael DeLorenzo, PhD, MaineHealth Management Coalition: Health Care Costs in Maine • Presentation by Elizabeth Mitchell, Executive Director, MaineHealth Management Coalition: Efforts to Impact Healthcare Costs and Performance • Presentation by Dr. Flanigan: MaineCare by the Numbers • Review and Finalize Guiding Principles – Suggested Principles • Future Topics/Agendas • Public Comment
September 25, 2012	• MaineCare by the Numbers Part 2 – Dr. Kevin Flanigan o Analysis of the top 5% of expenditures by services delivered o Deeper drill down of services that drive top 5% of expenditures o Further look at where services are being delivered and how dollars are distributed • Introduction of Consultant hired to staff Task Force • Presentation by Seema Verma, SVC Inc. & Rob Damler, Milliman o What are peer/like states doing to contain costs in the Medicaid program? o How are other states managing high cost utilizers?

Meeting Date	Agenda Items

October 9, 2012	• Introductions
	• Re-Cap/Status of Prior Requests
	• Presentation by Seema Verma, SVC Inc. & Rob Damler, Milliman
	  o Short-Term Savings – Compare to Other States
	  ▪ Mandatory Benefits
	  ▪ Optional Benefits
	  o Mid-Term Savings
	  ▪ Pharmacy
	  ▪ Program Integrity
	  ▪ Impact of Medicaid Managed Care in Other States
	  o Long-Term Savings
	• Develop Specific Categories for Recommendations Based on Data and Options
	• Public Comment

October 23, 2012	• Introductions • Review Outstanding Questions and Follow Up From Last Meeting • Changes to Meeting Schedule and Report Back to Legislature • Presentation by Seema Verma, SVC Inc. and Rob Damler, Milliman o Long-Term Savings Initiatives for Consideration in the MaineCare Program • Task Force Input and Decisions – Discuss Merits and Vote on Next Steps for the Long-Term Initiatives • Public Comment • Adjourn
November 6, 2012	• Introductions • Review Outstanding Questions and Follow up From Last Meeting • Presentation by Seema Verma, SVC Inc. & Rob Damler, Milliman – Matrix of Savings Initiatives • Task Force Input and Decisions – Discuss Merits and Vote on Next Steps for the Initiatives • Public Comment • Adjourn
November 14, 2012	• Introductions • Review Draft Report • Public Input • Adjourn
November 19, 2012	• Introductions • Review Draft Report • Public Input • Adjourn

Meeting Date	Agenda Items
December 11, 2012	• Introductions • Brief Remarks/Comments by Task Force Members • Public Testimony • Discussion • Housekeeping • Adjourn

Process

To begin, the Task Force undertook a comprehensive review of the MaineCare program. Current eligibility categories, benefits, cost-sharing requirements, enrollment, and expenditures were reviewed. This review included an in-depth analysis of high-cost members by provider type, eligibility level, and funding source. Current MaineCare initiatives such as the transportation broker procurement and Value-Based Purchasing strategies were also reviewed. MaineCare features were reviewed, with consideration of overall service utilization and spending trends in Maine and nationwide.

The Task Force also focused considerable attention to initiatives being used by Medicaid agencies across the nation to deliver cost-effective, high quality services. In addition to research on general nationwide trends, nine states were reviewed in depth to identify recent cost-cutting strategies, innovative solutions, and budget impacts. These states included Arizona, Arkansas, Florida, Idaho, Iowa, Louisiana, Maryland, Minnesota and Wisconsin.

Finally, short-term, mid-term, and long-term strategies for MaineCare reform were developed with public input received and incorporated. Short-term and mid-term strategies were reviewed in the context of the overall vision and long-term strategies of MaineCare. This focus was to ensure all cost-containment strategies and recommendations were aligned and that short-term strategies did not undermine the State's long-term vision for delivering high quality cost-effective services to MaineCare enrollees. All strategies were considered with the long range goals of investing in primary care, producing coordinated, quality services for Maine's most vulnerable citizens, and fostering effective and efficient use of services. The Task Force developed the following list of guiding principles to inform decision making and frame evaluation of proposed initiatives:

- Cost effective
- High quality
- Patient/consumer centered
- Program Sustainability
- Holistic and individualized approach based on unique needs
- Flexibility (not one size fits all)
- Evidence based
- Innovation/technical approach
- Data analytics
- Collaboration
- Payer alignment
  Medical necessity

In each meeting, the committee devoted time to public testimony and after the draft report and initial recommendations were developed it was posted and the committee devoted an entire meeting to public testimony.

Findings

Current Eligibility Levels, Options for Eligibility Levels and Changes

The Task Force reviewed the current eligibility categories in the MaineCare program. In addition to the federally-mandated eligibility categories, MaineCare currently provides coverage to the optional categories outlined in Table 4. Recent budget initiatives have addressed eligibility changes, including reducing the income level for parents and caretaker relatives from 200% FPL to 100% FPL and reducing Medicare Savings Programs by 10%. Additionally, the use of State funds has been eliminated for the elderly with incomes above 100% FPL living in a residential setting. The childless adults' waiver has been capped at 40 million, and eligibility for 19 and 20 year olds has been repealed. The Task Force did not recommend changes to the current eligibility categories. The task force did recognize that the Affordable Care Act will expand coverage to former foster children up to age 26 who were enrolled in Medicaid on their 18th birthday.

Table 4: MaineCare Coverage of Optional Categories[i]

Eligibility Group	Details	# Enrolled Individuals
Pregnant Women to 200% FPL	Mandatory but covered at an optional higher income level	1,813
Children Under Age 1 to 200% FPL	Mandatory but covered at an optional higher income level	688
Children Under 18 to 200% FPL	Mandatory but covered at an optional higher income level	110,292
Parents & Caretaker Relatives	Mandatory but covered at an optional higher income level	79,793
Children under a State Adoption Assistance Program	Optional Category	281
Non-SSI Aged & Disabled to 100% FPL	Optional Category	25,246
Residents of nursing homes with income < the private rate	Optional Category	3,407
Medically Needy	Optional Category	-
Katie Beckett Coverage	Optional Category	911
HCBS for the Elderly, Disabled, Adults with Physical Disabilities & MR ≤300% SSI Federal Benefit Rate	Optional Category	-

Individuals who are HIV Positive ≤250% FPL	Optional Category	417
Breast & Cervical Cancer Program ≤250% FPL	Optional Category	214
Working Disabled ≤250% FPL	Optional Category	887
TOTAL Optional MaineCare Clients		**223,062**

Current Benefits, Options for Benefits & Changes

The Task Force reviewed the current benefits provided under the MaineCare program. Coverage limitations and prior authorization requirements were compared against the practices of Medicaid agencies across the nation. Additionally, current MaineCare coverage was reviewed against federal requirements for coverage of optional and mandatory benefits.
Prior authorization is currently required by MaineCare for the following services:

- All out-of-state services
  - Including ambulance & air medical transport
- Optional treatment services for members under age 21
- Transportation for continuous treatments in hospital outpatient setting
- Dental services
  - Dentures
  - Orthodontia
  - TMJ surgery
- Hearing aids
- Certain medical supplies & DME
  - DME costing more than $699
  - Apnea monitor
  - Hospital beds
  - Infusion pump
  - Wheelchairs
  - Oxygen, etc.
- Vision services
  - Eyewear
  - Non-MaineCare frames
  - Low vision aids
  - Orthoptic therapy/visual training
- Certain physician services
  - Breast reconstruction & reduction
  - Gastric bypass
  - Mastopexy
  - Organ transplant, etc.

MaineCare has recently undertaken a variety of benefit changes as outlined in Table 5. As a result of the comprehensive review undertaken by the Task Force, additional benefit changes and prior authorization requirements are being recommended as outlined in the Recommendations section.

Table 5: MaineCare Benefit Changes Prior to 9/12

Service	Detail
Smoking cessation products	Eliminated except for pregnant women
Ambulatory surgical center reimbursement	Eliminated
STD screening clinic reimbursement	Eliminated
Optometry visits for adults	Limited to 1 every 3 years
Chiropractic visits	Limited to 12 per year
Case management for the homeless	Added medical eligibility criteria
Physical therapy	Limited to 2 hours per day
Occupational therapy	Limited to 2 hours per day & 1 visit per year for palliative or maintenance care

Current Cost-Sharing for MaineCare Participants

The Task Force reviewed the current cost-sharing requirements under MaineCare against federal requirements. The maximum allowable cost-sharing is not currently imposed. Children are exempt from co-pays and for adults the federally allowable amount is higher than that implemented by MaineCare as illustrated in Table 6. However, the Task Force is not recommending imposing cost sharing for children or imposing higher co-pays for adults. This is due to the concern that increased cost-sharing may reduce utilization especially for primary care and preventive services. Additionally, Medicaid savings may not be realized through the imposition of cost-sharing as care may shift to higher-cost hospital services if patients avoid necessary care. Finally, the burden may be shifted to providers if enrollees fail to pay their required cost-sharing, resulting in reduced reimbursement to the provider.[ii]

Table 6: MaineCare Adult Co-Pays vs. Federal Allowable Amounts

State Payment For Service	Federally Allowable Nominal Amount	MaineCare Co-Pay
$10.00 or less	$0.65	$0.50
$10.01 - $25.00	$1.30	$1.00
$25.01 - $50.00	$2.55	$2.00
≥$50.01	$3.80	$3.00

Increases to the premiums imposed on children are not allowable until 2019 with the expiration of the Affordable Care Act Maintenance of Effort.

Spending Analysis

The Task Force reviewed current MaineCare spending and utilization trends. Spending analysis included review by such factors as funding source, provider type, enrollee eligibility, and diagnosis. This analysis resulted in identifying that the top 5% of the MaineCare population generates 54% of the overall spending. This information was used to identify potential management and administrative strategies for reform and to inform the development of

recommendations targeted both to the entire MaineCare population and to specific sub-populations where appropriate.

Federal funding is the primary source of funding for MaineCare programs. However, the federal share has declined since 2012 and will drop again in 2014 as illustrated in Table 7. Therefore, even if no other factors change from FFY 2012-13, Medicaid expenditures from the State's perspective will increase. The State may also experience increases in administrative expenses due to implementation of the Affordable Care Act in 2013. Additionally, many States are projecting enrollment increases due to the individual mandate and advertising for the tax-credits available through Exchanges. This may bring individuals that are currently eligible for Medicaid but not enrolled. States will not receive higher federal funding for this group of individuals.

Chart 1: MaineCare Sources of Funds by SFY[iii]

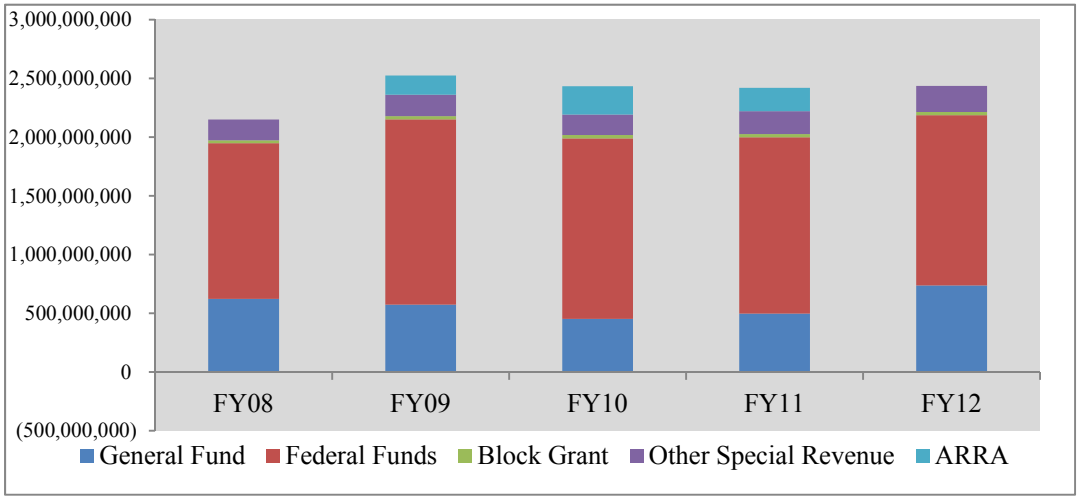


Table 7: Federal Medical Assistance Percentage

Impact of Updated Rates

FFY	Federal Share	State Share	State Budget Impact
2012	63.27%	36.73%	
2013	62.57%	37.43%	1.9%
2014	61.55%	38.45%	2.7%

Aligned with nationwide Medicaid trends, as illustrated in Chart 4, 54% of MaineCare expenditures are attributed to 5% of enrollees. This top 5% has significantly higher per member costs than other members, as demonstrated in Chart 5 and Table 8. The top 5% are primarily between the ages of 18 to 44, in the SSI disability category with a diagnosis of an intellectual disability or autism who meet State eligibility requirements for waiver services. The highest spend for this group is for waiver services. The next 5% of enrollees are also primarily between the ages of 18 and 44 in the SSI disability category. Their primary diagnoses are mental health related with significant spending in waiver services and private non-medical institutions (PNMI).

Chart 2: Expenses by Eligibility Category[iv]

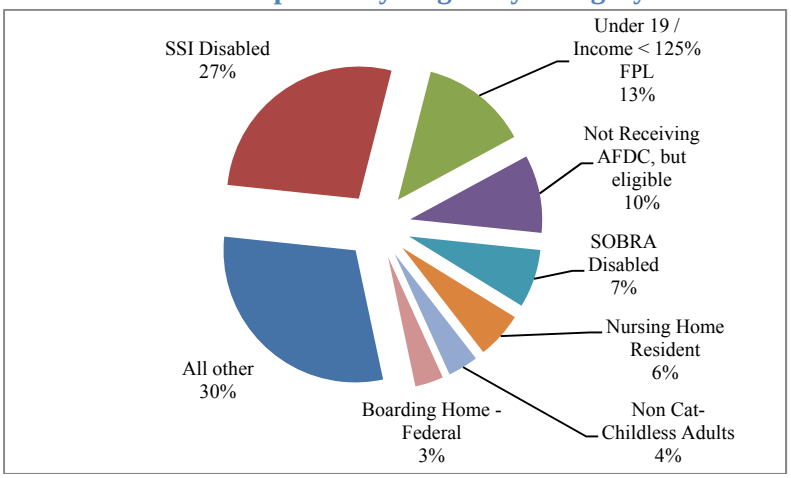


Chart 3: Expenses by Provider Type[v]

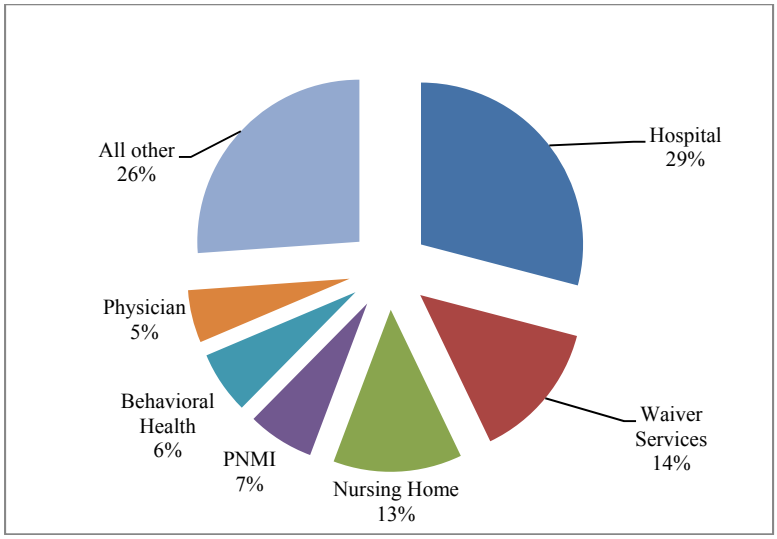


Chart 4: Expense by Cost Distribution FY 2011[vi]

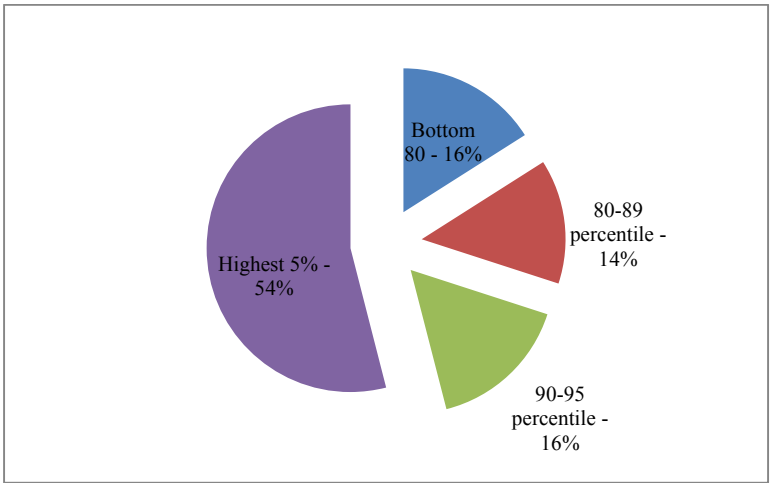


Chart 5: Annual Cost Per Member[vii]

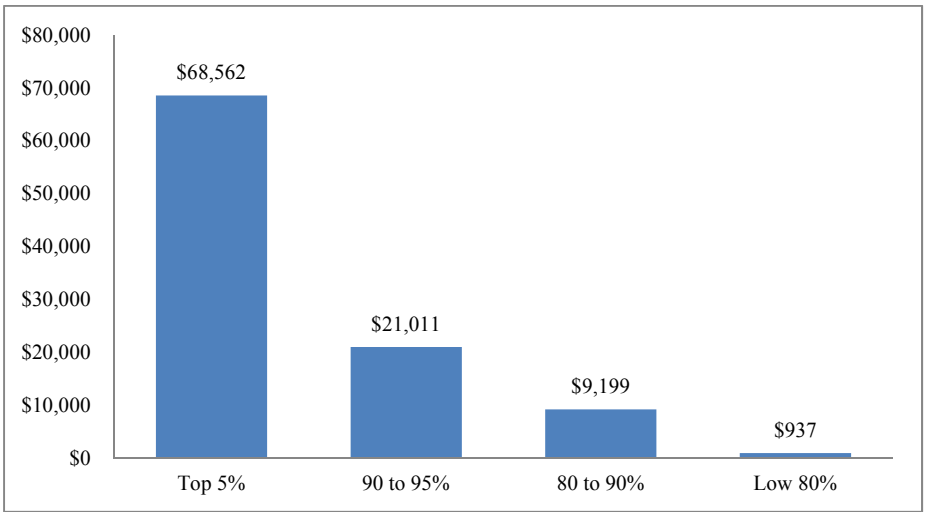


Table 8: Cost PMPM[viii]

Top 5%	90 to 95%	80 to 90%	Low 80%
$5,713	$1,750	$766	$78

Table 9: Cost Distribution – High 5% (Non-Dual)[ix]

State & Federal Expenditures – SFY '10
Expenditures in Millions

	Adult/Child	Disabled	Other
Hospital	$120.5	$142.8	$11.5
Mental health	$105.9	$68.2	$3.0
LTSS/Other	$29.1	$209.2	$22.6
Physician	$12.2	$14.9	$1.1
Pharmacy	$18.7	$36.3	$1.8
All other	$3.7	$9.2	$0.3
TOTAL	**$290.2**	**$480.6**	**$40.4**

Table 10: Cost Distribution – Next 15% (Non-Dual)[x]

State & Federal Expenditures – SFY '10
Expenditures in Millions

	Adult/Child	Disabled	Other
Hospital	$144.3	$31.2	$4.6
Mental health	$55.6	$23.0	$1.7
LTSS/Other	$26.4	$19.9	$3.8
Physician	$32.2	$8.7	$1.2
Pharmacy	$40.0	$26.8	$1.6
All other	$11.2	$3.8	$0.3
TOTAL	**$309.8**	**$113.4**	**$13.2**

Table 11: Cost Distribution for Low 80%[xi]

State & Federal Expenditures – SFY '10
Expenditures in Millions

	Adult/Child	Disabled	Other
Hospital	$88.9	$7.7	$2.6
Mental health	$30.6	$10.9	$1.5
LTSS/Other	$29.8	$7.7	$9.1
Physician	$51.9	$8.5	$9.3
Pharmacy	$38.8	$9.2	$1.8
All other	$22.3	$3.9	$1.1
TOTAL	**$262.4**	**$47.9**	**$25.3**
Lives	191,916	28,857	37,390

Table 12: Consumer Characteristics[xii]

	Top 5%	2nd 5%	80-89%	<80%
Age group	18-44	18-44	18-44	Under age 18
RAC	SSI disabled	SSI disabled	Not receiving AFDC, but eligible (parents/ caregivers)	Under 19, income <125% FPL
Clinical condition	Intellectual disability or autism	Mental health: neuroses	Pregnancy with complications	Preventive/ Admin encounters
Provider type	Waiver services	PNMI/Waiver services	Physician/ Hospital	Physician/ Hospital

As illustrated in Table 13, Maine's spending on waiver services for persons with intellectual disabilities or autism is above the national average and represents an area for potential cost savings through enhanced management strategies as discussed further in the Recommendations section. In reviewing this data it should be considered that Maine is one of 11 states that do not operate a state-run institution. Individuals with the most complex needs are more likely to remain in institutions versus being placed on HCBS waivers in states that operate this level of care, impacting the comparability of spending data among states. Additionally, a Task Force member presented additional comments for the record regarding analysis of this data in Appendix 5.

Table 13: Intellectual Disability & Autism HCBS Waiver[xiii]

Rank	Average Expenditures per Waiver Recipient in FY 2009 (State and Federal Expenditures)
25th percentile	$31,161
50th percentile	$42,155
US average	$42,896
75th percentile	$51,199
90th percentile	$68,478
Maine average	$77,736

Current DHHS Management & Administrative Strategies & Options

Current MaineCare management and administrative strategies were reviewed by the Task Force. These current initiatives were reviewed against nationwide trends for managing Medicaid populations. The Task Force examined multiple options for MaineCare's long-term management strategies. Management options were considered based on the analysis of spending patterns in the MaineCare program, separated by eligibility group and clinical diagnoses to determine the appropriate management strategy by population.

Recent MaineCare initiatives have centered on Value-Based Purchasing strategies. Under Value-Based Purchasing, payers reimburse for outcomes and quality versus volume-based reimbursement under traditional fee-for-service arrangements. Additionally, consumers have incentive to become active participants in their healthcare consumption and benefits are designed to provide appropriate intensity and levels of care. Under such strategies, the goal is for providers to better coordinate total care resulting in better outcomes at lower costs. MaineCare Value-Based Purchasing initiatives include an Accountable Communities Program, Health Homes, and a Primary Care Provider Incentive Program. Additionally, MaineCare collaborates with ER departments to identify high utilizers and drivers of utilization and to encourage members to seek care in appropriate treatment settings.

The Accountable Care Organization (ACO) model was reviewed by the Task Force. ACOs are provider-run organizations under which there is shared responsibility among providers for enrollees' care. In an ACO model providers have an opportunity to reap the benefits of shared savings. Medicaid ACOs are still in their infancy but a growing number of States are examining this model as a potential management strategy. [xiv]

Review of Initiatives Being Used in Other States' Medicaid Programs

Medicaid agencies around the country are experiencing significant budget constraints. Immediate savings have been realized through traditional strategies aimed at decreasing utilization and restricting reimbursement. Such strategies were reviewed by the Task Force in the context of long-term impact on access to care and cost shifting. Nationwide, longer-term strategies continue to be explored to transform the delivery of care to both improve quality outcomes and realize cost savings. Table 14 provides a summary of recent cost-cutting and quality initiatives being implemented by State Medicaid agencies.

Table 14: Nationwide Cost-Containment Trends

Strategy	Nationwide Trends	Recent MaineCare Initiatives
Increased cost-sharing	• FY 2012: 14 states adopted	N/A

Benefit reductions & limitations	• FY 2012:
	  o 17 states imposed limits
	  o 7 states eliminated
	• Use of Prior Authorization
	• Concurrent review
	• Targeting high cost imaging & radiology
	• Common benefits targeted:
	  o Home health & personal care
	  o Dental
	  o Physical, Speech & Occupational Therapy
	  o Vision
		• Eliminate - Smoking cessation products (except for pregnant women): 10/1/12 (pending)
		• Eliminate - Ambulatory surgical center services: 9/1/12 (pending)
		• Eliminate - STD screening clinic services
		• Limit - Optometry visits for adults (1/3 years)
		• Limit - Chiropractic visits (12/year)
		• Limit - Added medical eligibility criteria for Case Management for homeless
		• Limit - Physical therapy (2 hr./day)
		• Limit - Occupational therapy (2 hr./day & 1 visit/year for palliative or maintenance care
		• PA currently required for a multitude of services

Rate reductions	FY 2012: • 9 States reduced primary care reimbursement • 14 States reduced specialist reimbursement • 13 states reduced dental reimbursement	• Support services for adults with intellectual disabilities: 2010 • Nursing facilities: 7/1/10 • Rehab & community support services for children with cognitive impairments/physical limitations: 6/1/11 retro to 9/1/10 • Developmental & behavioral clinic services: 7/1/10 • Behavioral health services: 7/1/10 • Transportation: 8/1/10 • Occupational & physical therapy: 4/1/12 (pending) • Podiatrist: 4/1/12 • Private non-medical services: 10/1/10 • Family planning: 7/1/11 • Community support services: 7/1/10 • Behavioral Health (Methadone): 4/1/12, 1/1/13 (pending) • Group homes: 7/1/12 • Hospital outpatient (Conversion to Ambulatory Payment Classification system-based reimbursement): 7/1/12

Strategy	Nationwide Trends	Recent MaineCare Initiatives
Pharmacy targeted reforms	• PDLs & PA • MAC Rates – Blood Factor pricing • Supplemental rebates • Changes to ingredient cost & dispending fee reimbursement • Increased use of generics & mail-order • Enhanced management for high cost & overprescribed drugs • HIT to encourage appropriate prescribing • Cost sharing incentives • 340b payment at cost • Specialty drug vendors • Monitoring use of anti-psychotics • Pharmacy TPL – cost avoidance	• Rebates for crossover claims • Supplemental rebate agreements • Restrictions on narcotics use to begin 1/1/2013 • PAs for more costly drugs to begin 1/1/2013 o Tried & failed requirements o Additional step therapy • Restrictions on scripts to begin 1/1/2013 • Suboxone 2 year limit to begin 1/1/2013 • Average Wholesale Price – 16%: 4/1/12 (pending) • Mandatory generic substitution (pending) • Smoking cessation 50% reduction (pending) • Medication Management Initiative • No coverage for: o Anorexic or certain weight loss drugs o Most vitamins and herbal products o Hexachlorophene (for nursing facility patients) o Products listed as part of the per diem rate of reimbursement for Nursing Facility Services o Discontinued or recalled drugs o Less than Effective Drugs (defined by FDA) o TB drugs o OTC drugs (unless designated otherwise) o Fertility drugs Etc. (listed in MaineCare manual)
Eligibility Changes	• Review of eligibility categories to determine potential duplication with eligibility for tax credits beginning in 2014 • Increased asset tests • Reduced eligibility periods for spend-down	• SPA to reduce income eligibility for Medicare Savings Program to federal minimum • SPA to eliminate coverage for 19 & 20 year olds • SPA to reduce eligibility for parents from 200% to 100% FPL
Program integrity initiatives	• Oversight through audit, data review, survey & certification • Increased claims level analysis • Contracts with program integrity vendors	• Utilization of Recovery Audit Contractors • Centralized provider enrollment process • Centralized program integrity training across all pertinent agencies • Annual audit review by external agency or contractor • Ongoing review of Medicaid policy and procedure • Federal partnership best practice implementation (except CMS best practice annual summary report) • Review of repayments due upon TPL payment

Strategy	Nationwide Trends	Recent MaineCare Initiatives
Reimbursement reforms	• Expansion of list of hospital acquired conditions (HAC) for which reimbursement is barred beyond CMS required minimum • Not reimbursing for potentially preventable readmissions • No reimbursement for elective C-Section before 39 weeks • Provider taxes • Bundled payments	• Implements federal minimum requirement for HAC • MaineCare does not reimburse for readmits within 72 hours
Value-Based Purchasing	• Measuring and reporting comparative performance • Paying providers differentially based on performance • Designing health benefit strategies & incentives to encourage individuals to select high value services and providers and better managed their health care	• Health Homes • Accountable Communities • Primary Care Provider Incentive Program
Purchasing Strategies	• Managed Care • Health Homes • ACOs	• PCCM
HIT	• Electronic health records • Health information exchanges	• Current MaineCare initiative
Managing Duals	• Special Needs Plans (SNPs) • Program of All-Inclusive Care of the Elderly (PACE)	• N/A
Managing long-term care & high cost populations	• Changes to institutional reimbursement o Reductions in payments for bed-holds o Stricter nursing home LOC • Long-Term Care Partnership Programs • ACA provisions targeted at shifting long-term care to community settings o State Balancing Incentives Program o Community First Choice o Money Follows the Person Rebalancing Demonstration • Risk-based managed care • Behavioral & physical health integration strategies	• Money Follows the Person Rebalancing Demonstration • Plan to implement Care Coordination teams in 2013

Strategy	Nationwide Trends	Recent MaineCare Initiatives
Member Incentive Programs	• Some states have begun experimenting with member incentive programs to encourage healthy behaviors	• N/A
Managing Radiology	• Radiology benefits managers • Clinical decision support • Online interactive PA	• PA requirements

The Task Force reviewed other State designs in terms of benefits included in the managed care arrangements and covered populations. Nationwide, the majority of Medicaid children are enrolled in some form of managed care. The use of managed care is less prevalent among adults without disabilities, though still widespread and growing across the country. Additionally, Medicaid enrollees who are eligible under the "Aged" or "Disabled" categories are less likely to be enrolled in managed care, though States are increasingly moving toward expansion of mandatory managed care for individuals with special healthcare needs[xv]. The implications of a MCO model in rural settings were reviewed by the Task Force, and the group reviewed States that have moved away from MCO models.

Nationwide trends for managing Medicaid enrollees' care include extensive use of Primary Care Case Management (PCCM) and Managed Care Organizations (MCOs). Under PCCM models, as used in MaineCare, the State contracts directly with providers who are responsible for management of the beneficiaries assigned to their panel. Typically, providers receive a small per member per month fee in addition to the fee-for-services payments for services rendered. Under an MCO arrangement, states contract with an entity which receives a per member per month capitation. In turn, the MCO is responsible for managing all covered benefits for the assigned population.

Across the nation, States are increasingly exploring managing long-term services and supports (MLTSS) through MCO capitation versus fee-for-service arrangements. As of 2012, there were 16 States with MLTSS programs - double the number of programs in 2004; and 10 more States are in the process of implementing managed care for MLTSS. Of these states, eight currently enroll adults with intellectual and developmental disabilities in their MLTSS program[xvi].

Other management models reviewed included strategies targeted at duals (individuals enrolled in both Medicare and Medicaid). Dual management strategies currently being used by other States include Program of All-Inclusive Care of the Elderly (PACE) and contracting with Special Needs Plans (SNPs). The PACE program, offered in 29 states, provides multidisciplinary home- and community-based services to duals. PACE organizations receive prospective monthly Medicare and Medicaid capitation payments for each enrollee and assume full financial risk for all needed healthcare services. SNPs are a category of Medicare Advantage Plans targeting enrollees with special needs such as duals.

Recommendations

Based on the review of other state initiatives and cost-cutting strategies, the Task Force began to identify potential areas for consideration and identified data needs to evaluate potential strategies. Initiatives were considered along three main tracks: short-, mid-, and long-term strategies. The short- and mid-term strategies were intended to address the immediate budget concerns and to address the $5.25M/$14M (state/state & federal) shortfall. The longer-term

strategies reflected the Task Force's intention to re-design the MaineCare program, setting the stage for a program that has improved quality and outcomes and creating the foundation for long-term effective and efficient fiscal management of the program.
The Task Force was provided with information on previous DHHS cost-containment efforts, current policies and initiatives, and potential and estimated savings for each of the initiatives. A matrix (Appendix 4) was developed that contained the aforementioned data, in addition to the impact of each initiative, with the benefits and limitations of each strategy. Each potential initiative was also evaluated for its impact on the long-term strategy and the implementation requirements. Implementation requirements could include a need for State legislation, federal approval, system changes, and provider and member communication needs. Some ideas were eliminated if the implementation in terms of time, effort, and cost outweighed the savings potential. The committee also entertained ideas that could increase costs in the short-term by adding benefits, but may avoid costs in the long-term by promoting healthy behaviors through smoking cessation services, member incentive programs, and other potential initiatives. However, the Task Force did not have sufficient data to fully evaluate this option. After discussing each potential recommendation, Task Force members were each asked to rate their interest in potentially pursuing the recommendation on a scale of one to five, with five representing a high level of interest and one representing a low level of preference. Their scores were then used to calculate an average score for each potential recommendation. Recommendations were considered for any option that received an average score of 3.5 or higher and then the Task Force reviewed and refined the list to develop its final recommendations.

Short-Term

Short-term savings were the most difficult to identify. These savings were defined as those that could be implemented within three to six months and that would impact the budget in SFY '13. The Task Force was charged with identifying $5.25M in state savings or $14M in state and federal (combined) savings that must be counted in SFY '13. Given the fact that the committee started meeting in August 2012 - the end of the first quarter of the fiscal year - there was difficulty in identifying proposals that could achieve this goal while avoiding conflict with longer-term strategies, overall redesign efforts, and that would prevent cost increases in other areas of the program. All of the proposed short-term initiatives require a multi-step process including development of state plan amendments, federal approvals, and system changes and must be vetted through the State rule making process. After short-term strategies are implemented, additional time is needed to realize savings due to claims lag time and other factors. While producing savings in the short-term, the Task Force noted that some initiatives may create unintended consequences in other areas, including cost increases. Task Force members also expressed concern about whether the legislative goal was realistic and emphasized the importance of focusing on the overall redesign of MaineCare. To this end, the final recommendation did not identify the $5.25M of savings for FY 2012-2013; instead, $1.35M in State savings was identified.
Most States that have attempted such short-term savings are successful to the degree that they have been able to implement changes around eligibility, benefits, increased cost-sharing, or rate reductions. In considering short-term initiatives, the Task Force members eliminated some areas from consideration. The committee reviewed previous MaineCare cost containment strategies and did not want to duplicate these earlier initiatives. After consideration, the committee also chose not to recommend any changes to participant cost-sharing, citing concerns that it could

create barriers to care and could amount to provider cuts. These considerations received strong public support, as many external meeting participants cited the detrimental impact these short-term initiatives can have on MaineCare patient care and access. Eligibility changes were not recommended, either, although there was discussion that MaineCare coverage may overlap with coverage offered through Exchange-based tax credits available through the Affordable Care Act in 2014; but the group did recommend that this be examined in the future.

Mid-Term

Mid-term strategies were projects that would likely take beyond six months to implement due to their complexity, while savings could be gleaned within the first year and beyond. It is possible that some of the mid-term strategies could be short-term initiatives, depending on the implementation and priority given to some of the suggested projects. Most of the mid-term projects involved enhancements to the pharmacy program. These were later moved to short-term initiatives due to DHHS commitment to implement them more quickly. In the cursory review conducted by SVC Inc., Maine's pharmacy program was one of the best in the country in terms of its overall management and ability to glean rebates from manufacturers, as well as its use of generic drugs. The selected strategies were recommended due to high and growing use of specialty drugs, many drugs moving to generic, and other market changes. Mid-term changes may also require DHHS to obtain CMS approval and may require using new and different vendors; therefore time for procurement (developing RFP and evaluating RFP responses) was considered, as well.

Long-Term

The Task Force devoted an entire meeting to the discussion around long-term strategies. Long-term strategies were those focused on the overall re-design of the program. These strategies can take from 18 to 24 months to implement and beyond that to realize savings. Throughout the discussion of the short- and mid-term changes, the Task Force noted that many of the strategies had been utilized in the past and yet there was continual need to address Medicaid budget shortfalls. This sharpened the committee's focus on the longer-term strategy and re-design of MaineCare with the intention of creating a more efficient program focused on increasing quality and improving outcomes for participants, incorporating the guiding principles of the program. As a part of the true re-design efforts and legislative mandate, the committee spent time reviewing managed care strategies utilized in other States that involved both primary care case management (PCCM) and risk-based managed care (RBMC). It reviewed the success, cost savings, and challenges in those States, and examined mitigation strategies to address key challenges. The committee was particularly interested in recent DHHS efforts around Value-Based Purchasing. Members expressed desire to build upon those strategies, rather than re-creating a different approach that duplicated or eliminated the promising approaches in which DHHS has invested with community partners. Public comments also recognized the work going on in Maine, and expressed the same desire to build upon existing initiatives.

The data developed and presented by Dr. Flanigan was a critical component of shaping the Task Force's long-term strategy. In particular, the data that showed the high cost of the top 20% of MaineCare participants and the top 5% became a prime focus. Among the top 5% of high-cost enrollees, the primary eligibility category was SSI recipients ages 18 to 44 with developmental disabilities. The largest spend by provider type for this top 5% was for waiver services.

Additionally, among the next 5% of enrollees by cost, mental health diagnoses were prevalent with spending primarily for private non-medical institutions and waiver services.

Finally, other data presented by Milliman also outlined areas where Maine was an outlier as compared to other States. First, as illustrated in Table 15, there is a high incidence of poor birth outcomes among the MaineCare population. Forty six percent of babies delivered have health complications versus 17% in Indiana and 27% in Michigan. Therefore, targeted initiatives to increase the incidence of normal deliveries have the potential for significant cost savings.

Table 15: Potential Savings (State & Federal) for Improved Birth Outcomes[xvii]

	Base Admits	Base Spending		Redistributed Admits	Redistributed Spending
Normal newborns	3,316	$3,750,451		3,887	$4,396,035
Newborns with Health Complications	2,854	$21,620,671		2,283	$17,296,537
TOTAL	**6,170**	**$25,371,121**		**6,170**	**$21,692,571**
% with Health Complications	46%			37%	
Savings from redistribution					**$3,678,550**

Second, as illustrated in Table 16, while Maine has performed above the national average on Medicare readmissions, MaineCare's hospital readmission rate within 30 days is higher than the national average. The MaineCare average is 17.7% versus a national average of 9.4%.

Table 16: Maine Hospital Readmissions within 30 days[xviii]

	Maine Readmit Rate	US Readmit Rate
Pregnancy, Childbirth	7.0%	3.8%
Mental Health	21.5%	11.8%
Circulatory	21.5%	10.4%
Respiratory	22.4%	11.4%
Digestive	22.6%	10.3%
Alcohol/Drug Use	21.1%	13.0%
Musculoskeletal	10.8%	8.3%
Nervous	17.1%	9.5%
Liver, Pancreas	25.5%	12.3%
Metabolic	20.2%	10.7%
Skin, Breast	17.4%	8.0%
Infections	27.4%	11.5%
Kidney	23.9%	12.4%
Injuries, Poisonings	16.8%	8.4%
Health Status	18.6%	9.9%
Female Reproductive	6.4%	6.4%
Ear, Nose, Mouth & Throat	12.6%	7.2%

Myeloproliferative Diseases	49.7%	37.4%
Blood	36.4%	14.1%
Male Reproductive	12.8%	7.2%
HIV Infections	24.4%	17.2%
Multiple Trauma	10.5%	7.9%
Eye	40.9%	6.9%
Burns	5.9%	6.1%
TOTAL	**17.7%**	**9.4%**

Third, as illustrated in Table 17, Maine's spending on waiver services for persons with intellectual disabilities or autism is above the 90th percentile of nationwide spending. In reviewing this data it should be considered that Maine is one of 11 states that do not operate a state-run institution. Individuals with the most complex needs are more likely to remain in institutions versus being placed on HCBS waivers in states that operate this level of care, impacting the comparability of spending data among states.

Table 17: Intellectual Disability & Autism HCBS Waiver[xix]

Rank	Average Expenditures per Waiver Recipient in FY 2009 (State and Federal Expenditures)
25th percentile	$31,161
50th percentile	$42,155
US average	$42,896
75th percentile	$51,199
90th percentile	$68,478
Maine average	$77,736

Final Short-Term Strategy Recommendations

Prior Authorization

Prior authorization (PA) policies are used by State Medicaid agencies and other payers to apply medical necessity criteria to ensure the appropriate delivery of services and reduce overutilization. As outlined in the Findings section, MaineCare currently requires prior authorization for a variety of services and has increased the number of services that require prior authorizations in recent years. However, analysis identified where MaineCare does not currently require PA where other States do. Some of these services include psychiatric services for individuals under 21, elective surgeries, and various high cost imaging and radiology services. Elective inductions prior to 39 weeks are associated with longer labors, increased C-section rates and reduced birth outcomes. Other States such as Ohio and Utah have stopped reimbursing for elective inductions prior to 39 weeks. The Task Force is recommending implementing this policy with a prior authorization process for exception cases.

A State Plan Amendment (SPA) or waiver is not required to make changes to these PA policies. **With average scores ranging from 4.0 to 5.0, the Task Force recommended implementation of prior authorization policies for these services as outlined in Table 18.** Members of the community that attended the Task Force meetings were generally in agreement with the aims of

the prior authorization program, believing that patients would still have access to care, but would have appropriate oversight to ensure that the care would be both necessary and appropriate. **The implementation of these policies would yield savings in SFYs '13-'15 of an estimated $9.66 million for State & Federal spending and a savings of approximately $3.62 million in State spending alone (SFY '13: $0.40M, SFY '14: $1.61M, SFY '15: $1.61M).**

Table 18: Prior Authorization Recommendations

Service	Task Force Score	Estimated State Savings (SFY '13-15)
Individuals under 21: Concurrent review for psychiatric services & PA for all settings	4.7	$0.12M
Elective Surgeries	5.0	$0.67M
High Cost Imaging & Radiology	4.7	$2.11M
Inductions Prior to 39 Weeks	4.0	$0.72M
TOTAL		**$3.62M**

Hospital-Acquired Conditions

Per federal regulations, State Medicaid programs are not permitted to reimburse hospitals for certain hospital-acquired conditions. Examples of prohibited reimbursement include a foreign object retained after surgery and surgical site infections. With federal approval through a State Plan Amendment process, States can identify additional conditions for which Medicaid reimbursement may not be provided. Maine currently utilizes the federal minimum requirement. In 2009, Maryland expanded the list of hospital-acquired conditions for which reimbursement would not be provided to a total of 49 conditions. Hospitals with a higher-than-average complication rate receive an overall decrease in payment.[xx] The Task Force recommends mirroring Maryland's strategy, while also considering the possibility of extending this policy to other inpatient settings, such as nursing homes, to encourage improved care and to increased savings. **This short-term strategy received an average score of 3.9 from Task Force members. Estimated savings for SFYs '13-'15 include $3.95 million in State & Federal expenditures or $1.48 million in State expenditures (SFY '13: $0.16M, SFY '14: $0.66M, SFY '15: $0.66M) for hospitals, and additional research may reveal further savings through the expansion of this initiative.**

In order to realize these savings, the Task Force also recommends capitalizing on lessons learned by the MECDC Infectious Disease Program, discussing work done through the Hospital Acquired Infections (HAI) Task Force. The Task Force also recommends capitalizing on the existing efforts of the Maine Infection Prevention Collaborative (MPIC).

Readmissions

As previously discussed, Maine's readmission rate within 30 days is higher than the national average (17.7% vs. 9.4%). MaineCare does not currently reimburse for readmissions within 72 hours. States have explored additional strategies for reducing potentially preventable readmissions. For example, in New York hospitals that have excess readmissions within 14 days receive payment reductions for all non-behavioral health-related Medicaid discharges[xxi]. In Massachusetts, hospitals above the set threshold for readmissions receive a 2.2% reduction in their standard payment amount per discharge[xxii]. Under the Affordable Care Act, Medicare has also implemented policies related to preventable readmissions. With penalty amounts increasing

annually, hospital reimbursement is reduced for excess readmissions rates for certain clinical conditions (acute myocardial infarction, heart failure, and pneumonia).

The Task Force is recommending modification of the current readmissions policy and scored the overall strategy at 4.7. In place of the current policy of not reimbursing for readmissions within 72 hours, the Task Force recommends increasing the time span. This policy is intended to increase quality and promote and strengthen discharge planning to avoid readmissions. The committee noted that hospitals that did not have the first admission and discharge should not be penalized for the readmission; that is, if an individual readmitted to a different hospital the second admitting hospital would not lose reimbursement. The Task Force, in addition to community members, recommends potential exemptions for cases of substance abuse treatment and behavioral health concerns – similar to the New York policy – as readmissions for this population are difficult to prevent and costly to leave untreated. The committee discussed that while the hospitals may prefer the Medicare readmission policy, it may be more complex to implement and would take longer to realize savings. Use of the Medicare methodology could move the initiative to more of a mid-term or long-term strategy. Therefore, the task force noted that DHHS should evaluate both options and MaineCare-specific data to determine the appropriate strategy both in the short term and over the long term to address hospital readmission rates and to improve quality. To this end, the Task Force recommended the Department work closely with the Maine Hospital Association and other stakeholders in order to develop appropriate application and population exemption recommendations.

In order to implement this policy, a State Plan Amendment and federal approval is required.

Estimated savings for implementing the reimbursement rate reduction strategy include $9.17 million in State and Federal expenditures for SFYs '13-'15 or $3.44 million in State expenditures (SFY '13: $0.38M, SFY '14: $1.53M, SFY '15: $1.53M).

Reimbursement for Leave Days

Currently, MaineCare reimburses for hospital and therapeutic leave days as outlined in Table 19. Under this policy, facilities receive payment for days when the Medicaid enrollee is not present in the institution and receiving care. Some other States do not provide Medicaid reimbursement for such leave days. For example, seven states do not reimburse for any leave days for IMD facilities and three states do not reimburse for any leave days for ICFMRs.[xxiii]

Table 19: MaineCare Leave Days

Facility Type	Current MaineCare Reimbursement Policy
Nursing Facility	10 hospital leave days 36 therapeutic leave days
IMD	10 hospital leave days 36 therapeutic leave days
ICFMR	25 hospital leave days 52 therapeutic leave days

The Task Force recommends eliminating reimbursement for these leave days and scored this initiative at 3.5. Savings for SFYs '13-'15 are estimated at $3.85 million in State and Federal expenditures or $1.44 million in State expenditures (SFY '13: $0.16M, SFY '14: $0.64M, SFY '15: $0.64M). A State Plan Amendment would be required to implement this change.

While there is national precedence and preliminary savings data, there remains expressed concern from community and Task Force members that the cost savings might not be worth more indirect costs to patient care. One Task Force member did caution that, depending on the supply of beds, patients may not have a place to return to or may have to transfer to another facility. This raises the concern that complete elimination of reimbursement could cause longer inpatient hospitalizations Community members expressed concern that patients being relocated to different facilities will result in lost continuity of care and the need for greater communication and coordination between hospitals and nursing homes so that bed availability is less of a concern. The Task Force recommends that this policy be considered by the Legislature and that more study is needed to understand the costs and benefits of the strategy.

Pharmacy

Expand Medicaid Management Initiative

Currently MaineCare utilizes the Goold Med-Management tool, a health informatics tool to facilitate case management activities. This is a web-based tool available to clinicians and support staff to support "Intensive Benefits Management, Medication Therapy Management Program (MTMP), therapy compliance, and other programs requiring case management[xxiv]." The Task Force also noted it would be useful to explore expanding the Medicaid management initiative to include retail pharmacies in this initiative. **The Task Force recommends expansion of this program and scored this initiative at 5.0. Savings for SFYs '13-'15 are estimated at $3.87 million in State and Federal Expenditures or $1.45 million in State expenditures (SFY '13: $0.17M, SFY '14: $0.64M, SFY '15: $0.64M).**

As a part of the focus on quality patient health care and outcomes, the committee also recommends that DHHS explore tracking patients that pay cash for controlled substances and reviewing these individuals to assure there is no inappropriate use of such medications. The committee recommends that DHHS explore whether such data can be provided to the health home for review and follow-up.

Monitor Use of Anti-Psychotic Medications

With the steady increase of prescribed anti-psychotic medications, particularly among children, States have targeted monitoring their use among Medicaid enrollees both to ensure appropriate clinical outcomes and cost-effectiveness. For example, Maryland launched the Anti-psychotic Medication Initiative in which a peer review program was implemented and prior authorization required for anti-psychotic prescriptions for children under age 10. Additionally, prior authorization is required for Tier 2 and non-preferred anti-psychotic medications for patients' age 10 years and up.[xxv]

The Task Force is recommending implementation of such a program for MaineCare enrollees. Prior authorization would be required for use among children, adults, and seniors. A State Plan Amendment would not be required to implement. **This initiative scored at 4.8. Associated savings are estimated for SFYs '13-'15 at $1.8 million in State and Federal expenditures or $0.675 million in State expenditures (SFY '13: $0.075M, SFY '14: $0.3M, SFY '15: $0.3M).**

Recent program initiatives in Arkansas and Washington state have demonstrated particular promise for enhanced savings, and further research would be needed to determine whether comparable initiatives in Maine might also improve savings estimates as well as patient care.

Table 20: Summary Short-Term Recommendations

	Strategy	State Savings SFY '13	State Savings SFY '14	State Savings SFY '15
Prior Authorization	Psychiatric Services for Individuals under 21	$0.02M	$0.05M	$0.05M
	Elective Surgeries	$0.07M	$0.3M	$0.3M
	High Cost Imaging & Radiology	$0.23M	$0.94M	$0.94M
	Inductions Before 39 weeks	$0.08M	$0.32M	$0.32M
Hospital Acquired Conditions	Expand list of HACs & implement annual payment adjustments	$0.16M	$0.66M	$0.66M
Readmissions	Increase time span for which readmissions are not reimbursed to 14 days	$0.38M	$1.53M	$1.53M
Leave Days*	Eliminate reimbursement for hospital & therapeutic leave days	$0.16M	$0.64M	$0.64M
Pharmacy	Expand Medication Management Initiative	$0.17M	$0.64M	$0.64M
	PA for antipsychotics	$0.075M	$0.3M	$0.3M
Total Savings for Short-Term Strategies		**$1.35M**	**$5.38M**	**$5.38M**

* Require legislation, referred to the Legislature for further study and review.

Final Mid-Term Strategy Recommendations

Pharmacy

Competitive Bid for Specialty Pharmacy

To address the high cost of specialty pharmacy drugs, the Task Force is recommending a competitive bid for a specialty pharmacy vendor. Under this approach enrollees would be required to receive their specialty drugs from the contracted vendor. Typically, in addition to dispensing drugs, specialty pharmacy vendors conduct clinical outreach to doctors and enrollees to ensure proper prescribing patterns and medication use. These vendors offer the advantage of aggressive pricing discounts due to volume purchasing. A SPA and 1115 waiver would be required to implement this strategy.

This approach received an average score of 4.7 from the Task Force. Associated savings for SFYs '14-'15 are estimated at $3.15 million in State and Federal Expenditures or $1.18 million in State expenditures (SFY '14: $0.39M, SFY '15: $0.79M). This figure is anticipated to grow annually as specialty drug spending is expected to comprise around 40% of the total pharmacy spend by 2015.

Increase Generic Dispensing Rate by 1%

The Task Force is recommending increasing the generic dispensing rate by 1% and reducing the use of specialty drugs. The State should be mindful of the cost-benefit analysis, as many brand drugs offer rebates that make them less expensive than generics. **Associated savings for SFYs '14-'15 are estimated at $6.29 million in State and Federal Expenditures or $2.36 million in State expenditures (SFY '14: $1.01M, SFY '15: $1.35M).**

Program Integrity

Medicaid agencies are utilizing a variety of program integrity initiatives to combat fraud, waste, and abuse. MaineCare currently utilizes Recovery Audit Contractors, has a centralized provider enrollment process, and provides program integrity training across all pertinent agencies. Additionally, an annual audit is conducted by an external agency and there is ongoing review of Medicaid policies and procedures to ensure appropriate controls are in place. MaineCare has also implemented the Federal Partnership Best Practices with minor exceptions.

The MaineCare program integrity team is currently working to identify system algorithms that have been successful in other program integrity units across the United States, prioritizing the ones best-suited for Maine. The team is arranging for an all-day session with a vendor that specializes in program integrity and algorithms in exception processing and is working to identify different approaches. These programs could ultimately help to identify outliers and ongoing trending by service, provider payments, and units by member.

The Task Force is recommending increased initiatives surrounding program integrity including the development of operational policies and procedures to handle Medicaid discretionary functions. Additionally, the Task Force is recommending undertaking an internal review of data collected, utilizing the CMS Best Practice Annual Summary Report and developing policies, procedures and mechanisms to report to the Medicaid and CHIP Payment and Access Commission. SPAs would not be required to implement any of the program integrity initiatives.

These initiatives were given an average score of 4.4 by the Task Force. Such program integrity initiatives are anticipated to provide savings for SFYs '14-'15 of $11.39 million in State and Federal expenditures or $4.27 million in State expenditures (SFY '14: $1.83M, SFY '15: $2.44M).

Restore Smoking Cessation Benefits

Smoking cessation products were eliminated effective October 1, 2012 for all MaineCare enrollees except pregnant women. While counseling benefits are still available to all members, smoking cessation products may offer members more options and assistance as they attempt to break their tobacco addiction. Section 2502 of the ACA will require States to offer tobacco cessation drugs starting in 2014. Due to the significant health impact and costs associated with smoking, the Task Force considered reinstatement of these benefits. However, reinstating coverage of smoking cessation benefits creates new costs to the State in the short-term. While there was support from the public commenters, the Task Force recommended that the restoration of smoking cessation services be referred to the Legislature. Further study is needed to evaluate the short-term costs versus the potential for mid- and long-term savings benefits. While some literature points to savings over the long term if smoking related illnesses can be avoided, there was difficulty in pinpointing the amount of potential savings for MaineCare. This data was not available to the Task Force given the timeframe for deliberations. More study is needed to determine if providing MaineCare members with access to both counseling and products can create long term savings. Legislative action is needed to restore the benefits and a SPA is also needed.

This strategy received an average score of 3.7. Total State and Federal costs for SFYs '14-'15 are estimated at $2.1 million or $0.79 million in State costs (SFY '14: $0.394M, SFY '15: $0.394M).

Dental Benefits for Emergency Department Utilizers

Currently MaineCare provides limited dental services for adults. Extraction is available for severely decayed teeth which pose a threat of infection during a surgical procedure of the cardiovascular or skeletal system or during radiation treatment for a tumor. Treatment is covered to relieve pain or eliminate infection. Other dental services are covered if found to be medically necessary to correct an underlying medical condition or if they are determined cost-effective in comparison to the provision of other covered services for the treatment of that condition.
Due to the concern that dental pain is a driver of emergency room utilization, and therefore cost shifting to a more expensive treatment setting, the Task Force considered recommending allowing dental benefits for individuals who utilize the emergency room for dental services, working to reduce their dependence on the ER and receive lower cost and more effective preventive care. This would create new costs for the State in the short term. However, similar to the restoration of smoking cessation products, the Task Force deferred consideration to the Legislature as legislation would be needed to provide these services and further study is needed to understand the full cost benefit of this strategy. A State Plan Amendment would also be required. **The Task Force gave this initiative an average score of 4.2. Estimated costs associated with implementing this benefit for SFYs '14-'15 are $16.8 million in State and Federal expenditures or $6.3 million in State expenditures (SFY '14: $3.15M, SFY '15: $3.15M. The Task Force did not calculate the anticipated savings offsets anticipated such as reduced ER utilization.**

Table 21: Summary Mid-Term Recommendations

	Strategy	State Savings SFY '14	State Savings SFY '15
Pharmacy	Competitive Bid for Specialty Pharmacy	$0.39M	$0.79M
	Increase Generic Dispensing Rate by 1%, Reduce Use of Specialty Drugs	$1.01M	$1.35M
Program Integrity	• Develop operational policy and procedure to handle day to day Medicaid discretionary functions • Internal review of data collected • Utilize CMS's best practice annual summary report • Develop policy/procedure and mechanisms for reporting to the Medicaid and CHIP Payment and Access Commission	$1.83M	$2.44M
Total Savings for Mid-Term Strategies		$3.23M	$4.58M
Increase Benefits	Restore Smoking Cessation Benefits*	($0.394M)	($0.394M)
	Allow Dental Benefits for ER Utilizers*	($3.15M)	($3.15M)
Total Savings for Mid-Term Strategies with Additional Benefits		**($0.31M)**	**$1.04M**

***** These initiatives require legislation and are referred to the Legislature for further study and review.

Final Long-Term Strategy Recommendations

The final long-term recommendations were built around a strategy of targeted initiatives by population and/or category. There was recognition that different approaches were needed to

account for the complexity of different populations; but the goal for all is to manage, coordinate, and prevent disease progression. The committee developed two approaches, one for 80% of the MaineCare population designed for less complex disease states, which centers on strong primary care management and community partners to manage and coordinate care. Another approach was recommended for the highest-cost populations - the top 20% of MaineCare. This population is likely to have disabilities, either physical or mental, receive waiver services, and have significant co-morbidities, often mental health issues. This population requires medical care as well as long-term care support services, including institutional and home- and community-based services. The top 5% of the population is the most expensive, and the long-term strategy is to prevent the population just below the top 5% - the next 15% - from becoming the top 5%, where costs are difficult to control.

Value-Based Purchasing

MaineCare has been working on a variety of Value-Based Purchasing initiatives. Under these strategies, providers are reimbursed for outcomes and quality versus volume-based reimbursement under traditional fee-for-service arrangements. The goal is for providers to better coordinate total care resulting in better outcomes at lower costs. MaineCare Value-Based Purchasing initiatives include an Accountable Communities Program, Health Homes, and a Primary Care Provider Incentive Program. The approach continues the primary care case management program that has been in place, but adds community care coordinators to augment the health home care coordination activities. Under these initiatives, Community Care Teams will provide wrap-around support to physician practices that deliver intensive care management to members with the highest needs. Additionally, Community Care Teams with expertise in behavioral health will partner with practices to serve members with serious mental illness. The Primary Care Provider Incentive Program is an incentive program to reward practitioners that provide high quality care to MaineCare members. The goals of the program are to reduce disincentives associated with higher Medicaid patient panels, reduce inappropriate ER utilization, and increase the utilization of preventive and high quality services. Providers receive a monetary payment based on their ranking for select quality measures. Additionally, MaineCare collaborates with ER departments to identify high utilizers and drivers of utilization and to encourage members to seek care in appropriate treatment settings.

Following analysis of the cost distribution and enrollment of the entire MaineCare population, the Task Force identified these current strategies as effective management techniques for the low-risk and low-cost enrollees. These low-risk patients represent the bottom 80% of enrollees by cost and are comprised primarily of persons without disabilities, pregnant women, and children whose needs center primarily on primary care. The Task Force recommends increased promotion of targeted initiatives aimed at emergency room utilization, maternal and child health, care coordination, and provider incentive programs. **The Task Force scored these initiatives at 5.0. These management activities are anticipated to provide savings in SFYs '14-'15 of $9.09 million in State and Federal expenditures or $3.41 million in State expenditures (SFY '14: $1.46M, SFY '15: $1.95M).**

Value-Based Purchasing with Care Management Organization

The Task Force reviewed other States' use of managed care and contracted entities known as Care Management Organizations (CMO) in conjunction with Value-Based Purchasing initiatives. For example, in Louisiana, an enhanced PCCM model is used. The State contracts with two entities to provide care management and oversee the network of primary care providers. Savings

targets are established by the State and any savings attained must be shared with providers. If savings are not achieved, the entity is at risk and must return up to fifty percent of the monthly care management fee received.[xxvi]

The committee considered a full capitation managed care strategy, but was reluctant to recommend this strategy given the current investment in the Value Based Purchasing Initiative and limited managed care penetration in the State. Currently, provider-led Accountable Care Organizations forming in Maine are engaged in shared savings, but are not at risk for any losses. While the Value-Based Purchasing strategy creates the pathway for providers to accept risk for health care expenditures, in the current arrangement only the State is at risk and there is no budget predictability. In absence of providers taking risk, the CMO's role is intended to support DHHS in the implementation of the Value-Based Purchasing initiative and to provide expertise, oversight and accountability to achieve the intended goals. Claims would continue to be paid by the State, while the CMO would work with DHHS and provider networks, including health homes and accountable care communities. The entity would also undertake additional care management initiatives to support the health homes and accountable care communities. Additionally, as there is no absolute guarantee of savings under Value-Based Purchasing initiatives, contracting with a CMO and tying in savings guarantees reduces financial risk to the State and places that risk with the CMO. In the future, should providers be willing and prepared to accept risk for a savings target for the Medicaid population, a CMO would not be needed.

In order to maximize this initiative, the Task Force and community members recommend a CMO structure that complements the provider-patient relationships and infrastructure that has already been built through the health homes and Accountable Communities initiatives in Maine. The CMO should serve to reduce financial risk to the state while provider networks and ACOs continue efforts to develop a new model of care in which providers themselves are able to assume more risk and no longer require the oversight of the CMO. The Task Force recommends that the CMO serve in a complementary role to the health homes and should not duplicate services, but rather acts as an enhancement to ensure maximum cost savings and quality patient care. A State Plan Amendment or waiver would be necessary to implement this model. **The Task Force strongly supported the use of a CMO to strengthen the current Value-Based Purchasing initiatives and scored this at 5.0. Estimated State and Federal savings for SFYs '14-'15 are $3.17 million or $1.19 million in State expenditures (SFY '14: $0.51M, SFY '15: $0.68M).**

Strategies to Improve Birth Outcomes

As previously discussed and illustrated in Table 22, MaineCare has a high incidence of poor birth outcomes. The Task Force recommends targeted initiatives to increase the incidence of normal deliveries and healthy newborns. As part of this initiative, the Task Force recommends that the C-Section rate in the State be reviewed and that this effort include an initiative to reduce medically unnecessary C-Sections. This could be developed as either a separate initiative or as a responsibility of a CMO. **This initiative has strong support from the Task Force with an average score of 4.7. By reducing the percentage of newborns with health complications from 46% to 37%, State and Federal savings for SFYs '14-'15 of $5.58 million is anticipated or $2.09 million in State expenditures (SFY '14: $0.7M, SFY '15: $1.39M).**

Table 22: Estimated SFY '15 Savings (State & Federal) for Improved Birth Outcomes[xxvii]

	Base Admits	Base Spending		Redistributed Admits	Redistributed Spending
Normal newborns	3,316	$3,750,451		3,887	$4,396,035
Newborns with Health Complications	2,854	$21,620,671		2,283	$17,296,537
TOTAL	**6,170**	**$25,371,121**		**6,170**	**$21,692,571**
% with Health Complications	46%			37%	
Savings from redistribution					**$3,678,550**

Targeted Care Management for Top 20%

As previously discussed, the service costs for the top 5% of MaineCare enrollees represent 54% of total spending. These populations are primarily persons served under the various long-term services waiver programs and those living in residential facilities. States are increasingly exploring managing long-term services and supports (MLTSS) through MCO capitation versus fee-for-service arrangements. Such strategies have the advantage of providing budget certainty to States, as managed care entities are at risk for all patient claims. As of 2012, there were 16 States with MLTSS programs, double the number of programs existing in 2004, and at least half of states are currently planning for this type of initiative.[xxviii]

The committee actively explored full capitation for the high-cost users, which would provide significant cost savings for the State. There was concern that this strategy is not widely used currently, although many States are actively working towards implementation of managed care for persons with disabilities. As an alternative, the Task Force recommends utilization of the Value-Based Purchasing care management program to target MaineCare's top 20% of utilizers. While all of MaineCare would be under the oversight of a Care Management Organization, the services for the top 20% would be addressed by a highly specialized organization with a unique skill set geared to coordinating care for high cost users.

Enrollees in this initiative would include not only those in the top 5% of spending but also the next 15% to prevent the cost of their care from escalating into the top 5%. The Care Management Organization could be the same entity that provides services for the general MaineCare population (80%) or another entity that has more experience with populations with high-cost medical and long term services needs, including persons with developmental or other disabilities. The care management program would work with providers and health homes to provide aggressive care management to slow the progression of chronic diseases and avoid unnecessary hospitalization and institutionalization. Home- and community-based services would be promoted over institutional care, with enrollees continually re-evaluated to ensure the appropriate level of services is being delivered. The committee also expressed support for DHHS re-evaluating a fully capitated model for the high cost users in the future when more information and data is available from other States that are exploring this option. Additionally, as the Care Management Organization becomes more experienced with the MaineCare population, providers, underlying costs, and delivery system issues over time, a capitated model

may be more appropriate. A fully capitated model could be part of the Value-Based Purchasing initiative with providers/ACOs or Managed Care Organizations taking risk.
As part of the Care Management initiative for high-cost clients, the Task Force also recommends that DHHS efforts around individual assessment and resource allocation for high-cost individuals continue and be strengthened. Consideration should also be given to expanding the use of assistive technology to support individuals with disabilities in order to alleviate or lessen the need for support services provided by caregivers. Such assistive technology should be explored for use in group settings as well. Additionally, consideration of providing support services for families who are caring for a relative with disabilities may also reduce use of institutional services or use of private non-medical institutions/care facilities.
While continuing fee-for-service reimbursement for providers, the committee recommends a performance-based contract for the care management entity. Contracting strategies such as performance bonuses and withholds tied to quality outcomes and/or savings targets should be utilized to assure the delivery of high quality care and outcomes. DHHS should also explore use of performance bonds and/or liquidated damages to assure that goals are met.
The Task Force support for this approach was unanimous with an average score of 5.0. Estimated State & Federal savings for SFY '15 are $23.45 million or $8.61 million in State savings. A State Plan Amendment and potential modifications to existing waivers would be necessary to implement this initiative.

Table 23: Summary Long-Term Recommendations

	Strategy	State Savings SFY '14	State Savings SFY '15
Value-Based Purchasing	Increase promotion of targeted initiatives o ED o Maternal & child health o Care Coordination to assist transition o Provider incentive program	$1.46M	$1.95M
Value-Based Purchasing with CMO	Care Management Organization	$0.51M	$0.68M
Improve Birth Outcomes	Healthy Babies Initiative	$0.7M	$1.39M
Top 20%	Targeted Care Management	-	$8.61M
Total Savings for Long-Term Strategies		**$2.67M**	**$12.63M**

Next Steps

As outlined in Table 24, implementation of some of the Task Force recommendations will require submission of a SPA or waiver to the federal government, rule change or legislative approval. As federal approval is requested, the Task Force will submit monthly reports to the legislature to keep it abreast of the strategy progress and federal approval status.

Table 24: Implementation Requirements

Strategy	Rule Change Required	SPA/Waiver Required	Legislative Change Required
Hospital Acquired Conditions	X	X	
Readmissions		X	
Leave Days	X	X	
Expand Medication Management Initiative	X	X	
Competitive Bid for Specialty Pharmacy	X	X	
Increase Generic Dispensing Rate	X		
Restore Smoking Cessation Benefits		X	
Allow Dental Benefits for ER Utilizers	X	X	
Expand Value-Based Purchasing Initiatives	X	X	
Targeted Care Management for Top 20%	X	X	X

Conclusion

The Task Force is recommending a comprehensive package of short-term, mid-term, and long-term strategies to reform MaineCare to ensure long-term sustainability and the delivery of high-quality, cost-effective care. Together these strategies are projected to save the State $35.22 million in SFYs '13-'15 as outlined in Table 25.

Table 25: Summary of Task Force Recommendations

	Strategy	State Savings SFY '13	State Savings SFY '14	State Savings SFY '15
Prior Authorization	Implement concurrent review for psychiatric services for individuals under 21 in all settings	$0.02M	$0.05M	$0.05M
	Elective surgeries	$0.07M	$0.3M	$0.3M
	High cost imaging & radiology	$0.23M	$0.94M	$0.94M
	Elective inductions before 39 weeks	$0.08M	$0.32M	$0.32M
Hospital Acquired Conditions	• Expand list to include all of those listed for the State of MD • Payment adjustments made annually based on HACs	$0.16M	$0.66M	$0.66M

	Strategy	State Savings SFY '13	State Savings SFY '14	State Savings SFY '15
Readmissions	Increase time span from 72 hours to 14 days for which readmissions are not reimbursed	$0.38M	$1.53M	$1.53M
Leave Days*	Eliminate reimbursement for hospital leave days	$0.16M	$0.64M	$0.64M
Pharmacy	Expand Medication Management Initiative/J Code PDL	$0.17M	$0.64M	$0.64M
	PA for antipsychotics	$0.075M	$0.3M	$0.3M
Total Savings for Short-Term Strategies		**$1.35M**	**$5.38M**	**$5.38M**
Pharmacy	Competitive Bid for Specialty Pharmacy	-	$0.39M	$0.79M
	Increase generic dispensing rate by 1%, Reduce use of specialty drugs	-	$1.01M	$1.35M
Program Integrity	• Develop operational policy and procedure to handle day to day Medicaid discretionary functions • Internal review of data collected • Utilize CMS's best practice annual summary report • Develop policy/procedure and mechanisms for reporting to the Medicaid and CHIP Payment and Access Commission	-	$1.83M	$2.44M
Total savings for Mid-term strategies		**-**	**$3.23M**	**$4.58M**
Increase Benefits*	Restore Smoking Cessation Benefits	-	($0.394M)	($0.394M)
	Allow dental benefits for individuals using the ER for dental services	-	($3.15M)	($3.15M)
Total savings for Mid-term strategies with additional benefits		**-**	**($0.31M)**	**$1.04M**
Value-Based Purchasing	Increase promotion of targeted initiatives o ED o Maternal & child health o Care Coordination to assist transition o Provider incentive program	-	$1.46M	$1.95M

	Strategy	State Savings SFY '13	State Savings SFY '14	State Savings SFY '15
Value-Based Purchasing with CMO	Care Management Organization	-	$0.51M	$0.68M
Improve Birth Outcomes	Healthy Babies Initiative	-	$0.7M	$1.39M
Targeted Care Management	Targeted Care Management for top 20%	-	-	$8.61M
Total Savings for Long-Term Strategies		**-**	**$2.67M**	**$12.63M**
TOTAL (without additional benefits)		**$1.35M**	**$11.28M**	**$22.59M**

* These initiatives require legislation and are referred to the Legislature for further study and review.

Appendix 1 – MaineCare Task Force Authorizing Legislation

PUBLIC Law, Chapter 657, LD 1746, 125th Maine State Legislature
An Act to Make Supplemental Appropriations and Allocations for the Expenditures of State Government and To Change Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Year Ending June 30, 2013.

PART T

Sec. T-1. MaineCare Redesign Task Force established. The Commissioner of Health and Human Services shall establish the MaineCare Redesign Task Force, referred to in this Part as "the task force," to provide detailed information that will enable the Legislature to redesign the MaineCare program in a manner that will maintain high-quality, cost-effective services to populations in need of health coverage, comply with the requirements of the federal Patient Protection and Affordable Care Act of 2010 for state Medicaid programs and realize General Fund savings in fiscal year 2012-13 of $5,250,000.

Sec. T-2. Task force membership. Notwithstanding Joint Rule 353, the task force consists of the Commissioner of Health and Human Services or the commissioner's designee, who serves as chair of the task force, and the following 8 members who are appointed by the commissioner:

1. Two members of the MaineCare Advisory Committee, established pursuant to rule of the Department of Health and Human Services, who represent MaineCare members;

2. Two members of the MaineCare Advisory Committee, established pursuant to rule of the Department of Health and Human Services, who represent providers of MaineCare services;

3. One member of the public who has expertise in public health care policy;

4. One member of the public who has expertise in public health care financing;

5. One member of the public who has expertise in state fiscal policy; and

6. One member of the public who has expertise in economic policy.

Sec. T-3. Convening of task force. The task force shall convene no later than September 1, 2012.

Sec. T-4. Duties. The task force shall undertake a comprehensive review of the MaineCare program established pursuant to the Maine Revised Statutes, Title 22, chapter 855. The task force shall report on the following issues with regard to the MaineCare program:

1. Current eligibility levels, options for eligibility levels and changes to eligibility levels, including any changes that will be required pursuant to the federal Patient Protection and Affordable Care Act of 2010;

2. Current benefits, options for benefits and any changes to benefits, including any changes that will be required pursuant to the federal Patient Protection and Affordable Care Act of 2010;

3. Current premiums, cost-sharing and participation requirements, options for premiums, cost-sharing and participation requirements and any changes to premiums, cost-sharing and participation requirements, including any changes that will be required pursuant to the federal Patient Protection and Affordable Care Act of 2010;

4. The current fiscal status of the MaineCare program, including an analysis of MaineCare spending for the most recent 4 fiscal years and for the current biennium, with spending analysis detail provided by provider type, by eligibility level and by funding source;

5. Current management and administrative strategies and options for management and administrative strategies, including managed care, management of high-cost care and high-cost utilization, prior authorization, accountable care organizations, value-based purchasing and contracted and in-house administrative services;

6. A review of initiatives being used in other states' Medicaid programs to deliver high-quality services in a manner that is fiscally sustainable and cost-effective; and

7. Recommendations for redesign of the MaineCare program to achieve General Fund savings of $5,250,000 during fiscal year 2012-13 and annually thereafter, including detailed information on any required state plan amendments, applications and amendments to Medicaid waivers and amendments to state law and rule that would be required to implement the redesign and achieve the savings. The recommendations must include draft amendments to state law and rule to implement the redesign of MaineCare.

Sec. T-5. Staffing; consultant services. The Department of Health and Human Services shall provide necessary staffing services to the task force from its personnel. The department may contract for staffing services to supplement the work of departmental personnel. The department shall contract for professional services to research and prepare all necessary Medicaid state plan amendments and waiver applications and amendments that will be required to implement the redesign of MaineCare under section 4 once the redesign is approved by the Legislature under section 7. The contract for professional services must include, after action on the recommendations by the Legislature, final preparation, submission and services necessary to the approval process of all Medicaid state plan amendments and waiver application and amendments.

Sec. T-6. Report. The task force shall report 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 as follows.

1. By November 15, 2012, the task force shall report on issues detailed in section 4.

2. By January 1, 2013, and by the first of each month thereafter until final federal action has been completed, the task force shall file information regarding progress in the preparation of the Medicaid state plan amendments and waiver applications and amendments.

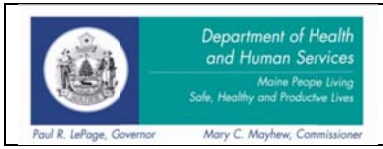
Sec. T-7. Implementation; achievement of savings. If, after receipt of the recommendations presented by the task force pursuant to section 6, subsection 1, the Legislature fails to enact legislation in the First Regular Session of the 126th Legislature that achieves

$5,250,000 in General Fund savings in fiscal year 2012-13, the Commissioner of Health and Human Services shall make recommendations to the Governor regarding the achievement of the balance of these savings through the use of the temporary curtailment of allotment power specified in the Maine Revised Statutes, Title 5, section 1668, and the Governor is authorized to achieve those savings using that power.

Appendix 2 – Presentations

All Task Force presentations, research, and supporting documentation can be found at http://www.maine.gov/dhhs/mainecare-task-force/index.shtml

Appendix 3 – Meeting Minutes

	**Department of Health and Human Services** **MaineCare Redesign Task Force Minutes 8/28/2012**

Attendance:
Mary C. Mayhew, Commissioner, DHHS
Nick Adolphsen, DHHS, staff
Rose Strout, Member of the MaineCare Advisory Committee representing MaineCare Members
Stefanie Nadeau, DHHS/MaineCare staff
Mary Lou Dyer, Member of the MaineCare Advisory Committee representing MaineCare Members
Michelle Probert, DHHS/MaineCare staff
Jim Clair, Member of the public who has expertise in public health financing
Kevin Flanigan, DHHS/MaineCare staff
Ryan Low, Member of the public who has expertise in economic policy
Jim Leonard, DHHS/MaineCare Staff
Frank Johnson, Member of the public who has expertise in public health care financing
Denise Gilbert, DHHS, staff
David Winslow, Member of MaineCare Advisory Committee representing providers of MaineCare Services
Scott E. Kemmerer (via the internet), Member of the public who has expertise in public health care policy
Ana Hicks, Member of the MaineCare Advisory Committee representing MaineCare Members

Agenda	Discussion	Next Steps
Welcome and Introductions	Introductions were made and the Commissioner provided an overview of the meeting agenda	
Housekeeping	Commissioner informed members that handouts/materials discussed at the meetings will be posted on the DHHS web site at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Minutes will be published on-line and e-mailed to all interested	

Agenda	Discussion	Next Steps
	parties. General Public members were encouraged to sign in if they wished to be added to the MaineCare interested parties distribution list. DHHS staff members available in support of the MaineCare Redesign Task Force are: Stefanie Nadeau, Jim Leonard, Nick Adolphsen, and Denise Gilbert. Questions should be forwarded to Nick at Nick.Adolphsen@maine.gov	
Review of Governing Statute	There was a brief review of the Governing Statute – Public Law 2011, Chapter 657, Part T (attached), noting the duties. Members discussed the possibility of working with a facilitator/consultant who has a national health policy perspective. The deadline for the report to the Joint Standing Committees of Appropriations and Financial Affairs and the Health and Human Services is 11/15/12. A draft report should be completed and sent to the DHHS Commissioner's office by 11/6/12 for review.	
Medicaid Overview	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Stefanie Nadeau presented "An Overview of the MaineCare Program". This outlined MaineCare's contractual relationship with CMS, identified the basic requirements of Medicaid, defined the MaineCare Waiver Populations, numbered MaineCare Enrollment, and provided a brief history of MaineCare Expenditures. Members requested additional information/data: • Section 32 regarding Children • Current caseload information • Chart similar to the "High 5% Service Types – by Net Payments" (Page 22 of the handout) for all populations • Information on co-payment limitations • SPA Waivers: what's available and what are the requirements	The Office of MaineCare Services will provide the requested information at the meeting scheduled on September 12th.
High Cost User	Handout located at: http://www.maine.gov/dhhs/mainecare-task-	

Agenda	Discussion	Next Steps
Overview	force/index.shtml Dr. Kevin Flanigan presented an overview of "The Top 5%" high cost user. The data indicates that the majority of the cost (approximately 74%) is for non-medical services and a majority of that (approximately 55%) is expended on long term care. An internal committee has been convened to identify and study the high cost user, by doing so the Department hopes to improve the quality of services, eliminate duplication by better coordination of care, thereby cutting costs. The current thinking is for the DHHS to act as its own "Accountable Care Organization" (ACO), across all DHHS programs and clients, matching services (departmental and community based) with identified needs. Questions discussed and additional information requested: • Deeper breakdown of the top 5%, such as age, waiver, etc. • Identify any budget barriers/issues • Criteria used to measure client stability • Define "Care Management" versus "Case Management" • Review of historical patterns by major categories such as pharmacies	The Office of MaineCare Services will provide additional information at the meeting scheduled on September 12th.
Value-Based Purchasing Overview	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Next Michelle Probert presented on DHHS' current initiatives: **MaineCare Value-based Purchasing Strategy**. "In August 2011, Maine DHHS moved away from Managed Care focused principally on cost-containment to leverage on-the-ground initiatives the right care for the right cost". Creating Accountable Communities (ACO) and Health Homes to "improve transitions of care" and "strengthen primary care". The handout identifies the current list of CMS approved conditions for coverage and the newly proposed conditions awaiting CMS approval. Development of the Health Homes is a two	

Agenda	Discussion	Next Steps
	stage process. Stage "A" will help individuals with chronic conditions. Timeline for implementation of stage "A" is: 6/12 select eligible health home practices; 7/12 Community Care Team application issued; 9/12 submit state plan amendment; 10/12 Community Care Team selected; 1/13 Stage "A" implemented. Stage "B" will help individuals with SPMI and/or SED. Stage "B" implementation timeline is: 9/12 issue request for information; late Fall 12 initiate discussion with CMS/SAMHSA; Early Winter submit state plan amendment; Spring/Summer implement. It was noted that these initiatives are only financed for 24 months beginning from the date of implementation for each stage. **Emergency Department (Ed) Collaborative Care Management Project**. Objectives are: "to reduce avoidable ED use and improve health outcomes for high needs, high utilizers of the ED through statewide care management efforts by leveraging care management resources in the community" and "identifying and filling gaps where no care management capacity exists" and "increase availability of ED for true emergency situations" building on the successful pilot with MaineGeneral. Suggestions/ideas discussed: - Look at pharmacy model - No need for DHHS Care Managers, providers see DHHS/MaineCare as the information source - This initiative has booked savings of approximately $5.4 million in state and federal funds for previous budgets **Accountable Communities Initiative (ACO)**. According to the DHHS definition and ACO is an entity responsible for population's health and health costs that is "provider-owned and driven", "a structure with strong consumer component and community collaboration" and "includes shared accountability for both cost and	Office of MaineCare Services will review pharmacy model and provide information.

Agenda	Discussion	Next Steps
	quality" featuring two models: Shared Saving Only: minimum 1,000 patients - Share in a maximum of 50% of savings, based on quality performance - Not accountable for any downside risk - Subject to lower per patient cap Shared Savings & Losses: minimum 2,000 patients - Share in a maximum of 60% savings, based on quality performance - Not accountable for any downside risk in the first performance year - In year 2, accountable for up to 5% of any losses - In year 3, accountable for up to 10% of any losses - Must demonstrate capacity for risk sharing Accountable Communities must include all costs for DHHS identified "core" services. Timeline for implementation is: 8/12 start discussions with CMS about State Plan Amendment; 9/12 issue the application; 11/12 send state plan amendment to CMS; 12/12 select accountable communities and 4/13 start the ACOs. Suggestions/Ideas discussed: - Need additional information/follow-up on Section 65 and 28. - Need to discuss global waiver Questions: • Can the savings from DHHS's current initiatives be counted in meeting the goal of the $5 million? No, the savings associated with current initiatives have already been budgeted.	Discuss global waiver at future meeting.
Guiding Principles	Principles suggested by members: • Cost effective	Members can send additional principle suggestions to Nick at Nick.Adolphsen@maine.gov for

Agenda	Discussion	Next Steps
	• High quality • Patient/consumer centered • Program Sustainability • Holistic and individualized approach based on unique needs • Flexibility (not one size fits all) • Evidence based • Innovation/technical approach • Data analytics • Collaboration • Payor alignment • Medical necessity	inclusion. A draft of the principles will be distributed to the task force.
Future Topics/Agendas	Suggestions: • GAP analysis • Review state and private initiatives • Further review of data presented (High Cost, Value-Based Purchasing) • Limitations by federal regarding incentive and benefit design for flexibility regarding waivers • DRGs	Members will send additional agenda items to Nick. UPCOMING MEETINGS – 1 -4 pm, Rm 228 State House September 12 September 25 October 9 October 23 November 6
Public Comment	Dale Hamilton CHCS asked if the $5 million was per quarter or annually. The $5 million is annual. During the first year the $5 million will have to be absorbed in the last quarter due to the timing of the task force work. Vanessa Santarelli, Maine Primary Care Association, offered to provide any information the Task Force would find helpful. She requested that members be mindful of dental care during the development of health homes. She expressed concern regarding the formal process for public input. Richard Kellogg, TSG spoke about the Independent Home and Community Based services model and offered to provide information	Task Force will consider a formal public input process at a future meeting.

Agenda	Discussion	Next Steps
	to the task force.	

Department of Health and Human Services Maine People Living Safe, Healthy and Productive Lives Paul R. LePage, Governor Mary C. Mayhew, Commissioner	**Department of Health and Human Services** **MaineCare Redesign Task Force Minutes 9/25/2012**

Attendance:
Mary C. Mayhew, Commissioner, DHHS
Nick Adolphsen, DHHS, staff
Mary Lou Dyer, Member of the MaineCare Advisory Committee representing MaineCare Members
Stefanie Nadeau, DHHS/MaineCare staff
Jim Clair, Member of the public who has expertise in public health financing
Kevin Flanigan, DHHS/MaineCare staff
Ryan Low, Member of the public who has expertise in economic policy
Jim Leonard, DHHS/MaineCare staff
David Winslow, Member of MaineCare Advisory Committee representing providers of MaineCare Services
Denise E. Gilbert, DHHS staff
Ana Hicks, Member of the MaineCare Advisory Committee representing MaineCare Members
Seema Verma, SVC, Consultant
Rob Damler, SVC, Consultant

Agenda	Discussion	Next Steps
Welcome and Introductions	Introductions were made. Following introductions Commissioner quickly reviewed agenda and asked members if additional items needed to be provided and/or discussed at a future date.	Need to discuss the Global Waiver Additional information regarding peer states may be needed
MaineCare by the Numbers Part II	Handouts/materials discussed at the meetings will be posted on the DHHS web site at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Dr. Flanigan presented "MaineCare by the Numbers, Part II" which provided a deeper review of claims data for the top 8 clinical conditions (*1. Mental Health; 2. Signs/Symptoms/Oth Cond, NEC; 3. Neurological Disorders, NEC; 4. Diabetes; 5. Dementia, Primary Degenerative; 6. Prevent/Admin Hlth Encounters; 7. Pregnancy with and without complications; 8. Infections – ENT EX Otitis Med*);	

Agenda	Discussion	Next Steps
	provider type , payments, procedure codes for waiver service providers, etc., Concerns/Issues/data requests: 1. Concern was expressed that some of the information shared was confusing. Suggestion was made to review mental health procedure codes, particularly for those under 18. 2. What is considered a waiver service? Staff providing residential support for individuals living in a community setting (not institutionalized) 3. Members expressed interest in additional information regarding the "churn" rate for the top 5 to 20% of claims.	MaineCare staff will provide requested information
Introduction of Consultant hired to staff Task Force – Seema Verma and Rob Damler	Jim Leonard introduced the two consultants Seema Verma and Rob Damler from SVC based in Indiana who will work with the Task Force to provide a national perspective on what other states are doing to improve quality, reduce costs, and restructure Medicaid services.	
Medicaid Cost Containment Strategies Presentation – Seema Verma and Rob Damler, SVC	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml Seema Verma and Rob Damler presented an overview of cost containment strategies being considered or used around the country. The three categories discussed, which members felt all should be on the table, were: a. short-term strategies (6-12 mos.) most times needing a CMS state plan amendment; • increased cost-sharing – which include co-pays, premiums, and deductibles – concern was expressed that this may limit access; that providers would incur the loss as most times it does not make business sense to collect a minimal co-payment, but it was thought that payments to incentivize for the use of preventative healthy living would be an agreeable option as opposed to punitive measures, members were also encouraged to consider the mid-term and long-term strategies for implementing systems	Seema, Rob and DHHS staff will provide information for discussion at the meeting scheduled for October 9, Room 228, State House

Agenda	Discussion	Next Steps
Medicaid Cost Containment Strategies Presentation – Seema Verma and Rob Damler, SVC cont.	change so Maine is not repeating this process every couple of years • Benefit reductions & limitations – limiting some of the mandatory benefits such as the number of inpatient and outpatient visits, elimination or reduction of optional services such as physical therapy, occupational therapy, dental services, etc. Members were reminded to consider the long term impact of implementing some of the short-term strategies. Sometimes limiting services in one area may increase cost in another. • rate reductions – which have been one of the most common cost-containment strategy among states, include rate reimbursement for medical equipment, medical supplies, ambulance, home health, mental health, outpatient hospital, chiropractor, non-emergency transportation, HCBS, podiatry, and C-section - it was suggested that DHHS develop a list of all changes Maine has implemented regarding Medicaid over the last few years so members would have a better idea of what other options would be available. b. mid-term strategies (1-3 years) • Pharmacy targeted reforms - which could include prior authorization, increased use of generics, cost sharing incentives, etc. • Reducing prescription drug abuse • Eligibility changes – asset tests, reducing or eliminating outreach activities; reporting changes, etc. • Quality Initiatives – Complex case management, outreach programs, care management, reducing fraud and abuse. • Managing high cost enrollees • Program integrity initiatives – such as with Maine's Medicaid Fraud Recovery Unit • Reimbursement reforms – such as limiting reimbursement for potentially preventable events, C-section reimbursement, provider taxes, etc. c. long-term strategies (3-5 years) • Value-Based Purchasing – managed care, health homes, accountable care organizations – additional information was requested regarding which states have been successful in implementing managed care systems (are they rural or more urban, impact of managed care in other states? • Health Information Technology – allows better coordination, reduction in	

Agenda	Discussion	Next Steps
Medicaid Cost Containment Strategies Presentation – Seema Verma and Rob Damler, SVC cont.	duplication of services and additional funding made available to states through ARRA for initiatives such as payment incentives for implementation of electronic health records • Managing duals – better coordination between Medicaid and Medicare • Managing long-term and high cost populations by integration with Medicare Following the discussion a worksheet was distributed "Maine Medicaid Cost Containment Strategy Summary" with the intent to help members prioritize/narrow Maine's focus. Members felt additional information and discussion was needed prior to this exercise. Items discussed/information requested: • Enhanced management of developmental disabilities – more information regarding Maryland's Children's anti-psychotic medications • More discussion regarding mid-term strategies such as preventative programs around high risk pregnancies implemented in North Carolina and Indiana • Both consultants felt risk was essential in for-profit markets and reward incentives could drive provider and health plans to improve/provide services • It was felt perverse incentives drive higher use of services • Has DHHS, through the Cost Work Group, assessed costs, developed strategies, projected savings, implemented interventions/initiatives they could share? • Additional information on how Maine's high cost user (top 5%) compares to other states • Need to include groups such as diabetes, behavioral, high cost, and developmental • Mary Lou Dyer distributed two handouts from the Maine Association for Community Service Providers "Analysis of High Cost Data Pertaining to Intellectual Disabilities (global waiver)	Seema, Rob and DHHS staff will provide information for discussion at the meeting scheduled for October 9, Room 228, State House
Public Comment	Megan Hannah, Planned Parenthood, agreed that Maine is getting the federal 90/10 match for high risk pregnancies but mentioned that Maine could realize an additional $4 million in savings if DHHS took	Ms. Hannah will provide her comments in writing

Agenda	Discussion	Next Steps
	advantage of all 90/10 match programs available. Hilary Schneider, American Cancer Society Cancer Action Network distributed materials regarding potential MaineCare Savings Initiative that Improve Cancer Prevention and Treatment such as: Tobacco Cessation Coverage and Palliative Care Programs Dawn Croteau mentioned that public service announcements regarding how to read nutritional labels would help reduce MaineCare costs related to obesity and diabetes	Ms. Schneider will provide sources for information provided
		UPCOMING MEETINGS – 1 -4 pm, Rm 228 State House; October 9, October 23, and November 6

Department of Health and Human Services Maine People Living Safe, Healthy and Productive Lives Paul R. LePage, Governor Mary C. Mayhew, Commissioner	**Department of Health and Human Services** **MaineCare Redesign Task Force Minutes** **10/9/12**

Attendance:
Mary C. Mayhew, Commissioner, DHHS
Nick Adolphsen, DHHS staff
Mary Lou Dyer, Member of the MaineCare Advisory Committee representing MaineCare Members
Kevin Flanigan, DHHS/MaineCare staff
Jim Clair, Member of the public who has expertise in public health financing
Jim Leonard, DHHS/MaineCare staff
Ryan Low, Member of the public who has expertise in economic policy
Denise E. Gilbert, DHHS staff
David Winslow, Member of MaineCare Advisory Committee representing providers of MaineCare Services
Seema Verma, SVC, Consultant
Ana Hicks, Member of the MaineCare Advisory Committee representing MaineCare Members
Rob Damler, Milliman, Consultant
Frank Johnson, Member of the public who has expertise in public health care financing
Rose Strout, Member of the MaineCare Advisory Committee representing MaineCare Members
Scott E. Kemmerer, Member of the public who has expertise in public health care policy

Agenda	Discussion	Next Steps
Welcome and Introductions	Introductions were made. Commissioner opened the floor for suggestions/ additions to the agenda. Suggestions/Comments: Keep in mind the need for dental/oral health Interested in more information regarding any high cost management programs Additional guidance needed to focus ideas and initiatives Need background/historical perspective of priorities Discuss Global Waiver How the initiative fit/connectivity These meetings are an opportunity for task force to "flesh out	MaineCare/DHHS will develop a matrix of Maine initiatives defining their connectivity.

Agenda	Discussion	Next Steps
	specifics"	
Re-Cap/Status of Prior Requests **Re-Cap/Status of Prior Requests cont.**	Jim Leonard provided an update on outstanding items/questions/data requests: 1. Information regarding pharmacies and pharmaceuticals – will be presented today 2. Care Management versus Case Management – care management is a technique to manage cost and case management is support staff managing Medicaid covered services 3. Measuring client stability – MaineCare measures stability over an 11 month period 4. Identify budget issues/barriers – will be covered in today presentation 5. Deeper breakdown of top 5% - provided in MaineCare by the Numbers – Part II 6. SPA Waivers – will be covered in today's presentation 7. Cost data – MaineCare staff currently working on this 8. Current Caseload data – MaineCare staff currently working on this *9.* Implementation of Section 32 (children) – approximately Nov. 21 It was mentioned that these meetings provide the opportunity to "flesh out specifics" for MaineCare redesign and interaction during the presentations was encouraged.	Cost data and current caseload information will be provided.
Presentation by Seema Verma and Rob Damler	Handout located at: http://www.maine.gov/dhhs/mainecare-task-force/index.shtml The presentation provided a comparison of Maine's costs to other states regarding short term savings for mandatory and options benefits, med term savings for pharmacy and program integrity, outlined the impact of Medicaid managed care in other states, presented long term savings options. Discussion:	

Agenda	Discussion	Next Steps
Presentation by Seema Verma and Rob Damler cont.	The federal medical assistance percentage will drop by 1.9% in FY '13 and could possibly drop 2.7% in FY '14. The FY '14 rate will be finalized in the spring of '13 and could change. Maine is below the national average in Medicaid per enrollee for the aged and adult populations. This presentation does not consider all state funding. More information is needed to clarify amount spent for each population. Maine is far above average for spending in disabled and children populations. Task force members requested additional information regarding the "high cost kids", the severity, Maine's rate of disability, and information regarding policy decisions that may have driven up the cost. States that are limiting ED visits are being challenged in the courts. This is shifting costs to the hospitals, may want to consider restrictive Medicaid cards as an option. Maine currently is piloting a project using restrictive care and urgent care options which is producing significant savings. Members asked if this program could expand. It was suggested that the matrix mentioned previously include **information on prior authorization; individual assessment; rate reduction; utilization management; payment reform; care management** ; **what is on-going; overlapping concerns;** and **what savings have been booked and what additional savings are expected**. *BELOW IS THE LIST OF INITITIVES MEMBERS HAD INTEREST IN RESEARCHING:* **Short-term: Changes to Mandatory Benefits** **Inpatient hospital** – PA for all non-emergency admissions except maternity PA for all elective admissions	DHHS staff and consultants will meet to coordinate responses regarding information requests.

Agenda	Discussion	Next Steps
Presentation by Seema Verma and Rob Damler cont.	Consolidate payment for readmit within so many days Potentially avoidable complications **Outpatient hospital** - coverage limits for cardiac rehab **Nursing facility** – review bed hold days **Physician services** – require PA for specified procedures and services **FQHC services** – wrap around managed care **Lab & X-ray** – focusing on high cost **Freestanding Birth Center services** – look at reimbursement models **Transportation to medical care** – Michelle Probert to provide additional information regarding Maine program **Short-term: Changes to Optional Benefits** **Self-Directed personal assistance services** – what might the consultants recommend **Inpatient psychiatric services for individuals under 21** – require periodic re-authorization **Out-of-state services** – provide any information on Medicaid services Maine pays for any out-of-state services. **Rehab Services (BH $ Substance Abuse)** – Med Management, further define "up to 1 hr." Is it annual? Weekly? More detail needed on Maine trends versus other states **Dental** – research studies regarding cost avoidance and provide list of states that contract services out **Chiropractic** – further limiting or elimination **Private duty nursing** – budget number by age group **Personal care** – budget numbers **Case Management** – provide list of groups eliminated **Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)** **Mid-Term Strategy: Eligibility Changes**	

Agenda	Discussion	Next Steps
Presentation by Seema Verma and Rob Damler cont.	Review spend down eligibility and current medical expenses considered for spend-down eligibility. **Increased use of generics –** need to explore **Rebates -** cross over pharmacy claims and specialty pharmacy costs in Maine compared to other states **HIT –** explore restricted card program **Mid-Term Strategy: Program Integrity** Need to review contracts for program integrity language **Overview: PCCM vs. MCO Model** Members felt additional information on the successful components of managed care When caring for the high cost user how do health homes versus managed care work An idea discussed was the possibility of tailoring the solutions by specific population i.e. Managed care for high cost user Additional information needed on PACE Need to consider the effect of any initiatives that will affect Maine's current initiatives (long range plans) of health homes and ACO There was a brief discussion regarding next steps in the drafting of the final report.	Members will forward any additional initiatives they feel worth discussion to Nick for distribution to Task Force prior to the next meeting. Draft of MaineCare Redesign Task Force Report will be presented at the November 6th meeting for public comments prior to finalizing. Nick will schedule an additional meeting in November to finalize report.

Agenda	Discussion	Next Steps
Public Comment	Vanessa Santarelli. CEO, Maine Primary Care – offered to provide information regarding the good work FQHAs are providing in Maine. She also invited members to visit any of the programs. Richard Kellogg, TSG suggested 4 models to consider in the interim/transition to ACO and Health Homes	Vanessa will forward additional information to Nick for distribution to the MaineCare Redesign Task Force Richard Kellogg will forward information to be distributed.

Department of Health and Human Services Maine People Living Safe, Healthy and Productive Lives Paul R. LePage, Governor Mary C. Mayhew, Commissioner	**Department of Health and Human Services** **MaineCare Redesign Task Force Minutes** **11/14/12**

Attendance:
Mary C. Mayhew, Commissioner, DHHS
Nick Adolphsen, DHHS staff
Mary Lou Dyer, Member of the MaineCare Advisory Committee representing MaineCare Members
Kevin Flanigan, DHHS/MaineCare staff
Jim Clair, Member of the public who has expertise in public health financing
Jim Leonard, DHHS/MaineCare staff
Ryan Low, Member of the public who has expertise in economic policy
Denise E. Gilbert, DHHS staff
David Winslow, Member of MaineCare Advisory Committee representing providers of MaineCare Services
Seema Verma, SVC, Consultant
Ana Hicks, Member of the MaineCare Advisory Committee representing MaineCare Members
Rob Dalmer, Milliman, Consultant
Rose Strout, Member of the MaineCare Advisory Committee representing MaineCare Members
Stefanie Nadeau, Director, OMS/DHHS
Scott E. Kemmerer, Member of the public who has expertise in public health care policy
Frank Johnson, Member of the public who has expertise in public health care financing

Agenda	Discussion	Next Steps
Introductions	Introductions were made.	
Review Draft Report	Copies of the MaineCare Redesign Task Force – Predicted Savings Summary Sheet were distributed. Seema and Rob developed this document and the draft report using the scoring sheets completed by members at the November 6 meeting and previous discussions. Strategies scoring 3.5 or higher were included on the Savings Summary Sheet. The original scoring sheets were also returned to members per the request made at the November 6th meeting. During the beginning of this discussion Rob completed a draft document showing potential savings for SFY ’13, SFY ’14 (implemented by Oct 1, 2013) and SFY ’15 (implemented by July, 2014) and distributed to be included in today’s	

Agenda	Discussion	Next Steps
	discussion. **Short-term Strategies:** <u>Prior Authorization</u>: • concurrent review for inpatient and outpatient psychiatric services for individuals under 21 • Elective surgeries – *members requested a list of surgeries included* • High cost imaging & radiology OMS staff is confident that these initiatives could be implemented without legislative action by March 1st. Some members felt that the review of antipsychotics for children, adults and seniors prescribed for 6 months or longer should be included in prior authorization. Members also felt that an implementation timeline would be helpful and the predicted savings should be reviewed on a line-by-line basis and updated for the next meeting. <u>Rate reductions</u>: There was a concern expressed regarding a majority of the suggested 10% rate reductions. • Medical Equipment & supplies • Home Health – *cutting community based services could have negative impact on hospitals and the long range system change initiatives* • Outpatient hospital – *inpatient hospital services were not included in the rate reductions.* • Dental • Physician – *this would include both primary care physicians and specialists. Some expressed concern that primary care was included. It was suggested that the ACA would negate some of the cuts to primary care physicians when implemented.* • Lab & X-ray • Optometry, Optician, Ophthalmology • Private duty nursing	A list of elective surgeries and prior strategies will be provided by OMS staff.

Agenda	Discussion	Next Steps
	• Hospice • Targeted Case Management • IMD/ICFMR – *Nursing homes, PNMIs and home and community based waiver services were excluded from the reductions.* OMS staff also feels confident that the rate reductions could be implemented by March 1st, either by emergency (which needs either Attorney General or Legislative approval and has a 30 to 45 day implementation) or APA rules (needing a 90 day turn around). It was mentioned that without the rate reductions the Task Force would fall short of the $5 million savings goal for SFY '13 outlined in statute. In order to meet the goal all short-term strategies identified would need to be implemented. A majority of the task force members agreed the rate reductions were not systems reform and even with a suggested sunset clause would impact long range initiatives. There was a lengthy discussion regarding the option of indicating in the final report, to the Legislature, that only a portion of the $5 million could be identified for SFY '13 but that with the implementation of the suggested mid- and long-term strategies the MaineCare Redesign would net much larger savings in future budgets and effect system changes. <u>Benefit changes</u>: • Elimination – Chiropractic care <u>Hospital-Acquired Conditions</u> (HACs): • Expand list to include all of those listed for the State of MD • Payment adjustments made annually based on HACs	A list of Maine and Maryland's HACs will be provided prior to the meeting scheduled for November 19th. The two models of re-admissions strategies discussed will be

Agenda	Discussion	Next Steps
	Re-admissions: • Increase time span for which readmissions are not reimbursed – *there was a lengthy discussion regarding this short-term initiative. Two options were discussed – if readmission was within 14 days the hospital would not be reimbursed through MaineCare (holding a second hospital harmless if lacking information from the first admitting hospital). If adopting this method the strategy could be considered in the short-term, but concern was expressed that even if the 14 days re-admission was adopted savings would not be realized in the short-term due to claims' delays. The second option to adopt the Medicare practice of an annual review and assessment of fines if the hospital was above an establish threshold, would move this initiative to the mid-term or long-term strategies. Members expressed interest in having this initiative broken out into the two examples discussed with their predicted savings for review.* Leave Days: (Nursing facility, IMD, ICFMR) • Eliminate reimbursement for hospital leave & therapeutic leave days • Eliminate – nursing facility: 10 hospital leave days and 36 therapeutic leave days • Eliminate – IMD: 10 hospital leave days & 36 therapeutic leave days • Eliminate – ICFMR: 25 hospital leave days & 52 therapeutic leave days There was concern expressed that if the leave days were eliminated an individual needing a bed would not have a place to return to if hospitalized etc. **Mid-term Strategies**: Pharmacy • Competitive bid for specialty pharmacy – *some felt that this initiative should be moved to long-term strategies due to the need to execute a Request for Proposal. Members expressed an interest in reviewing this strategy as specialty pharmacies are currently flooding the market*.	broken down and predicted savings will be updated.

Agenda	Discussion	Next Steps
	• Increase generic dispensing rate by 1%, reduce use of specialty drugs • Expand Medication Management Initiative - *it was mentioned that Gould Health Systems (GHS) under contract with DHHS has realized additional savings then had been identified by previous budgets and it was hoped that some of those savings could be added back to expand this service and generate savings that could be used in meeting this task force savings target. GHS is currently reviewing projected savings and a report will be delivered to DHHS by Friday, November 16th. Some felt this strategy could be moved into the short-term strategies.* • Monitor use of Anti-Psychotics in Children, Adults and Seniors – *some felt this should be moved under short-term strategies "Prior Authorization"* • Additional strategy: Restore smoking cessation services <u>Program Integrity</u> • Develop operational policy and procedure to handle day-to-day Medicaid discretionary functions • Internal review of data collected • Utilize CMS's best practice annual summary report • Develop policy/procedure and mechanisms for reporting to the Medicaid and CHIP Payment and Access Commission • Additional strategy: No Cash for controlled substances – *there was a brief discussion regarding this strategy. Jane Orbeton, Legal Analyst for the Health and Human Services Committee mentioned a bill proposed in a previous session to preclude MaineCare members from the ability to purchase controlled substances with cash. The Attorney General's issued the opinion that MaineCare members were allowed to purchase controlled substances with cash just as all other populations were allowed if they choose to. Limiting MaineCare member's ability to purchase controlled substances with cash could also negatively impact the DHHS Pain Management program. The suggestion was made that this strategy could be used as a monitoring tool by providers in helping eliminate abuse.* This strategy would need Legislative approval and the DHHS would want to be sure calculated savings were not duplicative of the RAC savings	DHHS will share savings information provided by Gould Health Systems when available. More detailed information will be provided regarding the program integrity strategy.

Agenda	Discussion	Next Steps
	already booked. A deeper drill down on the "Program Integrity" was requested. **Long-term Strategies** – *only one of the long-term strategies were discussed as time was limited* **Value-based purchasing** <u>Capitation for top 20%</u> • Aggressive case and disease management • Home & community-based care • Continually & periodically re-evaluate clients to assure appropriate level of care • Carve outs • Reduce waitlist • Risk adjustment • Performance bonus for meeting quality incentives • Withhold to assure that process measures achieved Concern was expressed regarding who the 20% are what services are provided, the timeline for implementation (maybe a phase-in approach could be considered), need consideration of the lack of medical treatment and research (only 4 states and 5 programs currently), less money would mean limited access to needed services. Some improvements suggested were that DHHS improve its performance based contracting and by a unanimous vote members felt a Care Management approach would be preferred over a capitation that would include: ✓ Individual Assessment ✓ System Technology ✓ Medical Care Management	Percentage of impact reduction and information on the Maine Medicaid spend over the last

Agenda	Discussion	Next Steps
	✓ Modified Family and Home Support After further discussion members felt we shouldn't "shut the door" on capitation should studies and programs developed show improved services. Members requested information be presented on the percentage of impact reduction and the Maine Medicaid spend over the last several years (PMP costs for target population).	several years will be provided prior to the meeting on November 19th.
Next Steps		Seema and Rob will prepare a second draft report based on recommendations and decisions made today. An updated Savings Summary Sheet and document showing projected savings for SFY '13, '14 and '15 will be disturbed to members by Friday, November 16th for review. Public input will be accepted during the first two hours of the December 11th meeting. The Taskforce will then review impact of the public input and vote (if necessary) on measures to be included in the final report. Meetings Dates: Monday, November 19th, 1 – 4 pm; Tuesday, December 11th, 1 – 5 pm
Public Input	Debra Hart – Collaborative Drug Therapy legislation will be proposed during the 126th legislative session based on a recent University of New England study. She will provide information during the December 11th meeting for review by the Taskforce.	

	**Department of Health and Human Services** **MaineCare Redesign Task Force Minutes** **11/19/12**

Attendance:
Mary C. Mayhew, Commissioner, DHHS
Nick Adolphsen, DHHS staff
Mary Lou Dyer, Member of the MaineCare Advisory Committee representing MaineCare Members
Jim Leonard, DHHS/MaineCare staff
Ryan Low, Member of the public who has expertise in economic policy
Denise E. Gilbert, DHHS staff
Jack Comart, replacing Ana Hicks, Member of the MaineCare Advisory Committee representing MaineCare Members
Rose Strout, Member of the MaineCare Advisory Committee representing MaineCare Members
Seema Verma, SVC, Consultant, by phone
Scott E. Kemmerer, Member of the public who has expertise in public health care policy
Rob Dalmer, Milliman, Consultant, by phone
Stefanie Nadeau, Director, OMS/DHHS

Agenda	Discussion	Next Steps
Introductions	Introductions were made.	
Review Draft Report	Updated copies of the MaineCare Redesign Task Force – Predicted Savings Summary Matrix were distributed. Columns added were "Policy Section" State Savings SFY '14", "State Savings SFY '15", "Implementation Date" "Rule: Required; Type", "SPA/Waiver Required", "Systems Changes Needed", "Legislative Approval Required", "Tribal", "Member", "Provider", and "Public Notice". It was noted that those previous strategies with low ratings such as "Rate Reductions" were removed from this updated list. **Short-term Strategies Changes:** <u>Prior Authorization</u>:	

Agenda	Discussion	Next Steps
Review Draft Report cont.	• concurrent review for psychiatric services for individuals under 21 **in all settings** – *changed from inpatient and outpatient settings* • Elective surgeries – *members requested a list of surgeries included* • High cost imaging & radiology • Inductions – *This as an addition to the short-term strate*gies. I*t was suggested that language be included in the report to clarify that this only refers to non-emergency, elective inductions prior to 39 weeks.* <u>Benefit changes</u>: • Elimination – Chiropractic care – *members felt this should be removed from this list similar to the rate reductions.* <u>Hospital-Acquired Conditions</u> (HACs): • Expand list to include all of those listed for the State of MD • Payment adjustments made annually based on HACs *Members felt that systems' changes such as this should be identified somehow.* <u>Re-admissions</u>: • Increase time span for which readmissions are not reimbursed to 14 days – *which now includes calculations for the claims lag. Members felt this could be implemented quickly, or* • Adopt Medicare re-admissions policy – *Members felt this is a longer term strategy and would require a detailed review to determine savings.* *DHHS will review the current policy to insure that the first hospital is not held responsible for re-admission, if they had originally transferred the individual to another hospital for care and treatment and the individual returned to first hospital within 14 days. Members felt that DHHS should*	OMS staff will provide a list of elective surgeries for both "Elective surgeries" and "High cost imagining & radiology". OMS staff will review re-admission policy.

Agenda	Discussion	Next Steps
Review Draft Report cont.	*have the flexibility to determine strategy* <u>Leave Days</u>: (Nursing facility, IMD, ICFMR) • Eliminate reimbursement for hospital leave & therapeutic leave days • Eliminate – nursing facility: 10 hospital leave days and 36 therapeutic leave days • Eliminate – IMD: 10 hospital leave days & 36 therapeutic leave days • Eliminate – ICFMR: 25 hospital leave days & 52 therapeutic leave days *There was concern expressed that if the leave days were eliminated an individual needing a bed would not have a place to return to if hospitalized, going home for weekends, etc. Members also questioned the savings if individuals were forced to stay in more acute settings when an alternative bed is not available. Another concern was that DHHS not pay for two beds. This item will be broken out to compare reimbursement for bed holds days to outright elimination of bed hold days.* **Mid-term Strategies**: <u>Pharmacy</u> • Competitive bid for specialty pharmacy • Increase generic dispensing rate by 1%, reduce use of specialty drugs – *some suggested this strategy could be moved to short-term. Still need to factor in the loss of any rebates when DHHS increases dispensing of generic medications.* • Expand Medication Management Initiative/ J Code PDL – *Suggestion was made to move into the short-term strategies. The report received by DHHS from Gould has been factored into the identified savings and concern was expressed that we achieve the first savings prior to layer on another level of savings.* • Monitor use of Anti-Psychotics in Children, Adults and Seniors – *some felt this should be moved under short-term strategies "Prior Authorization"* • Restore smoking cessation services – *concerned was expressed regarding adding this back in and that this would have to be approved legislatively as it was passed in the 125th Legislative session and this was not reflected in the Matrix.* <u>Program Integrity</u> • Develop operational policy and procedure to handle day-to-day Medicaid	Matrix will be updated to show comparison of reimbursement for bed hold days and outright elimination of bed hold days. Stefanie will work with Jim Leonard to update this matrix to reflect loss or rebates when switching to generics. OMS staff will meet with Gould to review the Gould report in greater detail. The matrix will be updated to indicate that Legislative approval is required to restore smoking cessation services.

Agenda	Discussion	Next Steps
Review Draft Report cont.	discretionary functions • Internal review of data collected • Utilize CMS's best practice annual summary report • Develop policy/procedure and mechanisms for reporting to the Medicaid and CHIP Payment and Access Commission *Concern was expressed regarding the lack of savings identified for SFY '13. It was felt that this would take some time to implement because practices, policies and procedures needed to be review.* **Long-term Strategies** **Value-based purchasing – this would include the bottom 80%** • Increase promotion of targeted initiative ED Maternal & child health Care Coordinator to assist transition Provider incentive program **Value-based purchasing with Care Management Organization (CMO) – this would include the top 20%** • Care Management Organization – *This includes behavioral health and severe and persistent mental illness* **Improve birth outcomes** • Healthy babies initiative/also combines with Care Management Organization - *A suggestion was made to clarify language regarding C-sections. This would require risk assessments and care coordination. Concern was expressed savings were not identified for SFY '13. OMS staff agreed to review and update the matrix if savings are identified.* **ER Utilization**	OMS will update the matrix and provide electronic copies to the Task Force by the close of business on Wednesday, November 21 for Long-term strategies.

Agenda	Discussion	Next Steps
Review Draft Report cont.	• Allow dental benefits for individuals using the ER for dental services – *concern was expressed regarding this add back. OMS was asked to review savings in ED against cost to add back. There was discussion as to whether dental services should be provided to anyone using alternative high cost services and if this would be allowed or a waiver would be required from CMS.* **Targeted care management for top 20%** • Aggressive case and disease management • Home and community based care • Continually & periodically re-evaluate clients to assure appropriate level of care • Carve outs • Reduce waitlist • Risk adjustment • Performance bonus for meeting quality incentives • Withhold to assure that process measures achieved *The savings moved from 4% - 5% to 2% - 3% savings projected due to the change from the "Capitation of the 20%" to the "Targeted care management for the top 20%" strategy.* **Radiology Benefits Management and Care Coordination for LTSS Strategies -** *will be removed from matrix as separate items as they have been include in the short-term and care management strategies.*	Stefanie will meet with Jack Comart to discuss optional coverage and access issues.
Review of Duties outlined in Part T of Public Law, Chapter 657, LD 1726	The suggestion was made that the actual language outlining the "Duties" of the Task Force be included in the final report. Each "duty" was reviewed to insure it was adequately covered by the report. Members reached consensus that duties 1, 2 and 3 were covered with the addition of language regarding mandatory eligibility requirements from the ACA added under "Findings " – "Current Eligibility Level, Options for Eligibility Levels and Changes". Duty 4 was covered adequately. Duty 5 is	OMS and Consultants will update report and matrix to distribute electronically to Task Force by the close of business Wednesday, November 21st. Final comments and suggestions are due by November 27th.

Agenda	Discussion	Next Steps
	covered with the additional of the amounts to charts 2 (Expenses by Eligibility Category), 3 (Expenses by Provider Type) and 4 (Expenses by Cost Distribution SFY '11) on pages 11 and 12 of the current draft report. Duty 6 was covered. Duty 7 will be covered once the matrix has been updated for inclusion in the report.	
Next Steps	There was a brief discussion on the process for public comment portion of the meeting on December 11th. Public Notice: An Executive Summary using the matrix format without rankings will be developed and provided. Options discussed for notification of the public hearing were newspaper advertisements; notice to providers, provider groups, and General Assistance Interested Parties e-mail distribution list. Guidelines: • Recommend comments be submitted in writing prior to the December 11th meeting • Oral presentations be limited to 3 – 5 minutes • Encourage feedback on report and additional recommendations Decisions/Discussion Following public input the Task Force will decide if an additional meeting is necessary or report can be finalized electronically through e-mail copied to all Task Force members with changes outlined in the e-mail.	OMS and Consultants will develop Executive Summary and methods for notification will be finalized. Nick will develop a timeline to share with the Task Force. Next meeting is scheduled for December 11th, 1 – 5 p.m., Room 228 State House
Public Input	Helen Bailey – Disabilities Rights Center – terminology of the report should be cleaned up to reflect people first. Julia Bell – Maine Disability Rights Council – also mentioned cleaning up the language to people first. She also encouraged members to consider	Julia will provide a red lined version of the report outlining language

Agenda	Discussion	Next Steps
	the lack of resources or services. (i.e. the waitlist)	requiring updating.

Appendix 4 - Matrix

	Proposed Change : Short-term Strategy	Policy Section	State Savings SFY '13	State Savings SFY '14	State Savings SFY '15	Implementation Date	Rule: Required; Type	SPA/ Waiver Required	Systems Changes Needed	Legislative Approval Required	Tribal	Member	Provider	Public Notice
• Prior Authorization	• Implement concurrent review for psychiatric services for individuals under 21 in all settings	Section 46, PH	$0.02M	$0.05M	$0.05M	3/1/13	No	No	No	No	No	No	Yes	No
	• Elective surgeries	Section 90, PS	$0.07M	$0.3M	$0.3M	3/1/13	No PA criteria would have to be listed on the portal.	No	Yes	No	Yes	Yes	Yes	No
	• High cost imaging & Radiology • Excluding Emergent Use	Section 101, MI	$0.23M	$0.94M	$0.94M	3/1/13	No PA criteria would have to be listed on the portal	No	Yes	No	Yes	Yes	Yes	No
	• Elective Inductions • Prior to 39 weeks	Section 90, PS; Section 14, APRN	$0.08M	$0.32M	$0.32M	3/1/13	No PA criteria would have to be listed on the portal		Yes	No	Yes	Yes	Yes	No

	Proposed Change : Short-term Strategy	Policy Section	State Savings SFY '13	State Savings SFY '14	State Savings SFY '15	Implementation Date	Rule: Required; Type	SPA/ Waiver Required	Systems Changes Needed	Legislative Approval Required	Tribal	Member	Provider	Public Notice
• Hospital-Acquired Conditions (HACs)	• Expand list to include all of those listed for the State of MD	Section 45, HS	$0.16M	$0.66M	$0.66M	3/1/13	Yes; Routine Technical	Yes	Yes	No	Yes	No	Yes	Yes
• Readmissions	• Increase time span for which readmissions are not reimbursed (14 days)	Section 45, Ch. III, HS	$0.38M	$1.53M	$1.53M	3/1/13	No	Yes	Yes	No	Yes	No	Yes	Yes
• Leave Days o Nursing Facility o IMD o ICF-MR	• Eliminate reimbursement for hospital leave & therapeutic leave days • Eliminate - Nursing Facility: 10 hospital leave days & 36 therapeutic leave days • Eliminate - ICFMR: 25 hospital leave days & 52 therapeutic leave days • PNMI-Appendix C and F	Section 67, NF; Section 45, HS; Section 50-ICF-MR; Section 97-PNMI	$0.16M	$0.64M	$0.64M	3/1/13	Section 45-Yes; Routine Technical Sections 67 (II and III), 50 (III) and 97 (II)-Major Substantive	Yes	Yes	No	Yes	Yes	Yes	No
• Pharmacy	• Expand Medication Management Initiative[xxix]/ J Code PDL	Section 80, RxS Section 90, PS	$0.17M	$0.64M	$0.64M	4/1/13-J Code PDL	Yes	Yes	Yes	No	Yes	No	Yes	No
	• Monitor use of Anti-Psychotics in Children and Adults and Seniors o PA required	Section 80, RxS	$0.075M	$0.3M	$0.3M	3/1/13	No; Managed through PDL	No	Yes	No	Yes	Yes	Yes	No
Total savings for Short-term strategies			**$1.35M**	**$5.38M**	**$5.38M**									

	Proposed Change: Mid-term Strategy	Policy Section	State Savings SFY '13	State Savings SFY '14	State Savings SFY '15	Implementation Date	Rule: Required; Type	SPA/ Waiver Required	Systems Changes Needed	Legislative Approval Required	Tribal	Member	Provider	Public Notice
• Pharmacy	• Competitive bid for specialty pharmacy	Section 80, RxS	-	$0.39M	$0.79M	1/1/14	Yes; Routine Technical	Yes SPA/ 1115 Waiver	Yes	No	Yes	Yes	Yes	No
	• Increase generic dispensing rate by 1%, Reduce use of specialty drugs	Section 80, RxS	-	$1.01M	$1.35M	3/1/13	Yes; Routine Technical	No	Yes	No	Yes	Yes	Yes	No
• Program Integrity	• Develop operational policy and procedure to handle day to day Medicaid discretionary functions • Internal review of data collected • Utilize CMS's best practice annual summary report • Develop policy/procedure and mechanisms for reporting to the Medicaid and CHIP Payment and Access Commission		-	$1.83M	$2.44M	10/1/13	No	No	No	No	No	No	Yes	No
Total savings for Mid-term strategies			**-**	**$3.23M**	**$4.58M**									
	Proposed Change : Additional Short-term Strategies	**Policy Section**	**State Savings SFY '13**	**State Savings SFY '14**	**State Savings SFY '15**	**Implementation Date**	**Rule: Required; Type**	**SPA/ Waiver Required**	**Systems Changes Needed**	**Legislative Approval Required**	**Tribal**	**Member**	**Provider**	**Public Notice**
• Increase benefits	• Restore smoking cessation benefits		-	**($0.394M)**	**($0.394M)**	7/1/13								
	• Allow dental benefits for individuals using the ER for dental services		-	**($3.15M)**	**($3.15M)**	7/1/13								
Total savings for Mid-term strategies with additional benefits			**-**	**($0.31M)**	**$1.04M**									

	Proposed Change : Long-term Strategy	Policy Section	State Savings SFY '13	State Savings SFY '14	State Savings SFY '15	Implementation Date	Rule: Required; Type	SPA/ Waiver Required	Systems Changes Needed	Legislative Approval Required	Tribal	Member	Provider	Public Notice
• Value-based purchasing	• Increase promotion of targeted initiatives o ED o Maternal & child health o Care Coordination to assist transition o Provider incentive program	Various	-	$1.46M	$1.95M	10/1/13	Yes	Yes	Yes	No	Yes for changes to PCPIP	No	Yes for PCPIP changes	Yes
• Value-based purchasing with Care Management Organization (CMO)	• Care Management Organization	N/A	-	$0.51M	$0.68M	10/1/13	No	No	No	No	No	No	No	No
• Improve birth outcomes	• Healthy Babies Initiative/Also combines with Care Management Organization	N/A	-	$0.7M	$1.39M	10/1/13	No	No	No	No	No	No	No	No

	Proposed Change : Long-term Strategy	Policy Section	State Savings SFY '13	State Savings SFY '14	State Savings SFY '15	Implementation Date	Rule: Required; Type	SPA/ Waiver Required	Systems Changes Needed	Legislative Approval Required	Tribal	Member	Provider	Public Notice
• Targeted care management for top 20%	• Aggressive case & disease management • Home & community-based care • Continually & periodically re-evaluate clients to assure appropriate level of care • Carve outs • Reduce waitlist • Risk adjustment • Performance bonus for meeting quality incentives • Withhold to assure that process measures achieved	Section 21-CW; Section 29-SW; Section 19-E/DW; Section 22-DW; Section 32-CW; Section 20-ORC	-	-	$8.61M	7/1/14	Yes; Routine Technical and Major Substantive	Yes; Waiver	Yes	Yes; Major Substantive Rule	Yes	Yes	Yes	Yes
Total savings for Long-term strategies			-	**$2.67M**	**$12.63M**									

Savings Initiatives	State Fiscal Year '13	State Fiscal Year '14	State Fiscal Year '15
Short-Term Savings	$1.35M	$5.38M	$5.38M
Mid-Term Savings (without additional benefits)	-	$3.23M	$4.58M
Long-Term Savings	-	$2.67M	$12.63M
Grand Total	$1.35M	$11.28M	$22.59M

Abbreviation	Meaning
CS	Chiropractic Services
HS	Hospital Services
MI	Medical Imaging
NF	Nursing Facility
PH	Psychiatric Hospital
PS	Physician Services
RxS	Pharmacy Services
DS	Dental Services
CW	Comprehensive ID Waiver
SW	Supports ID Waiver
E/DW	Elderly and Adults with Disabilities Waiver
DW	Physical Disabilities Waiver
CW	Children's Waiver
ORC	Other Related Conditions Waiver

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Appendix 5: Comments From Task Force Member on Costs of Enrollees who have Intellectual Disabilities

December 18, 2012
Task Force Member, Additional Comments on Members of High Cost Population who have Intellectual Disabilities

Comparing Apples and Oranges

The final draft of the Task Force report states that "Maine's spending on intellectual disability waiver services is above the national average."
While this may be accurate when comparing average waiver costs across States, it is highly misleading to assume that when comparing all State expenditures, Maine is above the national average. Waiver recipients and benefits vary greatly by State, some serving much higher need individuals (like Maine) than others. In addition, there exist a range of sources of funding for services to persons with intellectual disabilities that vary by each State. Some of the more common sources follow by cost category:
Most Costly Per Recipient

1. State-run Institutions
2. Skilled nursing level private facilities (Intermediate Care Facilities for Intellectual Disabilities, ICF-ID)

Less Costly Per Recipient

1. Waiver-funded services
2. Medicaid Free Standing Developmental Treatment Centers
3. State-only funded programs
4. County and local funded services
5. Other source's (grants etc.)

Maine operates no state-run facilities of any size and budgets almost no state funds, other than funds required to seed MaineCare services. Further, Maine operates a lower percentage of skilled nursing ICF-ID beds for this population than most other states. ICF-ID programs are the second most costly programs for this population, next to State institutions.

Limitations of Private Capitated/Risk-Based Payment Reform for the Population

The complex needs of adults with intellectual disabilities enrolled in Medicaid Home and Community Based Waiver services present significant barriers for the application of capitated/risk-based care management approaches typically operated by non-public entities. Capitated, risk bearing entities include managed care organizations and many care management organizations. That is why, prior to July, 2012, only four states implemented managed care for significant numbers of enrollees in this population, and all utilize either state government, local

government or statutorily designated quasi-governmental bodies as risk-bearing, managed care administrative entities. It is noteworthy that each of those four states operates large state-run institutions to serve individuals with the highest-needs, exempting the highest-cost service users from managed care populations. Further, public leaders in states exploring risk-based care management for the population have acknowledged great uncertainty about how they would implement such approaches for the population, and have accordingly scheduled potential inclusion of managed care planning for persons with intellectual disabilities in the out-years of implementation. They acknowledge the following realities of serving the population that include intellectual, legal, medical, behavioral and social diversity of the population.

- Maine citizens with intellectual disabilities who are eligible for HCB waiver services represent only 2% of the entire Medicaid populations, and 1/3 of 1% of the state population. As a small, high need sub-group, it eliminates the ability to spread financial risk across less needed beneficiaries.
- The responsibility for serving the population falls totally on State government. By definition, to qualify for services, intellectual disabilities must be pre-existing condition exempting individuals from private insurance coverage (Quinn, 2011).
- Services required supporting this population extent well-beyond typical coverage benefits, and including continuous supervision to insure safety and skill teaching in all life domains, in addition to more traditional health and behavioral services. Due to the staff intensity of such supports, they represent the highest costs of Medicaid benefits to this population.
- Social realities affect the level of services individuals receive. For example, aging family care givers or other factors influence the abilities of families to support individuals.
- Public legal responsibility stems relates to family social realities, and includes public guardianship as well as class action settlements created to address gross injustices of past treatment of the population, that have resulted in the positive results experienced today. For example, initial level of need assessments implemented in Maine indicate that individuals score as higher functioning, compared with national averages, evidence of the effectiveness of Maine's investment in its system of services to the population to date.

Maine's Legacy of Services for Person with Intellectual Disabilities

The history of Maine in supporting persons with intellectual disabilities has not always been one to be proud of. Maine was one of the early States that experienced Federal Court intervention to improve deplorable conditions in caring for its citizens with intellectual disabilities. Through extensive use of Federal waiver funding in the Medicaid program, Maine was able to satisfy the Court's Settlement Agreement. This was a major achievement for the State.

Recent levels of needs assessments administered by the Maine DHHS indicate that Maine citizens with intellectual disabilities are functioning at a slightly higher level than similar populations elsewhere in the United States. Because there are no other explanations for this, it should be assumed that the positive result is attributable to the quality of services available in Maine, 100% of which are provided by community-based providers. Unlike mental illness, intellectual disability is a condition that is not ameliorated by chemotherapy, and requires routine services to maintain growth in functioning. The relative success of Maine individuals with intellectual disabilities is something of which to be proud.

Addressing the Wait List for Services

Given limitations cited above, the use of private capitated/risk-based payment approaches for the population seems ill-advised as it re-directs valuable service resources from the Maine system of services to compensate private care management/managed care entities to perform the work of the State. Such approaches, though possibly producing savings in the shorter-term through payment methods, merely "kick-the-can down the road." As the sole payer for services to persons with intellectual disabilities, the State will always be responsible for the results of "care management."

The way to streamline costs and serve individuals on waiver service wait lists will not be through payment reform, but rather, through employing new methods for providing support and expanding the independent living skills of persons with intellectual disabilities. The Task Force report identifies some of these; however, it overlooks several important elements that, if implemented by DHHS, could produce savings that exceed those projected in the Task Force Report.

- Decrease per member per month costs of healthcare to persons with intellectual disabilities by implementing care management in long term support service providers.

- Increasing census of very-small home-support residential programs. Maine policy in the 1990s restricted new development to homes that supported no more than two individuals. As a result, in the following years, there existed more two-person homes than any other residential model. In some cases the smaller settings are necessary to address behavioral needs of residents. However, a State initiative to expand selected homes to serve 3 or more individuals could produce savings of scale.

- Filling vacant residential beds. Concerted efforts must be undertaken to ensure that vacancies are prioritized for individuals needing residential services.

- Expedite implementation of monitoring technology. Maine has been working on amendments to its waiver to add cost-effective technology to replace on-site staffing during low-activity periods since 2009. However, there still exists no waiver amendment to add this capability.

- Foster home support of individuals requiring more permanent living arrangements. This approach has expanded in the last ten years, is more cost effective than models that use paid hourly staff, and should continue to be employed where appropriate.

- Employing approaches that accelerate individuals learning independent living skills, especially for the younger populations transitioning from school to adult living. Several Maine programs have experienced noteworthy success, and produce some of the greatest savings potential.

- The Maine Association for Community Service Providers members stand ready to assist with implementing any of these recommendations.

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[ii] Kaiser Foundation, Health Insurance Premiums & Cost-Sharing: Findings From Research on Low-Income Populations, March 2003.
[iii] MaineCare analysis, MaineCare Redesign Taskforce, Maine by the Numbers, 2012.
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[xiv] Kaiser Foundation, Emerging Medicaid Accountable Care Organizations: The Role of Managed Care, May 2012.
[xv] Kaiser Foundation, Medicaid Managed Care: Key Data, Trends & Issues, February 2012 & Kaiser Foundation, A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey, September 2011
[xvi] Truven Health Analytics, The Growth of Managed Long-Term Services & Supports (MLTSS) Programs: A 2012 Update. July 2012.
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[xix] Data accessed at www.statehealthfacts.org; data developed from CMS-64 reports submitted by individual states
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[xxiv] Goold Medication Management Website, http://www.ghsinc.com/products/goold-med-management, retrieved November 10, 2012.
[xxv] http://www.marylandmedicaidpharmacyinformation.com/ & http://mmcp.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx retrieved September 19, 2012.
[xxvi] Louisiana Department of Health and Hospitals, Healthcare Delivery Changes/Birth Outcomes Initiative, 2011; Louisiana State Plan Amendment, 2011; Louisiana Department of Health and Hospitals, 2012.
[xxvii] MaineCare Data, SFY '10
[xxviii] Truven Health Analytics, The Growth of Managed Long-Term Services & Supports (MLTSS) Programs: A 2012 Update. July 2012.
[xxix] Data is not available to estimate potential savings.