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State of Maine
ONE HUNDRED AND TWENTY-FIFTH LEGISLATURE
COMMITTEE ON HEALTH AND HUMAN SERVICES

MEMORANDUM

To: Sen. Richard W. Rosen, Senate Chair
Rep. Patrick S. A. Flood, House Chair
Joint Standing Committee on Appropriations and Financial Affairs

From: Sen. Earle L. McCormick, Senate Chair
Rep. Meredith N. Strang Burgess, House Chair
Joint Standing Committee on Health and Human Services

Date: January 19, 2012

Re: Recommendations on LD 1746, 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 Years Ending June 30, 2012 and June 30, 2013

The Health and Human Services Committee is pleased to provide their report on LD 1746, the supplemental budget for the Department of Health and Human Services for FY12 and FY13.

We are pleased to provide the attached HHS Committee Program spreadsheet, which is attached as Appendix A. Minority members of the committee wish to bring to the attention of the Appropriations Committee the minority report of the committee, which is attached as Appendix B. And finally, Appendix C is a compilation of ideas for savings within DHHS that came to the committee from members of the public, interested parties and 2 committee members. We urge the Appropriations Committee to review these ideas for savings and to work with DHHS to determine which ones to include in LD 1746.

Committee members are interested in continuing to work with members of the Appropriations Committee on this supplemental budget. They feel passionately about many items in the budget, are mindful of the time required and wish to avoid duplication of effort.

Committee members are prepared to discuss this report with you. Thank you for your consideration.

cc: Members, Health and Human Services Committee
Mary Mayhew, Commissioner
Katrin Teel, Office of the Governor
Maureen Dawson, OFPR
Christopher Nolan, OFPR
Jane Orbeton, OPLA
Anna Broome, OPLA

Appendix A

Health and Human Services Committee Spreadsheet

Health and Human Services Committee Programs Spreadsheet, LD 1746

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
1	121	Mental Health Services - Community	A	S-A-7470	Reduces funding by limiting the availability of **mental health crisis intervention** to persons who experience severe and persistent mental illness.	Testimony questioned feasibility of determining diagnosis of SPMI for a person in crisis. Served 16,117 in FY11. Total GF $6.8 million. Reduction to contracted providers of 9.4% to 33%. MOE issue with SAMHSA community mental health block grant, at risk proportionally.	Adult MH	General Fund	2	7			$0	($2,084,746)
2	121	Mental Health Services - Community	A	S-A-7470	Reduces funding by limiting the availability of **mental health crisis intervention** to persons who experience severe and persistent mental illness.	Ditto	Adult MH	Federal Block Grant Fund	92	8			$0	($91,369)
3	545	Head Start	A	S-A-7472	Eliminates funding for the **Head Start** program.	See item 18 also. Provides Head Start and Early Head Start services to 4714 children in FY11. Cuts all GF Head Start funds. MOE issue.	Children's Services	General Fund	4	130	Y, 7-6		($800,000)	($2,448,875)
4	139	State-funded Foster Care/Adoption Assistance	A	S-A-7482	Eliminates funding for the supplemental **services for children** with complex emotional and behavioral needs.	Provides **wraparound** services, non-MaineCare. Served 300 children age 5 to 18 last year, in child welfare, juvenile corrections, children's behavioral health and DepEd special ed, and children at risk of involvement with those services.	Children's Services	General Fund	1	54			$0	($1,999,984)
5	139	State-funded Foster Care/Adoption Assistance	A	S-A-7483	Reduces funding by reducing contracts in the **family reunification** program.	Provides intensive reunification services to children in state custody and in out-of-state placements who are within 30 days of returning home.	Children's Services	General Fund	1	55			$0	($1,007,112)
6	139	State-funded Foster Care/Adoption Assistance	A	S-A-7484	Reduces funding by reducing contracts in the **alternative response program**.	Testimony indicated of CWS referrals, DHHS screens 53% out and 47% in for further work. Of those screened in, DHHS continues the work with 74% (5984 families) and ARP begins work with 26% (2135 families). Served 2275 in FY11, through 4 contractors, disbursement of cuts among them not determined. DHHS says average referral is 90 cases/mo., would require 11 caseworkers and 2 supervisors, at a cost of $810,000/yr, compared to $2,580,000 for ARP. Joan Churchill, Community Concepts, a contractor for ARP services says staff costs for case manager in DHHS are $899/mo and in Community Concepts are $433 per month. Info needed on budgeted cost and position count to bring work in house, proposal in budget? and net savings?	Children's Services	General Fund	1	56			$0	($1,290,000)

Health and Human Services Committee Programs Spreadsheet, LD 1746

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
7	136	Mental Health Services - Children	A	S-A-7485	Reduces funding by reducing contracts for **residential services.**	Provides services to 650 children with mental health/emotional disorders, DD and autism spectrum disorders in residential care through 14 contracted providers in 84 program sites. Cuts reimbursement rate for room and board costs to facilities. Does not cut treatment. Note: On broader topic of behavioral health services, "Administrative Initiatives" in 12/20 DHHS packet includes "Transition clinical services to Section 65 FY12 $.94 million and FY13$4.71 million." Also "Transition Section 65 to CPT Codes FY12 $.33 million and FY13 $1.68 million." Information needed on these proposals.	Children's Services	General Fund	7	13			$0	($1,250,000)
8	122	Developmental Services - Community	A	S-A-7469	Reduces funding for reimbursement in **rental assistance** to United States Department of Housing and Urban Development levels.	Served 1538 persons last year.. Applies to an agency operated group home. Reduces rate 11.9%. Testimony raised issue of potential ADA violation, by reducing access to community based services.	Developmental Services	General Fund	60	10			$0	($1,200,000)
9	987	Developmental Services Waiver - MaineCare	A	S-A-7487	Reduces funding to reflect savings from payment reform in the **Developmental Services Waiver - MaineCare** program.	Currently serve 2825 in Sec. 21 and 131 in Sec. 29. Replaces aggregate cap with individual cap of $161,000, reduces agency home support by 10%, removes medical add-on for home support, community support, work support and employment specialist services.	Developmental Services	General Fund	16	42			$0	($3,000,000)
10	147	Medical Care - Payments to Providers	A	S-A-7487	Reduces funding to reflect savings from payment reform in the **Developmental Services Waiver - MaineCare** program.	Ditto	Developmental Services	Federal Expenditures Fund	1	113			$0	($5,053,691)
11	640	Departmentwide	A	S-A-7460	Reduces funding from **salary savings.** Notwithstanding any other provision of law, the State Budget Officer shall calculate the amount of savings in this Part that applies to each General Fund account in the Department of Health and Human Services and shall transfer the amounts by financial order upon the approval of the Governor. These transfers are considered adjustments to appropriations in fiscal year 2011-12.		DHHS Management	General Fund	1	132	Y, 8-5		($5,000,000)	($3,000,000)

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
12	953	FHM - Bureau of Health	A	S-A-7489	Reduces funding to reflect a redistribution of funding in the **Fund for a Healthy Maine**.	07 - Community School Grants; 06 - Home Visits; 01- Oral Health. Of the cut $350,000 pays for **dental services subsidies** for persons without dental insurance and below 200% FPL, at 19 locations in 2011, 37,000 dental services to 19,259 persons. Remaining $250,000 of cut is to **school oral health** which in 2011 in 77 school districts, 230 schools, serving 23,248 low-income children with mouth rinse, classroom education and dental sealants. Priority given to Aroostook and Washington Counties. Last year Portland served 2100 children through this program. Cuts all FHM-Oral Health funds.	FHM	Fund for a Healthy Maine	1	134	Y, 7-6		$0	($600,000)
13	953	FHM - Bureau of Health	A	S-A-7489	Reduces funding to reflect a redistribution of funding in the **Fund for a Healthy Maine**.	07 - Community School Grants; 06 - Home Visits; 01- Oral Health. This cut is to **home visiting**, cutting 26.9% of total funding, placing at risk $3 million federal expansion grant that includes nonsupplantation language. Total families served by program is 2500 per year, eligibility from pregnancy to child's 3rd birthday, priority to families in at risk communities, vulnerable families with teen parents, substance abuse, domestic violence, mental health, health and developmental issues. Cuts all FHM-Home Visiting funding. MOE issue.	FHM	Fund for a Healthy Maine	6	135	Y, 7-6		$0	($2,653,383)
14	953	FHM - Bureau of Health	A	S-A-7489	Reduces funding to reflect a redistribution of funding in the **Fund for a Healthy Maine**.	07 - Community School Grants; 06 - Home Visits; 01- Oral Health. This cut is to **community and school grants** which fund efforts to reduce tobacco use, tobacco-related chronic disease, associated risk factors, and substance abuse, school based health centers, obesity and healthy Maine Partnerships. Portland testified against cuts to public health prevention programs supported by FHM funds. Cuts most of FHM-Community/school funds, leaving $249,032 in FY13.	FHM	Fund for a Healthy Maine	7	136	Y, 7-6		$0	($7,529,890)

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Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
15	958	FHM - Donated Dental	A	S-A-7489	Reduces funding to reflect a redistribution of funding in the **Fund for a Healthy Maine.**	This cut is to **donated dental**, which by contract coordinates dental services to elderly and disabled persons, in 12 years has served 873 persons. Cuts all FHM-Donated Dental funds.	FHM	Fund for a Healthy Maine	1	140	Y, 8-5		$0	($36,463)
16	Z015	FHM - Drugs for the Elderly and Disabled	A	S-A-7489	Reduces funding to reflect a redistribution of funding in the **Fund for a Healthy Maine.**	This cut is part of cuts that eliminate 100% the **DEL program,** which provides discounted drug benefits persons who are elderly and disabled, who are underinsured and uninsured. For Part D enrollees pays for drugs in the donut hole, pays premiums, deductibles and copayments. Pays 100% for certain drugs not covered by Medicare. Pays for enrollment in Part D plans, appeals process. Pays for Part B premiums for MSP members. DHHS says cut will impact 45,380 low-income seniors and adults with disabilities, says DHHS pays Part D premiums for 50,319 this month and pays Parts A and B for 87,144 persons. DHHS says average Part D premium is $78.60. Cuts all FHM-DEL funds. See items 120, 122, 128, 129. See Language Part G and J.	FHM	Fund for a Healthy Maine	1	157	Y, 7-6		$0	($10,332,353)
17	956	FHM - Family Planning	A	S-A-7489	Reduces funding to reflect a redistribution of funding in the **Fund for a Healthy Maine.**	Funds teen pregnant prevention, health and sex education, reproductive health services, through schools and community based organizations. Cut is 22% to 26% of funds. Will cut 16 jobs, reduce clinic hours, close 7 centers, cut services to 2500 students. Cuts all FHM-Family Planning funds. MOE issue.	FHM	Fund for a Healthy Maine	1	138	Y, 7-6		$0	($401,430)
18	959	FHM - Head Start	A	S-A-7489	Reduces funding to reflect a redistribution of funding in the **Fund for a Healthy Maine.**	See item 4 also. Cuts all FHM-Head Start funds. MOE issue.	FHM	Fund for a Healthy Maine	1	142	N, 8-5		($700,000)	($1,354,580)
19	Z048	FHM - Immunization	A	S-A-7489	Reduces funding to reflect a redistribution of funding in the **Fund for a Healthy Maine.**	Vaccine program purchases 90,000 vaccine doses for administration to employees and residents of health facilities, pregnant women, uninsured and underinsured adults. 6% of funding.	FHM	Fund for a Healthy Maine	1	159	Y, 8-5		$0	($1,078,884)
20	961	FHM - Purchased Social Services	A	S-A-7489	Reduces funding to reflect a redistribution of funding in the **Fund for a Healthy Maine.**	Provides child care subsidies to 925 children and after school programs for 2200 12-15 year olds. Cuts all FHM-Purchased Social Services funds.	FHM	Fund for a Healthy Maine	1	147	Y, 7-6		$0	($3,942,236)

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
21	960	FHM - Medical Care	A	S-A-7490	Notwithstanding any provision of law, adjusts funding by increasing funding in the Medical Care - Payments to Providers program and reducing funding in the **FHM - Medical Care** program to reflect a redistribution of funding within the Fund for a Healthy Maine.	Allocates FHM funding to MAP account. Deappropriation from GF in same amount is in item 22.	FHM	Fund for a Healthy Maine	1	145	Y, 7-6		$1,003,844	$25,031,096
22	147	Medical Care - Payments to Providers	A	S-A-7490	Notwithstanding any provision of law, adjusts funding by increasing funding in the **Medical Care - Payments to Providers** program and reducing funding in the FHM - Medical Care program to reflect a redistribution of funding within the Fund for a Healthy Maine.	See item 21.	FHM	General Fund	1	116	Y, 7-6		($1,003,844)	($25,031,096)
23	129	Bureau of Medical Services	O		Lapses $5,000,000 from the **Bureau of Medical Services** account within the Department of Health and Human Services to the unappropriated surplus of the General Fund at the end of fiscal year 2010-12.	Lapses $5 million at year end to GF.	MaineCare Admin	General Fund	1				($5,000,000)	$0
24	987	Developmental Services Waiver - MaineCare	A	S-A-7473	**Provides funding** in the MaineCare and MaineCare-related accounts necessary to make cycle payments through the remainder of the 2012-2013 biennium.		MaineCare Cycle Payments	General Fund	16	40			$5,808,535	$6,299,768
25	Z006	Developmental Services Waiver - Supports	A	S-A-7473	**Provides funding** in the MaineCare and MaineCare-related accounts necessary to make cycle payments through the remainder of the 2012-2013 biennium.		MaineCare Cycle Payments	General Fund	1	44			$1,967,371	$5,658,034
26	202	Low-cost Drugs To Maine's Elderly	A	S-A-7473	**Provides funding** in the MaineCare and MaineCare-related accounts necessary to make cycle payments through the remainder of the 2012-2013 biennium.		MaineCare Cycle Payments	General Fund	1	128	Y, 7-6		$1,401,437	$0
27	705	Medicaid Services - Developmental Services	A	S-A-7473	**Provides funding** in the MaineCare and MaineCare-related accounts necessary to make cycle payments through the remainder of the 2012-2013 biennium.		MaineCare Cycle Payments	General Fund	12	17			$0	$1,201,050
28	147	Medical Care - Payments to Providers	A	S-A-7473	**Provides funding** in the MaineCare and MaineCare-related accounts necessary to make cycle payments through the remainder of the 2012-2013 biennium.		MaineCare Cycle Payments	General Fund	1	102			$91,805,960	$38,142,642
29	147	Medical Care - Payments to Providers	A	S-A-7473	**Provides funding** in the MaineCare and MaineCare-related accounts necessary to make cycle payments through the remainder of the 2012-2013 biennium.		MaineCare Cycle Payments	Federal Expenditures Fund	1	103			$207,077,368	$124,626,202
30	731	Mental Health Services - Child Medicaid	A	S-A-7473	**Provides funding** in the MaineCare and MaineCare-related accounts necessary to make cycle payments through the remainder of the 2012-2013 biennium.		MaineCare Cycle Payments	General Fund	17	21			$5,290,051	$4,709,869

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
31	Z009	MR/Elderly PNMI Room and Board	A	S-A-7473	**Provides funding** in the MaineCare and MaineCare-related accounts necessary to make cycle payments through the remainder of the 2012-2013 biennium.		MaineCare Cycle Payments	General Fund	1	153			$0	$8,210,778
32	148	Nursing Facilities	A	S-A-7473	**Provides funding** in the MaineCare and MaineCare-related accounts necessary to make cycle payments through the remainder of the 2012-2013 biennium.		MaineCare Cycle Payments	General Fund	1	122			$0	$7,036,142
33	148	Nursing Facilities	A	S-A-7473	**Provides funding** in the MaineCare and MaineCare-related accounts necessary to make cycle payments through the remainder of the 2012-2013 biennium.		MaineCare Cycle Payments	Federal Expenditures Fund	1	123			$0	$11,852,830
34	844	Office of Substance Abuse - Medicaid Seed	A	S-A-7473	**Provides funding** in the MaineCare and MaineCare-related accounts necessary to make cycle payments through the remainder of the 2012-2013 biennium.		MaineCare Cycle Payments	General Fund	1	35			$983,953	$869,928
35	129	Bureau of Medical Services	A	S-A-7407	Adjusts funding for the 2012-2013 biennium only for the **Cub Care** program for families with income greater or equal to 150% but less than 200% of the nonfarm income official poverty line as the result of contributions from the Dirigo Health Fund to provide MaineCare seed for the program.	Deappropriates GF, to be offset by allocation from Dirigo Health Program. No change in enrollment, eligibility.	MaineCare Eligibility/ Recipients	General Fund	1	50			($44,413)	($241,124)
36	147	Medical Care - Payments to Providers	A	S-A-7407	Adjusts funding for the 2012-2013 biennium only for the **Cub Care** program for families with income greater or equal to 150% but less than 200% of the nonfarm income official poverty line as the result of contributions from the Dirigo Health Fund to provide MaineCare seed for the program.	Dirigo Health Program initiative needed.	MaineCare Eligibility/ Recipients	General Fund	1	58			($410,995)	($2,231,331)
37	147	Medical Care - Payments to Providers	A	S-A-7407	Adjusts funding for the 2012-2013 biennium only for the **Cub Care** program for families with income greater or equal to 150% but less than 200% of the nonfarm income official poverty line as the result of contributions from the Dirigo Health Fund to provide MaineCare seed for the program.	Dirigo Health Program initiative needed.	MaineCare Eligibility/ Recipients	Other Special Revenue Funds	3	59			$472,800	$2,556,881
38	136	Mental Health Services - Children	A	S-A-7407	Adjusts funding for the 2012-2013 biennium only for the **Cub Care** program for families with income greater or equal to 150% but less than 200% of the nonfarm income official poverty line as the result of contributions from the Dirigo Health Fund to provide MaineCare seed for the program.	Dirigo Health Program initiative needed.	MaineCare Eligibility/ Recipients	General Fund	7	12			($17,392)	($94,426)

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
39	147	Medical Care - Payments to Providers	A	S-A-7411	Reduces funding by eliminating optional coverage under the **MaineCare program for families** who are covered above mandatory federal levels.	DHHS says serves 21,156 members, enrollment chart from 12/20 DHHS info shows 22,000 members at 101% to 150% FPL and 7,700 members at 151% to 200% FPL.. __?__ parents will lose coverage. Dirigo Health has paid GF cost for parents 150-200% FPL since FY12. See Title 24-A, sec. 6914. Beginning 1/1/12 Dirigo will pay for parents 133-200% FPL. This proposal would eliminate Dirigo's responsibility to pay for parent coverage. Savings for parents 200% to 133% would accrue to Dirigo. Savings from 133% down to 100% would accrue to GF. How many persons lose coverage, how much savings? MOE issue. Waiver needed to 100% to implement proposal or to another level below 200%. Portland testified that eliminating noncat program might force closure of their 2 FQHCs, which provide care for over 2200 persons/yr, access to needed prescription drugs to treatable conditions. Language Part F.	MaineCare Eligibility/ Recipients	General Fund	1	60	Y, 7-6		($2,184,239)	($8,533,575)
40	147	Medical Care - Payments to Providers	A	S-A-7411	Reduces funding by eliminating optional coverage under the **MaineCare program for families** who are covered above mandatory federal levels.	Ditto.	MaineCare Eligibility/ Recipients	Federal Expenditures Fund	1	61	Y, 7-6		($5,791,515)	($30,571,405)
41	147	Medical Care - Payments to Providers	A	S-A-7411	Reduces funding by eliminating optional coverage under the **MaineCare program for families** who are covered above mandatory federal levels.	Ditto.	MaineCare Eligibility/ Recipients	Other Special Revenue Funds	3	62	Y, 7-6		($1,159,127)	($9,614,390)

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
42	147	Medical Care - Payments to Providers	A	S-A-7424	Reduces funding by eliminating optional coverage under the **MaineCare program for persons 19 and 20** years of age with income less than or equal to 150% of the nonfarm income official poverty line.	Serves 8700 members, under a State Plan amendment not a waiver. MOE issues regarding whether waiver to cut eligibility is possible and whether can secure waiver and eliminate eligibility completely or only down to 133% FPL. Note: Maine may not be able to waive as to this population as Maine elected to cover 19 and 20 year olds as children under the State Plan, making them a 1902(gg)(2) population. Waiver process under federal law, Social Security Act, section 1902(gg)(3) states that waivers are possible for 1902(gg)(1) certain adult populations only. Clarification needed on availability of waiver for Maine to eliminate coverage for 19 and 20 year olds or to reduce eligibility to 133% FPL or whether waiver is not applicable under section 1902(gg)(3). If eligibility is to end information needed on transition planning, timeframe for terminating coverage, staffing needs.	MaineCare Eligibility/ Recipients	General Fund	1	63	Y, 8-5		($993,649)	($5,393,575)
43	147	Medical Care - Payments to Providers	A	S-A-7424	Reduces funding by eliminating optional coverage under the **MaineCare program for persons 19 and 20** years of age with income less than or equal to 150% of the nonfarm income official poverty line.	Ditto.	MaineCare Eligibility/ Recipients	Federal Expenditures Fund	1	64	Y, 8-5		($1,898,564)	($10,021,863)
44	731	Mental Health Services - Child Medicaid	A	S-A-7424	Reduces funding by eliminating optional coverage under the **MaineCare program for persons 19 and 20** years of age with income less than or equal to 150% of the nonfarm income official poverty line.	Ditto.	MaineCare Eligibility/ Recipients	General Fund	17	20	Y, 8-5		($64,775)	($351,600)
45	732	Mental Health Services - Community Medicaid	A	S-A-7424	Reduces funding by eliminating optional coverage under the **MaineCare program for persons 19 and 20** years of age with income less than or equal to 150% of the nonfarm income official poverty line.	Ditto.	MaineCare Eligibility/ Recipients	General Fund	14	25	Y, 8-5		($37,593)	($204,059)
46	Z009	MR/Elderly PNMI Room and Board	A	S-A-7462	Reduces funding by eliminating optional coverage under the **MaineCare program for individuals in the medically needy category**.	Serves 2100 people, who are over 100% FPL and under asset limit of $2000, in spend down category who cannot afford private pay rates, who are residents of Appendix C and F residential care facilities. DHHS says that coverage is 100% from GF, no MOE issue.	MaineCare Eligibility/ Recipients	General Fund	1	152			($2,533,359)	($13,511,247)

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
47	147	Medical Care - Payments to Providers	A	S-A-7463	Adjusts funding in fiscal year 2011-12 as a result of contributions from the Dirigo Health Fund to provide MaineCare seed for the **childless adult waiver**.	Dirigo Health Program initiative needed. Provides funding for noncat waiver population in FY12 only (coverage is terminated in FY13). Served 18,800 persons in Oct 11. DHHS says no MOE issue. Others disagree. Note that "Administrative Initiative" list from DHHS 12/20 shows freeze in noncat program and savings due to freeze in FY12 of $1.8 million. MOE issue clarification needed. Language F.	MaineCare Eligibility/ Recipients	General Fund	1	90	Y, 8-5		($10,000,000)	$0
48	147	Medical Care - Payments to Providers	A	S-A-7463	Adjusts funding in fiscal year 2011-12 as a result of contributions from the Dirigo Health Fund to provide MaineCare seed for the **childless adult waiver**.	Ditto. Dirigo Health Program initiative needed.	MaineCare Eligibility/ Recipients	Other Special Revenue Funds	3	91	Y, 8-5		$10,000,000	$0
49	147	Medical Care - Payments to Providers	A	S-A-7474	Reduces funding from the elimination of the **childless adult waiver** program.	Eliminates eligibility 7/1/12. Noncat waiver serves 18,800 persons. MOE issue? Would waiver be needed to cut eligibility to 133$ FPL or to eliminate eligibility? CMS requires transition plan that review all members for eligibility under other categories. Info needed on time and staff needed to review, time for appeals, when members would move off coverage, increased enrollment in other categories of eligibility, net savings?	MaineCare Eligibility/ Recipients	General Fund	1	104	Y, 8-5		$0	($22,000,000)
50	147	Medical Care - Payments to Providers	A	S-A-7474	Reduces funding from the elimination of the **childless adult waiver** program.	See item 48.	MaineCare Eligibility/ Recipients	Federal Expenditures Fund	1	105	Y, 8-5		$0	($37,060,403)
51	147	Medical Care - Payments to Providers	A	S-A-7486	Reduces funding by reducing optional coverage for **children who are behaviorally challenged and who are in a residential setting**.	See below.	MaineCare Eligibility/ Recipients	Federal Expenditures Fund	1	112			$0	($842,282)
52	731	Mental Health Services - Child Medicaid	A	S-A-7486	Reduces funding by reducing optional coverage for **children who are behaviorally challenged and who are in a residential setting**.	Serves 195 children with serious mental and emotional health disorders, DD, autism spectrum disorders who will not have access to the service. MOE issues with ACA and match issues with federal mental health block grant. Information needed on how MaineCare services will be provided to this population.	MaineCare Eligibility/ Recipients	General Fund	17	23			$0	($500,000)
53	987	Developmental Services Waiver - MaineCare	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage**.		MaineCare FMAP	General Fund	16	41			$0	$1,190,669
54	Z006	Developmental Services Waiver - Supports	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage.**		MaineCare FMAP	General Fund	1	45			$0	$91,346

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
55	734	Disproportionate Share - Dorothea Dix Psychiatric Center	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage.**		MaineCare FMAP	General Fund	15	32			$0	$73,700
56	733	Disproportionate Share - Riverview Psychiatric Center	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage.**		MaineCare FMAP	General Fund	10	30			$0	$151,512
57	120	Dorothea Dix Psychiatric Center	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage.**		MaineCare FMAP	Other Special Revenue Funds	25	5			$0	($73,700)
58	960	FHM - Medical Care	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease in the **Federal Medical Assistance Percentage.**		MaineCare FMAP	Fund for a Healthy Maine	1	144	Y, 8-5		$0	$113,010
59	948	FHM - Substance Abuse	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage.**		MaineCare FMAP	Fund for a Healthy Maine	2	38	Y, 8-5		$0	$17,976
60	137	IV-E Foster Care/Adoption Assistance	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease in the **Federal Medical Assistance Percentage.**		MaineCare FMAP	General Fund	1	52			$0	$13,579
61	705	Medicaid Services - Developmental Services	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage.**		MaineCare FMAP	General Fund	12	18			$0	$592,079
62	147	Medical Care - Payments to Providers	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease in the **Federal Medical Assistance Percentage.**		MaineCare FMAP	General Fund	1	106			$0	$6,997,873
63	147	Medical Care - Payments to Providers	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease in the **Federal Medical Assistance Percentage.**		MaineCare FMAP	Federal Expenditures Fund	1	107			$0	($10,382,324)
64	731	Mental Health Services - Child Medicaid	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage.**		MaineCare FMAP	General Fund	17	22			$0	$470,754
65	732	Mental Health Services - Community Medicaid	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage.**		MaineCare FMAP	General Fund	14	28			$0	$614,409
66	148	Nursing Facilities	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease in the **Federal Medical Assistance Percentage.**		MaineCare FMAP	General Fund	1	124			$0	$1,538,014

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67	148	Nursing Facilities	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease in the **Federal Medical Assistance Percentage.**		MaineCare FMAP	Federal Expenditures Fund	1	125			$0	($1,538,014)
68	844	Office of Substance Abuse - Medicaid Seed	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage.**		MaineCare FMAP	General Fund	1	36			$0	$53,748
69	105	Riverview Psychiatric Center	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage.**		MaineCare FMAP	Other Special Revenue Funds	20	3			$0	($151,512)
70	Z042	Traumatic Brain Injury Seed	A	S-A-7478	Adjusts funding for Medicaid services as a result of the decrease of the **Federal Medical Assistance Percentage.**		MaineCare FMAP	General Fund	1	47			$0	$1,669
71	147	Medical Care - Payments to Providers	A	S-A-7464	Reduces funding by reducing reimbursement for **critical access hospitals from 109% to 105%.**	Will apply to claims and settlements. In addition "Administrative Initiative" list from DHHS 12/20 lists expansion of nonpayment for readmission for same diagnosis from 3 days to 14 days saving $.62 million in FY12 and $2.48 million in FY13. Language Part M.	MaineCare Hospitals	General Fund	1	92			($290,834)	($1,179,804)
72	147	Medical Care - Payments to Providers	A	S-A-7464	Reduces funding by reducing reimbursement for **critical access hospitals from 109% to 105%.**	Ditto.	MaineCare Hospitals	Federal Expenditures Fund	1	93			($503,794)	($1,987,455)
73	147	Medical Care - Payments to Providers	A	S-A-7467	Reduces funding by limiting reimbursement to 15 **outpatient hospital visits per year.**	3342 MaineCare members exceeded 15 OP visits/yr. Not applicable to visits to physician with office in hospital or to emergency department services. Note from testimony: unclear how will be enforced, unclear how patients with serious illness will be served, i.e. dialysis and chemotherapy.	MaineCare Hospitals	General Fund	1	96			($277,540)	($1,480,214)
74	147	Medical Care - Payments to Providers	A	S-A-7467	Reduces funding by limiting reimbursement to 15 **outpatient hospital visits per year.**	Ditto.	MaineCare Hospitals	Federal Expenditures Fund	1	97			($480,766)	($2,493,515)
75	147	Medical Care - Payments to Providers	A	S-A-7468	Reduces funding by limiting reimbursement for **hospital admissions to 5 per member per year.**	Note from testimony: unclear how will be enforced, unclear how patients with serious illness will be served. Note: With regard to the larger issue of MaineCare reimbursement of hospitals, "Administrative Initiatives" info from DHHS 12/20 includes "Emergency room FY12 $.5 million." Information needed on this initiative.	MaineCare Hospitals	General Fund	1	98			($91,890)	($490,081)
76	147	Medical Care - Payments to Providers	A	S-A-7468	Reduces funding by limiting reimbursement for **hospital admissions to 5 per member per year.**	Ditto.	MaineCare Hospitals	Federal Expenditures Fund	1	99			($159,176)	($825,573)

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77	147	Medical Care - Payments to Providers	A	S-A-7481	Reduces funding for **outpatient services at acute care hospitals by 5%**, effective July 1, 2012.	Is in addition to proposed streamlining 5% OP cut and 5% OP cut from last year's budget.	MaineCare Hospitals	General Fund	1	110			$0	($3,180,269)
78	147	Medical Care - Payments to Providers	A	S-A-7481	Reduces funding for **outpatient services at acute care hospitals by 5%**, effective July 1, 2012.	Ditto.	MaineCare Hospitals	Federal Expenditures Fund	1	111			$0	($5,357,366)
79	147	Medical Care - Payments to Providers	A	S-A-7488	Reduces funding by reducing reimbursement for **hospital inpatient services by 10%.**	"Administrative Initiative" list from DHHS 12/20 lists Readmission Policy to 14 days FY12 $.62 million and FY13 $2.48 million." Current rule does not reimburse for readmission within 3 days for same diagnosis. Information needed on this proposal. Testimony: rate cuts and usage cuts will lose hospital $50 million/yr, will shift costs to insurers, employers, private pay and other payors.	MaineCare Hospitals	General Fund	1	114			($768,208)	($3,127,406)
80	147	Medical Care - Payments to Providers	A	S-A-7488	Reduces funding by reducing reimbursement for **hospital inpatient services by 10%.**	Ditto.	MaineCare Hospitals	Federal Expenditures Fund	1	115			($2,098,929)	($5,268,314)
81	147	Medical Care - Payments to Providers	A	S-A-7427	Reduces funding by eliminating **adult family care** as an optional service in the MaineCare program.	Served 88 members who have medical necessity, need assistance with or cueing for at least 2 activities of daily living. Information needed on plans for MaineCare services for this population.	MaineCare Optional Services	General Fund	1	65			($40,810)	($220,068)
82	147	Medical Care - Payments to Providers	A	S-A-7427	Reduces funding by eliminating **adult family care** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	66			($68,641)	($362,332)
83	Z009	MR/Elderly PNMI Room and Board	A	S-A-7427	Reduces funding by eliminating **adult family care** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	General Fund	1	149			($22,609)	($121,918)
84	147	Medical Care - Payments to Providers	A	S-A-7429	Reduces funding by eliminating **ambulatory surgical center services** as an optional service in the MaineCare program.	Served 800 persons who received surgical procedures requiring less than 24 hour hospitalization. Information needed for plans for MaineCare services for these medical procedures.	MaineCare Optional Services	General Fund	1	67			($17,200)	($93,274)
85	147	Medical Care - Payments to Providers	A	S-A-7429	Reduces funding by eliminating **ambulatory surgical center services** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	68			($28,155)	($148,619)

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
86	147	Medical Care - Payments to Providers	A	S-A-7430	Reduces funding by eliminating **consumer-directed attendant services** as an optional service in the MaineCare program.	Served 1700 persons, MaineCare eligible, adults with permanent or chronic disabilities that impair ability to provide self-care, providing members with care coordination, skills development and personal care services. Alpha One testified that consumer directed attendant services are the lowest cost of any MaineCare long-term care services, costing $11.67/hr, next closest rate being agency based personal care at $14.98/hr. Simply shifting the 430 consumers on this program to agency based personal care will increase MaineCare GF costs $444,000/yr. Information needed on plans for MaineCare services for this population.	MaineCare Optional Services	General Fund	1	69			($449,605)	($2,440,130)
87	147	Medical Care - Payments to Providers	A	S-A-7430	Reduces funding by eliminating **consumer-directed attendant services** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	70			($772,450)	($4,077,499)
88	705	Medicaid Services - Developmental Services	A	S-A-7431	Reduces funding by eliminating **targeted case management services** as an optional service in the MaineCare program.	Served 4767 members, adults with DD, SA, and HIV/AIDS diagnoses and homeless persons. Provides intake/assessment, plan of care development, coordination/advocacy, monitoring and evaluation. Testimony: provides all care management at Portland's homeless shelters and refugee services centers, serving 240 families last year, necessary part of management of MaineCare services and shifting services to less expensive more appropriate location and coverage.	MaineCare Optional Services	General Fund	12	15			($389,340)	($1,772,320)
89	147	Medical Care - Payments to Providers	A	S-A-7431	Reduces funding by eliminating **targeted case management services** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	General Fund	1	71			($94,312)	($429,320)
90	147	Medical Care - Payments to Providers	A	S-A-7431	Reduces funding by eliminating **targeted case management services** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	72			($908,725)	($4,846,533)

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
91	147	Medical Care - Payments to Providers	A	S-A-7434	Reduces funding by eliminating **dental services** as an optional service in the MaineCare program.	Served 14,416 members, adults, providing medically necessary services to alleviate pain, infection or prevent imminent tooth loss and surgical care after an accident. Dentures only when medically necessary to treat an underlying medical condition. Information needed on possible deterioration of health and shift of cost. See Language Part E and K.	MaineCare Optional Services	General Fund	1	73			($410,611)	($2,225,611)
92	147	Medical Care - Payments to Providers	A	S-A-7434	Reduces funding by eliminating **dental services** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	74			($652,668)	($3,445,208)
93	147	Medical Care - Payments to Providers	A	S-A-7442	Reduces funding by eliminating **occupational therapy** as an optional service in the MaineCare program.	Served 6477 members with rehabilitation potential and if medically necessary, with goal of improving physical function, preventing deterioration in function, treatment following a hospital stay, treatment to improve performance of ADLs. Information needed on possible deterioration of health and shift of cost. See Language Part B.	MaineCare Optional Services	General Fund	1	75			($78,846)	($426,996)
94	147	Medical Care - Payments to Providers	A	S-A-7442	Reduces funding by eliminating **occupational therapy** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	76			($124,966)	($659,650)
95	Z009	MR/Elderly PNMI Room and Board	A	S-A-7442	Reduces funding by eliminating **occupational therapy** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	General Fund	1	150			($4,088)	($22,141)
96	148	Nursing Facilities	A	S-A-7442	Reduces funding by eliminating **occupational therapy** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	General Fund	1	118			($7,516)	($40,706)
97	148	Nursing Facilities	A	S-A-7442	Reduces funding by eliminating **occupational therapy** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	119			($11,088)	($58,532)
98	147	Medical Care - Payments to Providers	A	S-A-7443	Reduces funding by eliminating **vision services** as an optional service in the MaineCare program.	Served 35,441 adults, providing eye exams, treatment, therapies, studies, prosthesis, therapies. Does not provide corrective lenses, except will provide 1 pair per lifetime if power is greater than 10.00 diopters. Information needed on possible deterioration of health and shift of cost. Language Part C.	MaineCare Optional Services	General Fund	1	77			($151,826)	($823,447)

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
99	147	Medical Care - Payments to Providers	A	S-A-7443	Reduces funding by eliminating **vision services** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	78			($250,663)	($1,323,161)
100	147	Medical Care - Payments to Providers	A	S-A-7445	Reduces funding by eliminating **physical therapy** as an optional service in the MaineCare program.	Served 11,067, adults, with potential for rehabilitation, treatment after surgical procedure or to improve performance of ADLs, to prevent deterioration of function and for medically necessary palliative care. Information needed on possible deterioration of health and shift of cost. See Language Part B and C.	MaineCare Optional Services	General Fund	1	79			($97,657)	($529,071)
101	147	Medical Care - Payments to Providers	A	S-A-7445	Reduces funding by eliminating **physical therapy** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	80			($158,352)	($835,885)
102	Z009	MR/Elderly PNMI Room and Board	A	S-A-7445	Reduces funding by eliminating **physical therapy** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	General Fund	1	151			($4,890)	($26,490)
103	148	Nursing Facilities	A	S-A-7445	Reduces funding by eliminating **physical therapy** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	General Fund	1	120			($9,087)	($49,230)
104	148	Nursing Facilities	A	S-A-7445	Reduces funding by eliminating **physical therapy** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	121			($13,732)	($72,488)
105	147	Medical Care - Payments to Providers	A	S-A-7446	Reduces funding by eliminating **podiatry** services as an optional service in the MaineCare program.	Served 12,374 adult members for whom self-care or foot care by a nonprofessional person would be hazardous and pose a threat or the person has an illness, diagnosis or condition that if left untreated may cause loss of function or risk loss of limb. Information needed on possible deterioration of health and shift of cost. Language Part C.	MaineCare Optional Services	General Fund	1	81			($68,407)	($370,903)
106	147	Medical Care - Payments to Providers	A	S-A-7446	Reduces funding by eliminating **podiatry** services as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	82			($110,904)	($585,423)
107	147	Medical Care - Payments to Providers	A	S-A-7451	Reduces funding by eliminating **sexually transmitted disease screening clinic services** as an optional service in the MaineCare program.	Served 8477, adults, providing screening, testing, medication, treatment follow-up and counseling. Information needed on possible deterioration of health and shift of cost.	MaineCare Optional Services	General Fund	1	86			($40,397)	($217,951)

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
108	147	Medical Care - Payments to Providers	A	S-A-7451	Reduces funding by eliminating **sexually transmitted disease screening clinic services** as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	87			($45,771)	($241,610)
109	147	Medical Care - Payments to Providers	A	S-A-7461	Reduces funding by eliminating **chiropractic** services as an optional service in the MaineCare program.	Served 15,514 adults following evaluation by physician and determination of rehabilitation potential. Provides manual or mechanical manipulation and x-ray services for diagnosis of subluxation. Information needed on possible deterioration of health and shift of cost. Language Part C.	MaineCare Optional Services	General Fund	1	88			($69,199)	($375,344)
110	147	Medical Care - Payments to Providers	A	S-A-7461	Reduces funding by eliminating **chiropractic** services as an optional service in the MaineCare program.	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	89			($114,901)	($606,525)
111	147	Medical Care - Payments to Providers	A	S-A-7480	Reduces funding by eliminating the reimbursement for **smoking cessation products.**	Served 2000 persons. Will maintain benefit for pregnant women. Information needed on possible deterioration of health and shift of cost.	MaineCare Optional Services	General Fund	1	108			($80,000)	($430,000)
112	147	Medical Care - Payments to Providers	A	S-A-7480	Reduces funding by eliminating the reimbursement for **smoking cessation products.**	Ditto.	MaineCare Optional Services	Federal Expenditures Fund	1	109			($138,580)	($724,363)

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
113	705	Medicaid Services - Developmental Services	A	S-A-7448	Reduces funding by eliminating **private nonmedical institution services** as an optional service in the MaineCare program effective July 1, 2012.	Served 5542 persons in facilities: medical and remedial (assisted living, dementia care, DD, ABI, HIV/AIDS, blindness), SA, MH facilities. Clarification needed on reimbursement for facilities, plans for residents' care, available options and funding for care, cost shifting, plans for MaineCare and nonMaineCare residents. 12/20 info indicates cost of care as a cause of the shortfall in FY12 and cost of care collections. Much testimony against proposed elimination of PNMI services, citing frailty, need, inability to care for self, eligibility for NF care for many and shortage of NF beds, short term and long term needs of elderly, persons with disabilities and persons in treatment, need for time for transition to new home and community based and facility based care in an orderly manner. Information needed on options for transitioning, timeframe with CMS, available resources. Language Part D.	MaineCare PNMI	Other Special Revenue Funds	42	16			$0	($83,408)
114	147	Medical Care - Payments to Providers	A	S-A-7448	Reduces funding by eliminating **private nonmedical institution services** as an optional service in the MaineCare program effective July 1, 2012.	Ditto.	MaineCare PNMI	General Fund	1	83			$0	($47,637,039)
115	147	Medical Care - Payments to Providers	A	S-A-7448	Reduces funding by eliminating **private nonmedical institution services** as an optional service in the MaineCare program effective July 1, 2012.	Ditto.	MaineCare PNMI	Federal Expenditures Fund	1	84			$0	($104,043,080)
116	147	Medical Care - Payments to Providers	A	S-A-7448	Reduces funding by eliminating **private nonmedical institution services** as an optional service in the MaineCare program effective July 1, 2012.	Ditto.	MaineCare PNMI	Other Special Revenue Funds	1	85			($319,609)	($5,113,739)
117	732	Mental Health Services - Community Medicaid	A	S-A-7448	Reduces funding by eliminating **private nonmedical institution services** as an optional service in the MaineCare program effective July 1, 2012.	Ditto.	MaineCare PNMI	General Fund	14	26			$0	($12,754,745)
118	732	Mental Health Services - Community Medicaid	A	S-A-7448	Reduces funding by eliminating **private nonmedical institution services** as an optional service in the MaineCare program effective July 1, 2012.	Ditto.	MaineCare PNMI	Other Special Revenue Funds	44	27			$0	($341,170)
119	844	Office of Substance Abuse - Medicaid Seed	A	S-A-7448	Reduces funding by eliminating **private nonmedical institution services** as an optional service in the MaineCare program effective July 1, 2012.	Ditto.	MaineCare PNMI	Other Special Revenue Funds	1	34			$0	($89,487)

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
120	Z015	FHM - Drugs for the Elderly and Disabled	A	S-A-7456	Reduces funding by eliminating the coinsurance deductible and copay for prescription drugs and the payment of Medicare Part D premiums for certain individuals receiving benefits from the **Low-cost Drugs To Maine's Elderly** program.	See item 16. See Language Part G and J. Note: On the larger issue of MaineCare Prescription Drugs, "Administrative Initiatives" 12/20 info from DHHS includes "Pharmacy AWP-16% FY12 $.14 Million and FY13 $.7 million. Information needed on this initiative. Information needed on possible deterioration of health and shift of cost.	MaineCare Prescription Drugs	Fund for a Healthy Maine	1	155	Y, 7-6		($247,964)	($1,322,475)
121	202	Low-cost Drugs To Maine's Elderly	A	S-A-7456	Reduces funding by eliminating the coinsurance deductible and copay for prescription drugs and the payment of Medicare Part D premiums for certain individuals receiving benefits from the **Low-cost Drugs To Maine's Elderly** program.	Ditto.	MaineCare Prescription Drugs	General Fund	1	127	Y, 7-6		($836,743)	($4,462,786)
122	Z015	FHM - Drugs for the Elderly and Disabled	A	S-A-7465	Reduces funding by reducing the number of prescriptions for **brand name drugs** for which reimbursement is allowed from 4 to 2 per month unless the prescription is determined to be medically necessary.	See item 16 and 123. Information needed on possible deterioration of health and shift of cost. See Language Part G.	MaineCare Prescription Drugs	Fund for a Healthy Maine	1	156	Y, 7-6		($56,880)	($279,402)
123	147	Medical Care - Payments to Providers	A	S-A-7465	Reduces funding by reducing the number of prescriptions for **brand name drugs** for which reimbursement is allowed from 4 to 2 per month unless the prescription is determined to be medically necessary.	Served 10,200 members, will provide prior authorization for more than 2 brand name drugs per month. Testimony raised questions about persons with complex conditions requiring brand name drugs. Title 32, section 13781 already requires generic unless prescriber designates brand, with exception for MaineCare drugs if DHHS has determined brand to be more cost-effective.	MaineCare Prescription Drugs	General Fund	1	94			($1,168,120)	($5,840,598)
124	147	Medical Care - Payments to Providers	A	S-A-7465	Reduces funding by reducing the number of prescriptions for **brand name drugs** for which reimbursement is allowed from 4 to 2 per month unless the prescription is determined to be medically necessary.	Ditto.	MaineCare Prescription Drugs	Federal Expenditures Fund	1	95			($2,023,465)	($9,838,860)
125	147	Medical Care - Payments to Providers	A	S-A-7471	Reduces funding by **limiting the use of Suboxone** for the treatment of opioid dependency to coverage for a 2-year period.	Served 700 persons beyond the suggested 2-year limit. This is for FY12 only. Proposed streamlining bill will suggest this for FY13. Testimony opposed as contrary to best medical practice in treating chronic conditions. Information needed on possible deterioration of health and shift of cost.	MaineCare Prescription Drugs	General Fund	1	100			($147,563)	$0
126	147	Medical Care - Payments to Providers	A	S-A-7471	Reduces funding by **limiting the use of Suboxone** for the treatment of opioid dependency to coverage for a 2-year period.	Ditto.	MaineCare Prescription Drugs	Federal Expenditures Fund	1	101			($1,082,650)	$0

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
127	415	Budget Stabilization Fund	Q		Transfers **$39,500,000** from General Fund unappropriated surplus to the **Maine Budget Stabilization Fund** in order to ensure funds will be available to support services through the Department of Health and Human Services to Maine's most vulnerable citizens.			General Fund	1				$0	$39,500,000
128	921	Fund for a Healthy Maine	N		Eliminates the transfer of $4,500,000 of net **slot machine revenue to the Fund for a Healthy Maine** for the fiscal year ending June 30, 2013	Cuts remaining funding in DEL program. See items 16, 120, 122.		General Fund	2		Y, 7-6		$0	($4,500,000)
129	921	Fund for a Healthy Maine	N		Eliminates the transfer of $4,500,000 of net **slot machine revenue to the Fund for a Healthy Maine** for the fiscal year ending June 30, 2013	Ditto.		Fund for a Healthy Maine	2		Y, 7-6		$0	$4,500,000
130	56	State Controller - Office of the	P		Increases the **interfund advance** from Other Special Revenue Funds to the General Fund unappropriated surplus required for one day at the end of fiscal year 2011-12 from $43,000,000 to $102,000,000.			General Fund	1				($59,000,000)	$59,000,000
131	56	State Controller - Office of the	P		Increases the **interfund advance** from Other Special Revenue Funds to the General Fund unappropriated surplus required for one day at the end of fiscal year 2011-12 from $43,000,000 to $102,000,000.			Other Special Revenue Funds	1				$59,000,000	($59,000,000)
			Part		**Language Summary**	**Language Notes**								
132			B		This Part repeals the requirement that MaineCare cover optional services under the MaineCare program for adults for **physical and occupational therapy services** provided to residents of intermediate care or skilled nursing facilities, subject to federal guidelines and approval.	See items 93-97 on OT and 100-104 on PT.								
133			C		This Part repeals provisions requiring **copayments for physical therapy services, occupational therapy services, speech therapy services, podiatry services, chiropractic services, optical services and optometric services** which are proposed for elimination subject to federal guidelines and approval.	Speech therapy is not proposed for elimination but is included in this amendment to the co-pay law. Correction needed. See items 93-97 on OT, 98-99 on vision, 100-104 on PT, 105-106 podiatry, 109-110 on chiropractic.								

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
134			D		This Part repeals the requirement that the Department of Health and Human Services administer the program of **medical coverage for persons residing in cost reimbursement boarding homes** effective July 1, 2012, subject to federal guidelines and approval.	See items 113-119 on PNMIs.								
135			E		This Part repeals the requirement that the MaineCare program provide coverage for **adult dental services** as an optional service under the MaineCare program.	See items 91-92 and Language Part K.								
136			F		This Part does the following: 1. It reduces to the maximum income level for **parent and caretaker relatives of a child** under 18 from 200% FPL to the minimum federal requirement of no less than Standard of Need for AFDC in place in 1996 (approximately 51% FPL). 2. It eliminates medical coverage for **childless adults** between the ages of 21 and 64.	See items 39-41 on parent coverage and 47-50 on childless adult coverage.					Y, 7-6			
140			G		This Part does the following: 1. It repeals the **elderly low-cost drug program**. 2. It repeals the requirement that the Department of Health and Human Services provide prescription drug wrap benefits and pay Medicare Part D premiums for certain individuals receiving benefits from the **elderly low-cost drug program**.	See items 16, 120, 122 and Language Parts J and N (at item 128, 129) on DEL program. Note Part G repeals DEL and portions of MaineCare law on eligibility for infants and elderly and disabled persons, resource tests and authorization of benefits consistent with federal OBRA law.					Y, 7-6			
144			H		This Part **authorizes the Department of Health and Human Services to make changes** to MaineCare service provisions if necessary to comply with state balanced budget provisions.	Note: Amends 22 section 3174-Q, which refers to Title 5, section 1664, which requires the state budget document to embrace a general budget summary setting forth the aggregate figures of the budget in such a manner as to show "the balanced relationship between the total proposed expenditures and the total anticipated revenues together with the other means of financing the budget..."								

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
145			I		This Part repeals the **MaineCare Basic program**.	Note: MaineCare Basic in 22 section 3174-FF contains limits on speech therapy, rehabilitation services for brain injury, psychological counseling services, durable medical equipment, PT, chiropractic, private duty nursing and personal care, waivers and noncategorical adults. Some of these services are not being eliminated.								
146			J		This Part repeals the provision authorizing the Department of Health and Human Services to provide prescription drug services for MaineCare members through the **Elderly Low-Cost Drug Program**.						Y, 7-6			
147			K		This Part eliminates the requirement that the MaineCare program cover optional **dental services to adults,** subject to federal guidelines and approval.	See items 91-92 and Language Part E.								
148			L		This Part gives the Department of Health and Human Services the **authority to adopt emergency rules** to implement any provisions of the bill over which it has specific authority that has not been addressed by some other Part of the bill.									
149			M		This Part does the following: 1. It reduces the reimbursement rate for **critical access hospitals from 109% to 105%** and strikes the provision that repealed this method of reimbursement effective April 1, 2012. 2. It repeals the provision that requires the Department of Health and Human Services to phase in a system to reimburse **critical access hospitals for inpatient services under the MaineCare program based on diagnosis-related groupings**. 3. It repeals the provision that requires the Department of Health and Human Services to phase in a system to reimburse **critical access hospitals for outpatient services under the MaineCare program based on ambulatory payment classifications**.	See items 71-72 on reimbursement to critical access hospitals.								

Line	Prog. Code	Program	Bill Part	Change Package	Initiative Text	Initiative Notes (compiled by OPLA)	Sort Class	Fund	Unit	Line Number	HHS Vote	AFA Vote	FY 12	FY 13
155			O		This Part **lapses $5,000,000 from the Bureau of Medical Services** account within the Department of Health and Human Services to the unappropriated surplus of the General Fund at the end of fiscal year 2010-12.									

Appendix B

Minority Report

SENATE

EARLE L. MCCORMICK, District 21, Chair
NICHI S. FARNHAM, District 32
MARGARET M. CRAVEN, District 16

JANE ORBETON, Legislative Analyst
ANNA BROOME, Legislative Analyst
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State of Maine
ONE HUNDRED AND TWENTY-FIFTH LEGISLATURE
COMMITTEE ON HEALTH AND HUMAN SERVICES

January 19, 2012

Senator Richard W. Rosen, Chair
Representative Patrick S. A. Flood, Chair
Appropriations and Financial Affairs Committee

Dear Senator Rosen and Representative Flood:

Introduction

Attached to this letter is the Health and Human Services Committee's minority report for specific proposals in LD 1746. As members of a policy committee, we believe that it is our job to assess the policy ramifications of any budget proposals related to health and human services and make recommendations to the Appropriations and Financial Affairs committee based upon that assessment. We cannot justify supporting the Governor's proposals that would make deep cuts to critical programs funded through the Fund for Healthy Maine and eliminate MaineCare coverage for more than 65,000 people.

We believe these proposals are irresponsible and short-sighted, which will undoubtedly lead to a cost shift to more expensive services for the state and our health care system as a whole. They would put the health and well-being of thousands at risk. The state of Maine would not realize the entire expected savings from these proposals. In addition, we would see the loss of thousands of more jobs in our economy if these cuts are put forward.

Maintenance of Effort

You asked our committee to examine the proposals that clearly violate the Maintenance of Effort provisions of the Affordable Care Act. Not only did we learn that the state would have to enter into a potentially lengthy process to apply for a waiver from these provisions, we also feel even more strongly after our work session that it is highly unlikely that the Department of Health and Human Services would be granted such a waiver. In January 2011, Arizona applied for a Section 1115 waiver to make a number of changes to their Medicaid program. Their waiver proposal to eliminate coverage for parents with income between 75% and 100% of the federal poverty level was denied by CMS in a letter dated October 21, 2011. This was the only proposal from Arizona to eliminate coverage for a population protected by the ACA MOE provision and the request was denied. No state at this time has received a waiver of the MOE provisions. We believe that it is irresponsible to continue to put these proposals forward when they are clearly illegal and we are unlikely to get a waiver.

100 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0100 TELEPHONE 207-287-1317

Putting aside the MOE provisions, we voted against cutting MaineCare eligibility for low-income working parents, 19 and 20 year olds, childless adults andseniors and people with disabilities because it will put too many Maine people at risk. We know that people without health coverage are more likely to be diagnosed with late stage cancer, more likely to die from undetected or untreated health conditions such as heart disease and unlikely to get the preventive and appropriate care that they might need to manage a chronic health condition. Many of the people on these programs have significant health care needs. Their health care needs won't go away. In fact, people will delay the care that they need and end up seeking more costly care in the Emergency Department.

Fund for a Healthy Maine

The Governor's Budget proposes to make sweeping changes to how the Fund for a Healthy Maine is allocated. Roughly half of the total funds are diverted from current programs and deposited in Medicaid accounts. This is an irresponsible and short-term solution that ignores the special intent of these funds and their proven track record. The Fund for a Healthy Maine is not taxpayer money; it is a combination of proceeds from a lawsuit with the tobacco industry and racino money. The public health impacts of the Fund are enormous. Maine saves $7.50 per $1.00 spent on prevention efforts—and the Fund for a Healthy Maine is our primary source of prevention funds. Without the Fund, we would rank 48th in the country for public health funding. Without the Fund we will never win the battle against skyrocketing health care costs.

Throughout both sessions of the 125th and the Fund for a Healthy Maine Commission we heard evidence that the FHM is working. In fact, the bi-partisan FHM Commission that included 5 members of this committee, the State Health Officer and other public health professionals concluded that: "the Commission recognizes the importance of investments in public health and prevention and believes that the original intent of the funding should be maintained and efforts should be made to eliminate health disparities." This Commission was created in order to evaluate the effectiveness of the FHM programs and to advise the legislature on whether the current allocations were appropriate. The Commission's hard work and opinions need to be respected.

We oppose all cuts to the Fund for a Healthy Maine and hope that your committee will stand by your decision last session that the Fund is our key to a healthy Maine and should be protected.

Alternative Approaches to Balancing the Budget

There are more responsible approaches to addressing the challenges in this supplemental budget. We do not believe that the proposals in the budget should be limited to cuts in the Department of Health and Human Services. Cuts of this magnitude would be devastating to vital investments that support Maine people to be healthy and protect vulnerable populations from harm. We urge the Appropriations and Financial Affairs Committee to broaden the discussion and not move forward with recommendations for solutions until you have the full understanding of the budget challenges facing the state. With an understanding of the entire budget situation, we can make more informed, responsible decisions based on our priorities and values as a state.

As for savings within DHHS, we would like to continue to work with members of your committee to identify ways that we can find savings within the Department. We believe that more can be done to address the true issues facing our MaineCare program. The truth is that we

face a health care crisis and simply cutting people off of coverage will exacerbate the problem. We should be doing more to address the way in which we deliver health care in our MaineCare program and our larger health care system. We know that 5% of the population on MaineCare accounts for 55% of the cost. We applaud the Department for their efforts to improve the coordination of care through their Value-Based Purchasing Initiatives. However, we remain frustrated that this new Administration chose to curtail initiatives in place to improve care management within MaineCare. We believe that the Department could be much more aggressive in its efforts to manage the care of high cost users and ensure that they are getting preventive and appropriate care that is needed to manage their serious health conditions. In addition, we should be doing all that we can to ensure that MaineCare truly is the payer of last resort. We need to make sure that DHHS has all necessary systems in place to collect funding that is owed to the program, either for Medicare, private insurance companies or the veteran's health care programs. We look forward to continuing to work with your committee to identify savings within the MaineCare program that better address the challenges faced by the program.

Conclusion

We understand the desire to move forward with the process in the Appropriations and Financial Affairs Committee, but we are uncomfortable with the fact that the policy committee overseeing the Department of Health and Human Services will not have the opportunity to weigh in on the remaining proposals in the Governor's supplemental budget. We hope that you will consider us as a resource and will be interested in helping in any way we can as you move forward with your deliberations. We remain concerned about most of the other proposals in the Governor's supplemental budget. We believe that many of the remaining proposals in the budget are short sighted and will just lead to people needing more costly care and services. For example, we know that legislators have looked in the past at eliminating certain optional services within MaineCare and have rightly decided that this will just result in people not receiving the medically necessary care that they need and end up costing MaineCare more in the long run. We hope that your committee will reject proposals that will clearly shift costs and makes cuts to important investments in preventive care and public health. We must seek alternatives that will truly address the challenges faced by the MaineCare program and the state as a whole.

Thank you for the opportunity to weigh in with our thoughts and recommendations.

Sincerely,

Mark Eves

Rep. Mark Eves

Community and School Grants: The Governor's supplemental budget proposal effectively eliminates funding for all lines under the Community/School Grants and Statewide Coordination line. This decimates Maine's tobacco and obesity programs. Cuts include the Healthy Maine Partnerships, school health coordinators and SchoolBasedHealthCenters.

- The Healthy Maine Partnerships are the base of Maine's fragile public health infrastructure and an important part of a comprehensive approach to tobacco and obesity control that focuses on supporting families and businesses by helping to improve health, lower costs, and making their communities places where young people and small businesses can thrive.
- In the 2009/2010 school year 7,121 students were enrolled in SBHCs. There were 13,108 encounters including acute care, behavioral health, oral health and preventive health visits.

Home Visiting: Home Visitation funds programs that support and assist new and adolescent parents so children have better health outcomes, developmental issues are identified earlier, child abuse is prevented and children are given the best possible chance of entering school ready to learn.

- 93% of HV children had up to date immunizations (Maine rate 72.3%)
- 68% of the HV children who were exposed to second-hand smoke are no longer exposed or had reduced exposure, reducing their risk of developing respiratory and other related health issues.

Oral Health and Donated Dental: OH funds programs that provide access to oral health care services for low income individuals without dental insurance. This includes school-based oral health care and dental subsidies. Tooth Decay is one of the leading causes of avoidable emergency room visits and improved oral health is an important factor in lowering health care costs. This proposal also eliminates the part-time coordinator for the thousands of hours volunteered by dentists.

- In FY11, (before the biennial budget cuts), 77 school districts reached 23,248 children in more than 230 K-4 schools.
- In 2009, 18.2% of Kindergarten students and 29.5% of third graders had tooth decay, compared to 31.4% of Kindergarten students and 44.7% of third graders in 1999 when the FHM was created.

Family Planning: The elimination of family planning within the Fund for a Healthy Maine would have the following likely result:

- Closure of 7 family planning health centers: Houlton, Dexter, Norway, Rumford, Damariscotta, Topsham, Sanford and ending 6 partnerships with local health

centers: Harrington, Jonesport, Milbridge, Washington County Community College, UMaine Machias and Lincoln.
- Reduced hours at several other centers
- The above clinical reductions would affect approximately 5,900 current patients

Head Start: Currently, Head Start providers can only serve approximately 30% of eligible Head Start children and less than 10% of those eligible for Early Head Start. If this proposed cut moves forward, another 303 children and their families will lose access in each year of the biennium. This program has been proven to prepare children for school and have long lasting effects on their likelihood of succeeding in life and school.

- Maine has supported Head Start since the mid-1980s. Now is not the time to abandon that commitment.
- Over 70% of Head Start parents work or full-time students. Losing access to this care will force many to abandon work or school.

Immunizations: Fund for a Healthy Maine funds vaccine administration and preventive services, including influenza and pneumococcal vaccines to reduce the impact of certain infectious diseases on people with tobacco related chronic diseases. Influenza vaccine can prevent 60% of hospitalizations and 80% of deaths from influenza-related complications.

Purchased Social Services/child care subsidies: The Governor's Proposed Budget will eliminate nearly $10 million dollars from Maine's child care subsidy program. This would cut funding for this program in half.

- At a minimum, more than a 1,000 working families in Maine who use this support in order to stay employed will be faced with either losing their jobs or compromising the well-being of their children in order to stay at work. The number is likely much higher.
- These cuts will also mean the curtailment and/or elimination of programs that work towards ensuring that families in the program can access high quality child care that will provide the foundation to help children succeed in school and life.

Drugs for the Elderly and Disabled: The Governor's proposals to cut eligibility for the Medicare Savings Programs and the elimination of the state funded Drugs for the Elderly program will harm seniors and people with disabilities who need assistance with their Medicare costs and prescription drugs costs. These two programs have been extremely successful in ensuring that seniors do not have to choose between purchasing prescription drugs, heat and/or food. If seniors and people with disabilities are unable to access prescription drugs, their health will deteriorate and they will end up needing more intensive, costly care in either a hospital or nursing facility.

THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER
WASHINGTON DC

SCHOOL OF PUBLIC HEALTH & HEALTH SERVICES

DEPARTMENT OF HEALTH POLICY

LEIGHTON KU, PHD, MPH

January 19, 2012

Honorable Mark Eves
Maine House of Representatives
2 State House Station
Augusta, Maine 04330

By email to markweves@yahoo.com

Dear Representative Eves:

You asked for my input on a matter recently proposed by Governor LePage, regarding changes to Maine's Medicaid program (MaineCare) As I understand it, Gov. LePage has proposed elimination of Medicaid coverage for "noncategoricals," such as the childless adult waiver group; parents with incomes between 100 percent and 200 percent of poverty, coverage of 19 and 20 year olds and those helped by the Medicare Savings Program for low-income people who have problems meeting their Medicare cost-sharing requirements.

I am a Professor of Health Policy at the School of Public Health and Health Services at George Washington University and am Director of the Center for Health Policy Research, a multidisciplinary unit with more than 50 faculty and researchers who focus on health policy and health services research. I am a nationally-known expert on Medicaid with over 20 years of experience. I have authored or co-authored more than 200 reports on health policy issues. I have testified in Congress and in many state legislatures at the invitation of both Democratic and Republican legislators.

A particular issue that has come up in Maine is the consequences of Medicaid cutbacks on hospital utilization and costs, such as uncompensated care costs. It is worth starting by mentioning that, in general, only 25 percent of all hospital admissions are for *elective* reasons.[1] Elective admissions include voluntary reasons like cosmetic surgery, but also admissions for many serious, but not life-threatening conditions, such as arthroscopic knee surgery (for knee injuries), back surgery, etc. Most hospital admissions (75 percent) are for *non-elective* reasons; these include childbirth and procedures that require immediate treatment, such as care for heart attacks, appendicitis, trauma (e.g., broken leg or major wound), hip fractures, cancer treatment, etc. While the loss of health insurance can lead to reductions in or delays of *elective* admissions, *even uninsured people need to be hospitalized when they have non-elective conditions* because their medical problems are so serious and immediate. Thus, most people who are hospitalized will obtain care regardless of whether they have insurance or not. If low-income people lose their Medicaid, they will be uninsured and will instead become uncompensated care cases and may be subject to indebtedness, bill collection, liens on their houses, etc. Both the hospitals and the patients suffer adverse circumstances in those cases. If people retain Medicaid, the hospitals

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and physicians will receive payments to help cover their costs of care and the low-income individuals will not face even more financial burdens.

Serious medical problems are particularly an issue for Medicaid beneficiaries, because they are low-income and typically have serious health problems. In one recent analysis of national health data, I found that about half of non-elderly adults on Medicaid report having serious health problems, like diabetes, arthritis, pregnancy, hypertension, or mental health problems., a rate about three to four times higher than the privately insured population.[2] In many cases, it is their poor health that has trapped them in lives of poverty, because they cannot work at their full potential.

An example of the consequences of Medicaid cutbacks is the state of Oregon, which made major cuts beginning in 2003 due a state budget crisis. Research showed that by 2004, the average number of emergency department (ED) visits by the uninsured rose by 35 percent above 2002 levels. Moreover, the share of uninsured coming to the ED who had severe medical problems that required hospital admission rose substantially.[3] When low-income uninsured people come to EDs and require hospital admission, this leads to increased requirements for uncompensated care at the hospitals.

I will acknowledge that there is limited information about the impact of large Medicaid cutbacks because these have been quite uncommon across states and time. When faced with budget problems, almost all states – whether led by Republicans or Democrats -- have tried to maintain Medicaid coverage for low-income patients and made other types of cuts or even raised revenues. The relationship between insurance coverage and uncompensated care can also be seen by the state of Massachusetts. As you know, Massachusetts instituted a major health insurance expansion, led by Governor Romney, in 2006. After their health insurance expansion was implemented, the level of uncompensated care in the state fell by about 35 percent by 2009.[4]

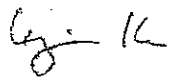
Similarly, when Minnesota expanded insurance under its MinnesotaCare program in the early 1990s, uncompensated care in the state fell significantly. Research found that every 1 percent point increase in MinnesotaCare enrollment led to a $2 per state resident reduction in uncompensated care costs.[5]

I understand why states are struggling to find new ways to reduce Medicaid costs during a period when many states are still facing serious financial difficulties. But I repeat that almost all states have been able to avoid Medicaid eligibility cutbacks as serious as those as being proposed by Governor LePage at this time. There are alternative ways that states can find savings. For example, I recently co-authored a paper which evaluated the effect of a comprehensive smoking cessation program in Massachusetts which led to major reductions in smoking, to reductions in the number of people admitted for cardiovascular conditions like heart attacks and which saved Medicaid more than $3 for every $1 invested in the program. Moreover, these savings were recouped very quickly, in a little more than a year.[6, 7] A number of states are seeking to find ways to reduce Medicaid hospital readmissions by improving the quality of care and planning for the period after people are discharged from the hospital, so that they do not need to be admitted a second time.

I hope this letter helps explain some of the serious problems that can occur if Maine institutes such draconian cuts in its Medicaid program. The Maine health care system is not a closed system; cuts in Medicaid will lead to hardships elsewhere, such as increased uncompensated care costs for hospitals (and other health care facilities). The advantage of maintaining services in Medicaid is that Maine will continue to attract federal matching funds under Medicaid. In 2012, the federal matching rate is 63.27 percent for Maine, so the federal government covers almost two-thirds of the program costs. This means that a dollar saved by Maine when it cuts Medicaid results in almost $2 in lost federal funding. In turn, this means there is less money to help pay the salaries for nurses, doctors, pharmacists, medical aides and others as well as less to serve needy Maine residents, so this leads to other economic hardships.

If you have any questions, please feel free to contact me.

Yours truly,



Leighton Ku, PhD, MPH
Professor of Health Policy
Director, Center for Health Policy Research

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[2] Ku L, Ferguson C. Medicaid Works: A Review of How Public Insurance Protects the Health and Finances of Children and Other Vulnerable Populations. Washington, DC: First Focus, June 2011.

[3] Lowe R, McConnell KJ, Vogt, M, Smith J. Impact of Medicaid Cutbacks on Emergency Department Use: The Oregon Experience. *Annals of Emergency Medicine.* 52(6): 628-34, Dec. 2008.

[4] Massachusetts Division of Health Care Finance and Policy. Health Care in Massachusetts: Key Indicators. Nov. 2009. Since that time, as the recession has continued, the level of uncompensated care in Massachusetts has increased again slightly, but remains far below the levels that existed before their health reform.

[5] Blewett L, et al. "Hospital Provision of Uncompensated Care and Public Program Enrollment." *Medical Care Research and Review,* December 2003, 60 (4), 509-27.

[6] Richard P, West K, Ku L. "The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts" *PLoS ONE,* 7(1): e29665, Jan. 6, 2012.

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Appendix C

Ideas for Savings from the Department of Health and Human Services

1/18 Maine Association of Substance Abuse Providers

ALTERNATIVES:

1. Reallocate the $39.5 million designated in the budget for the Rainy Day Fund back to the General Fund Budget to reduce Medicaid cuts.
2. Implement an alcohol tax of 10 cents per drink, which could raise $41 million to reduce cuts.
3. Investigate the alternative called Psychiatric Residential Treatment Facilities (PRTF) which is Medicaid reimbursable and may be an alternative for some of the higher needs children currently in PNMIs.
4. Investigate the possible use of Title IV-E funds to reduce cuts in Medicaid for children. 4E is a match program as is Medicaid.
5. Engage the Congressional Delegation is supporting work to retool the SA PMNIs to fit Medicaid Rehab regs.
6. Contact Washington State to learn how they have been successful in getting the VA system to reimburse Medicaid for services currently provided to veterans under the Medicaid program.
7. Investigate how EPSDT can be used to support Medicaid services for children.
8. Review with State Association of Addiction Services (SAAS) to see if there are other federal resources which may be available to reimburse some of the services currently in jeopardy.
9. Consider the possibility of limited unbundling (say housing coupled with day treatment) as an alternative to PNMIs.
10. Require all transportation companies receiving reimbursement from MaineCare to have a secure web site. All service providers would have a user name and pin and could verify client/patient attendance via this site, eliminating fraud and reduce the administrative burden on both ends. MaineCare's department of program integrity should stop searching for past transportation reimbursement fraud. The people who may have used this system inappropriately have no means by which to pay restitution in the first place and to prosecute and incarcerated them will just cost the state more money. It is a waste of time and money.
11. File an Acquired Brain Injury 1915c Waiver. By engaging in the waivers we could gain the flexibility that allows for lower cost step down models of care.
12. Use the Section 1915i -State Plan Amendment for those with SPMI
    Follow through on the Values Based Purchasing Initiative for Accountable Care Organizations. North Carolina has used the 1915 b/c waiver for a managed care initiative. This may be an avenue for the Value Based Purchasing effort.
13. By increasing the rates slightly in Daily Living Support Services and Skills Development Services they could make them viable models of community care for folks with SPMI who are living in the community as an alternative to more costly level of residential care.
14. Utilize the PACE Model (Program of All Inclusive Care for the Elderly) for seniors and expand the population to include individuals with severe mental illness and other special populations (CMS is open to this). The National PACE Association has suggested PACE can be used for: Adults age 21 and older who meet their states' eligibility criteria for nursing home level of care; Individuals who meet criteria for being "at risk" of future

nursing home placements; Individuals with chronic and complex medical conditions. Other high-need, high-cost populations as identified by the state and would benefit from comprehensive, highly integrated care.

15. Daily Living Skills and Skills Development Services as written in MaineCare Benefit Manual Rules and as funded are Custodial Care Service Programs and not eligible for Medicaid Rehabilitation for two reasons: the Provider is not a qualified mental health professional as defined in our State Plan under Medicaid Rehabilitation Services and secondly, the assessment, service plan and on-going progress notes when reviewed are not likely to qualify as an Optional Rehabilitation Customary and Accepted Professional Practice. When CMS gave guidance to DHHS they stressed that the State Plan approved for Medicaid Rehabilitation Services was based on Federal definitions in 1905, Qualified Professionals, and Costs. Para-professionals are not paid by Medicaid in state plans or rules except when included under the direct supervision of qualified professionals in the service model that uses Optional Medicaid Rehabilitation Services. A rewrite of the MaineCare Benefits Manual Mental Health Rehabilitation Optional Service can provide for varying levels of intensity of Rehabilitation Service with both a 15 minute fixed rate and a per diem rate with two to three levels of intensity for 8 hours a day, 16 hours a day, and 24 hours a day. This optional service would qualify for short-term up to 1 year with an additional 1 year extension based on clinical criteria and functional progress or relapses. For longer term and indefinite services three options may be very helpful: 1915 Waiver with MH added, 1915(i) added to the state plan, 1915 (k) added to the state plan.
16. It is critical to differentiate the need for residential care versus alternative forms of care. Specifically, the programs that operate as scattered site programs could/should be supported through existing community based services. Any savings we can identify before we begin the task of finding alternatives is an important step for us to take.
17. APS contract – eliminate APS and reallocate funds.
18. Currently, individuals who are in private practice (psychiatrists, private practice therapists, etc.) use the state funded crisis intervention system to provide on call coverage for after hours and weekends instead of providing that coverage themselves. We propose a charge for this coverage be levied on all private practitioners to cover the cost of this service.

Planned Parenthood®
of Northern New England

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207.210.3409

TO: Senator McCormick, Representative Strang Burgess, Members of the Health and Human Services Committee
FROM: Megan Hannan, Director of Public Affairs, Planned Parenthood of Northern New England
DATE: January 18, 2010
RE: Suggested Savings to MaineCare

As I have testified to in this and the Appropriations and Financial Affairs committee, the state MaineCare program could see significant savings by employing the Family Planning State Plan Amendment (FP SPA), which allows women up to 200% of poverty to qualify for family planning services *only*. This program comes with a $9 Federal match for every $1 the state invests. This applies to all providers who serve MaineCare patients, but many MaineCare patients already use family planning health centers, which have long been recognized as low-cost, high quality women's health providers.

Twenty-two states have the FP SPA, with at least two more beginning this year, and in each case states have documented significant savings. Using funds now targeted at unmatched family planning services to draw down this funding is a better use of state funds, as well as a good policy decision for the people of Maine. With no changes in MaineCare eligibility (if the proposed budget cuts are not accepted), Maine could serve over 8,700 people, avoid 1,230 unintended pregnancies, 410 abortions, and 640 MaineCare births, and therefore save just under $2 million in the first full year.

If the proposed cuts are made to CHIP parents, non-categoricals, and 19-20 year olds, there will be unintended pregnancies, resulting in many of those who have been taken off the MaineCare rolls going back on. As an alternative, the FP SPA will allow those women to access appropriate and affordable birth control, thus avoiding unintended pregnancies, abortions, and state-funded births. Because we don't know the extent of the cuts, I don't have numbers to say what it would cost and what we would save,, but it can be extrapolated that more women not becoming pregnant means more money not being spent on the cost of pre-natal care, birth and the other programs to which she and the baby are entitled.

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MaineCare births cost the system $31.3 million in 2006; $11.6 million of that was state dollars. The cost of the FP SPA is about $200 per member per year. The difference is obvious, and the opportunity to both save the state money, give women the tools they need to either have families later or space children, and to help bring families out of the cycle of generational poverty, is measurable and has been proven. If the goal is to save the state money, this is a program that should be started as soon as possible.

Cited data are from the Guttmacher Institute, 2011, various reports.

Orbeton, Jane

From: Cote, Lisa
Sent: Wednesday, January 18, 2012 9:01 AM
To: Broome, Anna; Cote, Lisa; Craven, Sen. Margaret ; Eves, Rep. Mark; Farnham, Sen. Nichi; Fossel, Rep. Les; Malaby, Rep. Richard; McCormick, Sen. Earle; Nolan, Christopher; O'Connor, Rep Beth ; Orbeton, Jane; Peterson, Rep. Matthew; Sanborn, Rep. Linda; Sanderson, Rep. Deborah ; Sirocki, Rep. Heather ; Strang Burgess, Rep. Meredith; Stuckey, Rep. Peter
Subject: FW: Potential savings in DHHS per HHS request for ideas

Lisa Cote
Health and Human Services Committee Clerk
Maine State Legislature
100 SHS Augusta, ME 04333
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From: Joan Churchill [mailto:JChurchill@Community-Concepts.org]
Sent: Wednesday, January 18, 2012 6:52 AM
To: Cote, Lisa
Cc: Executive Team; Christine Hufnagel
Subject: Potential savings in DHHS per HHS request for ideas

This brief list is the result of the Committee Analyst's request for ideas:

1. DHHS could be asked to carefully review the need for its existing staff compliment as the result of whatever cuts are approved. When programs and services are decreased at the community level (Medicaid as well as all the proposed programs); there will be less contracts, less Medicaid billing, less everything. The proposed cuts are so substantial it seems highly likely that the DHHS current infrastruture would be larger than needed.

2. There are services that could be completed less costly by the private sector.

3. The Legislature could recognize that some level of service to our citizens is required to keep our vulnerable citizens from health and safety risk. The Legislature could require that the DHHS submit a business plan identifying how these services could be delivered in a more cost effective manner.

Joan Churchill, M.S., CADC

Director of Development

Community Concepts, Inc.

17-19 Market Square, PO Box 278

South Paris, ME 04281

Orbeton, Jane

From: Cote, Lisa
Sent: Tuesday, January 17, 2012 4:16 PM
To: Broome, Anna; Cote, Lisa; Craven, Sen. Margaret ; Eves, Rep. Mark; Farnham, Sen. Nichi; Fossel, Rep. Les; Malaby, Rep. Richard; McCormick, Sen. Earle; Nolan, Christopher; O'Connor, Rep Beth ; Orbeton, Jane; Peterson, Rep. Matthew; Sanborn, Rep. Linda; Sanderson, Rep. Deborah ; Sirocki, Rep. Heather ; Strang Burgess, Rep. Meredith; Stuckey, Rep. Peter
Subject: FW: Savings

Lisa Cote
Health and Human Services Committee Clerk
Maine State Legislature
100 SHS Augusta, ME 04333
Room 209 Cross State Office Building
(207) 287-1317
FAX (207) 287-1457

From: Karen Higgins [mailto:khiggins@pshouse.org]
Sent: Tuesday, January 17, 2012 9:48 AM
To: Cote, Lisa
Subject: Savings

A few years ago the State started using Goold to do assessments. Prior to that each facility did their own. When the State came in to see how many people we had assessed ourselves that weren't appropriately placed, they found absolutely no one at this level of care that didn't belong here. My suggestion would be to give us a tool if you want to control the assessment, but let us do it ourselves. This would be a huge savings to the State. This would also save time as often we have to wait on Goold.

Karen Higgins
Executive Director, Phillips-Strickland House
21 Boyd Street, Bangor ME 04401
khiggins@pshouse.org

Orbeton, Jane

From: Richard Erb <rerb@mehca.org>
Sent: Friday, January 13, 2012 12:04 PM
To: earlmccormick; nichi@aol.com; Craven, SenMargaret; StrangBurgess, RepMeredith; StrangBurgess, RepMeredith (FWD); Fossel, RepLeslie; Malaby, RepRichard; OConnor, RepBeth (FWD); OConnor, RepBeth; Mathew Peterson
Subject: Question on PNMI Tax Revenue

There was a question to DHHS regarding the PNMI tax that received a response on 1/3/12:

19. When the administration figured the savings from closing PNMIs did they account for the loss of PNMI provider tax? If so, how was that calculated? If not, why not?

Response: The PNMI Tax reduction was included in the initiative for PNMIs. We lowered the PNMI Tax based on the percent drop in the program from the expected drop in expenditures.

I was recently in contact with the Maine Revenue Service on this. Jerome Stanhope estimates that the PNMI tax generates $15.6 million annually. If under the current proposal all PNMIs are eliminated (except possibly children's facilities), wouldn't that mean that this revenue would be lost? Conversely, if PNMI funding is restored, shouldn't most of this revenue also be restored? Please consider this in your discussions next week. Thank you.

Rick

To: Members of the Joint Standing Committee on Health and Human Services
Fr: Hilary Schneider, American Cancer Society (ph: 373.3707,
email: hilary.schneider@cancer.org)
Date: January 18, 2012
Re: Potential Savings Initiatives

At the worksession on Wednesday, January 18 on the Governor's Proposed Supplemental Budget, Representative Strang Burgess said the Committee is accepting ideas from interested parties about potential savings initiatives that could be considered by the Appropriations Committee. In my testimony at the public hearings in December, I provided the following savings proposals for consideration: improvements in care management, including ensuring that members are receiving evidence-based care, further implementation of medical homes, and providing access to coverage for palliative care and an enhanced tobacco cessation benefit are all ways in which care can be improved and MaineCare costs lowered/savings achieved.

This memo is intended to provide further information on some of the options outlined above.

Palliative Care Programs

Palliative care is care given by specialized health professionals to improve the quality of life of individuals and families who face a serious illness, like cancer. It focuses on relief from symptoms, pain, and stress – whatever the diagnosis. The goal is to improve quality of life for both patient and family. While many people think that palliative care is the same as hospice care or end-of-life care, this is not true. While they have similarities, palliative care is given throughout a patient's illness, while hospice care is given near the end of life. However, both focus on improving the quality of life of the patient while they are living.

A growing number of studies have found that broader implementation and use of interdisciplinary palliative care programs provide a way to improve quality and reduce cost for some of the most seriously ill Medicaid patients. A study published in *Health Affairs* in March 2011 examined the effect on hospital costs of palliative care for Medicaid patients at four New York State hospitals. The study found that, on average, patients who received palliative care incurred $6,900 less in hospital costs during a given admission than a matched group of patients who received usual care. The study's authors estimated that New York could eventually see reductions in Medicaid hospital spending of $84 million to $252 million annually through the use of palliative care consultation teams in every hospital with 150 or more beds. The main savings come from shortening hospital stays and keeping patients out of the Intensive Care Units. The researchers also stated that targeted access to palliative care could lead to savings for state Medicaid programs beyond the hospital costs evaluated in the study and could reduce pressures to cut other important Medicaid services. They went on to say that "the contribution of palliative care teams are key to reducing readmissions, emergency department visits, and unnecessary inpatient and outpatient services, and they need further evaluation." The full study can be found at: http://content.healthaffairs.org/content/30/3/454.full.pdf+html.

It is important to note that other studies have found that advanced cancer patients who received early palliative care in combination with standard care not only reported increased quality of life, but also lived longer than those who did not receive palliative care.

Tobacco Cessation Coverage

As stated in my testimony at the public hearings in December, studies of the Massachusetts Medicaid tobacco cessation benefit found that a positive return on investment happens within one year. A recent study of this benefit by George Washington University found a $2.21 net gain for every $1.00 spent on the Massachusetts Medicaid cessation benefit, which is a more comprehensive benefit than Maine's benefit. Tobacco use is the leading preventable cause of death. Tobacco use increases the risk of at least 15 types of cancer. Thirty percent of all cancer deaths, including 87 percent of lung cancer deaths, can be attributed to using tobacco. Thirty percent of all cancer deaths are due to tobacco use alone. According to the US CDC, 10.6% of MaineCare expenditures, equivalent to $216 million, are attributed to tobacco use. According to the 2008 Maine CDC Behavioral Risk Factor Surveillance System survey (BRFSS), 76% of MaineCare smokers have a desire to quit smoking. Moreover, individuals who have health coverage for cessation services are 40% more likely to quit smoking successfully. The tobacco cessation benefit in MaineCare should be heavily promoted to members and improved (by reducing remaining barriers to utilizing the benefit), instead of reduced. This could result not only in improved health outcomes for MaineCare members, but also cost savings.

Thank you for the opportunity to provide this information on potential savings initiatives. Please let me know if you have questions or need further information.

Orbeton, Jane

From: Cote, Lisa
Sent: Wednesday, January 18, 2012 11:06 AM
To: Broome, Anna; Cote, Lisa; Craven, Sen. Margaret ; Eves, Rep. Mark; Farnham, Sen. Nichi; Fossel, Rep. Les; Malaby, Rep. Richard; McCormick, Sen. Earle; Nolan, Christopher; O'Connor, Rep Beth ; Orbeton, Jane; Peterson, Rep. Matthew; Sanborn, Rep. Linda; Sanderson, Rep. Deborah ; Sirocki, Rep. Heather ; Strang Burgess, Rep. Meredith; Stuckey, Rep. Peter
Subject: FW: Ideas for Savings from within DHHS to replace savings from the PNMIs
Attachments: Scan f001.pdf; Social Services GA Legislative testimony on LD 1370 MWDA bill 2011.doc; Social Services GA Legislative testimony on LD 539 MMA bill 2011.doc

Lisa Cote
Health and Human Services Committee Clerk Maine State Legislature
100 SHS Augusta, ME 04333
Room 209 Cross State Office Building
(207) 287-1317
FAX (207) 287-1457

-----Original Message-----
From: Sue Charron [mailto:SCharron@lewistonmaine.gov]
Sent: Wednesday, January 18, 2012 10:52 AM
To: Cote, Lisa
Subject: Ideas for Savings from within DHHS to replace savings from the PNMIs

Ms. Cote,
I was forwarded an e-mail from Jane Oberton stating that "...the HHS Committee, in working budget issues this week, will be discussing savings from within DHHS to replace savings from the PNMIs. I expect the "other savings" items to come up late on Wednesday. If you have ideas for savings from within DHHS that you wish the HHS Committee to consider, please place them in written form and...:"

I am the social services director for the city of Lewiston, and I am requesting that this e-mail along with the attached information be delivered to the HHS committee for consideration. I am attaching my previous testimonials on LDs1370 and 539 which address the General Assistance program and potential savings to both the state and the municipalities. These proposals were in front of the HHS committee last session, but I am hoping they might be reconsidered.
I am also attaching my scanned letter that I sent to Representative Dennis Keschl on 1/17/2012 regarding LDs 1680, 1693 and 1725, which all have the potential of being intertwined with the GA program to increase savings and accountability. I realize the GA budget is a small piece of the HHS budget and even a smaller piece of the entire budget, but every bit of savings should be considered.
The important thing for our legislators to keep in mind is that is that when the state implements changes to its programs (i.e. implementing the TANF 60-month time limit and eliminating state benefits for non-qualified persons) it shifts the cost to the municipalities; and the state still ends up spending money in reimbursements to the GA program at either 50 or 90%. The more money the municipality spends the sooner the municipalities reach the 90% reimbursement rate, and that equates to more money being spent by the state.
I am already serving clients who are no longer eligible for state funded TANF benefits, and I am receiving applications from clients who will be losing their TANF in the coming months as they will be reaching or surpassing their 60-month time limit.

Best regards,
Sue Charron

-----Original Message-----
From: Sue Charron
Sent: Tuesday, January 17, 2012 4:52 PM
To: keschl@yahoo.com; 'RepDennis.Keschl@legislature.maine.gov'
Subject: FW:Letter from Sue Charron RE: LD 1680;1693 and 1725. Attachment on LD1370

Representative Keschl,
I had the pleasure of serving with you on the Governor's Streamline Task Force, and at your request I sent you some testimony that I had previously presented to the HHS and Appropriations committees. I am not sure if you have read them as yet, but when I found out you were sponsoring LD1693, I had to send along a letter supporting the LD, but also requesting an expansion to the proposal. In my letter I also mention LD1680 and my support for LD 1725, but the language in LD 1725 must include General Assistance in order to avoid an increase in the municipal expenditures.
I have also attached my testimony on LD1370 talking about circuitbreaker and Unemployment benefit proposals.
I eagerly await your response and hope that we can have a dialogue soon.
Best Regards,
Sue

-----Original Message-----
From: printer@lewistonmaine.gov [mailto:printer@lewistonmaine.gov]
Sent: Tuesday, January 17, 2012 4:35 PM
To: Sue Charron
Subject: Scan from a Samsung MFP

Please open the attached document. It was scanned and sent to you using a Samsung MFP. For more information on Samsung products and solutions, please visit http://www.samsungprinter.com.

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Social Services Department
Sue Charron
Social Services Director

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January 17, 2012

Dennis Keschl
Appropriations and Financial Affairs Committee
Augusta ME 04330

RE: LDs: 1693, 1680, and 1725

Dear Representative Keschl:

I had the pleasure of serving with you on the Governor's Streamline and Prioritize Core Government Services Task Force this past year, and at your request I e-mailed you some of my testimony regarding various LDs, that were presented to the Health and Human Services and Appropriations and Financial Affairs Committees in 2011, concerning the General Assistance (GA) program. At your request, I also sent along some of the concerns the City of Lewiston is dealing with regarding the refugee population. I am not sure if you have had the opportunity to read any of the proposals, but Included in my testimonial regarding LD 1370, is proposed language concerning the circuit breaker program, and unemployment benefits (forfeits or causes a reduction in benefits) as they relate to the GA program. I have copied both of those proposals to this letter. I am also attaching my entire testimony on LD1370 just in case it was lost in the mountains of e-mails that you must receive on a daily basis. I am hoping that at some point these proposals might resurface and be viewed as responsible measures to assist in balancing the state budget.

I am truly encouraged by the fact that you are sponsoring LD1693, An Act To Amend the Law Governing Abatements of Property Taxes for Infirmity or Poverty, and I respectfully request that you consider broadening the requirements proposed in LD 1693. I will briefly mention LD 1680, An Act to Amend the Circuitbreaker Program To Include Claimants Occupying Property Pursuant to a Trust and To Require Proof of Payment of Rent, because the additional requirements that I am requesting could be added to the language in either LD 1680 or 1693.

LDs 1693 and 1680 address some of the concerns that I and other municipal General Assistance (GA) administrators spoke about in our testimonials regarding the circuit breaker program, and those proposals are to be applauded; however the requirements must be broadened to include the GA program– specifically counting the refund as income when determining GA eligibility.

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Sue Charron
Social Services Director

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I also want to bring your attention to LD1725, An Act To Strengthen the Unemployment Insurance Laws and Reduce Unemployment Fraud, and respectfully request that you advocate for broadening these requirements to also include the GA program– specifically counting the refund as income when determining GA eligibility. Furthermore, the requirements in LD1725 must be defined in such a way that if the proposals regarding tiered penalties are approved, the tiered penalties must also be applied to the GA program.

It must be remembered that when a federal or state program undergoes changes, those changes tend to shift the cost to the municipalities and impact the local taxpayers. Each of these LDs, if expanded upon, would save the municipalities and the state money.

- **LD1370 testimony regarding the circuit breaker program dated 4/26/2011:**

Sec. 9. 36 MRSA §6216, 2nd ¶, as amended by PL 1989, c. 614, is further amended to read:

Benefits received under this chapter may ~~not~~ be included as income for purposes of any state or municipally administered public benefit program ~~but may be considered~~and as income for purposes of determining eligibility for abatement under section 841, subsection 2.

Maine Residents Property Tax Refund (Circuit breaker Program): Under existing law, the Maine Residents Property Tax Refund is prohibited from being used as income in determining an applicant's GA eligibility. However, under existing law, the refund is allowed to be used as income in determining an applicant's eligibility for a poverty abatement.

Whether an applicant's property taxes are abated or an applicant receives GA, municipal and state taxpayers are impacted, and the same rules regarding income should be applied.

I have no problem with applicants using the rebate to "catch up" and pay back property taxes or rent for a period in which they were unable to pay for those expenses (we do allow for this), but I have difficulty ignoring the benefit when calculating GA eligibility in situations where there is no arrears.

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What is fair about one person acting responsibly and using the benefit to pay on back or current property taxes or rent, while another person uses the benefit to pay for other things, just because s/he can; and still be eligible for tax payer money to be allocated for a mortgage or rental payment that s/he could have paid? The benefits should be used toward property taxes or rental payments.

This proposal would reduce GA expenses by as many clients that we can verify are receiving the refund. The amount of the reduction would depend on how many clients we can track and how large the refund is.

A suggestion is to implement a tracking system between the municipalities and the state whereby the municipality could input an identifying number and be able to see the date and amount of the refund (similar to tracking unemployment Insurance benefits).

Additionally, all municipalities should report delinquent taxpayers to the state so that the state can track them and then send refunds directly to the municipality. I have had several poverty abatement applicants receive the refund and not use it for their taxes.

- ***LD1370 testimony regarding unemployment benefits dated 4/26/2011:***

Sec. 8. 22 MRSA §4317, 4th ¶, as amended by PL 1993, c. 410, Pt. AAA, §11, is further amended to read:

An applicant who forfeits receipt of or causes reduction in benefits from another public assistance program <u>or private assistance program, including but not limited to unemployment insurance benefits,</u> because of fraud, misrepresentation or a knowing or intentional violation of program rules or a refusal to comply with program rules without just cause is not eligible to receive general assistance to replace the forfeited assistance for the duration of the forfeiture.

<u>Forfeits or causes a reduction in benefits</u>: Under existing law, an initial applicant is held accountable for fraud and for committing work violations without just cause. An initial applicant who forfeits receipt of or causes a reduction in benefits from another public assistance program <u>or</u> private assistance program, including but not limited to unemployment insurance benefits, <u>must be held to the same standards.</u>

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Social Services Director

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Current law only addresses the forfeiture or reduction of public benefits. Hence the law is interpreted in such a way that private benefits are excluded. The result is that an

applicant, initial or repeat, who forfeits or causes a reduction in benefits from a private source, particularly Unemployment Insurance, is not held accountable. GA cannot use the forfeited or reduced Unemployment Insurance benefits in determining eligibility as we can with TANF and other public benefits.

What is fair about penalizing a TANF recipient for forfeiting or causing a reduction in benefits, and not penalizing an individual who forfeits or causes a reduction in benefits
from a private program, particularly Unemployment Insurance?

You will hear the argument that it is unfair to penalize initial applicants for something they did prior to applying for GA, and had no way of knowing how that would impact their eligibility for GA. Why is it fair for an initial applicant to be disqualified for quitting or being terminated from a job, but it is not fair for an initial applicant to be disqualified for forfeiting or causing a reduction in benefits. Penalizing an initial applicant for forfeiting or causing a reduction in public and private benefits without just cause is fair—it is common sense.

I thank you for taking the time to read my letter. I am hoping that you and other legislators would be willing to assist the municipalities in building accountability and uniformity into the GA program, in a fiscally responsible manner, while continuing to serve our most vulnerable populations.

Sincerely,

Sue Charron

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Testimony of the City of Lewiston

LD 539
An Act to Build Accountability into the General Assistance Laws

April 26, 2011

Senator McCormick, Representative Strang Burgess, members of the Health and Human Services Committee, my name is Sue Charron and I am the Social Services Director for the City of Lewiston. I am providing testimony in **support of LD 539 on behalf of the City of Lewiston.**

Under existing law, an initial applicant is held accountable for committing fraud and violating work violations. Therefore, an initial applicant who forfeits receipt of or causes a reduction in benefits from an available resource because of fraud, misrepresentation or a knowing or intentional violation of available resource rules, or a refusal to comply with available resource rules without just cause, **must be held to the same standards.**

Additionally, an applicant who abandons or refuses to use an available resource without just cause should not be eligible to receive general assistance to replace the forfeited benefits for either the duration of the forfeiture or 120 days, whichever is greater. I would go even one step further and suggest that the proposed disqualification period of 120 days in LD 539 **be extended to 180 days in order to be consistent with the proposals in LD1370.**

Available resources are defined as including but are not limited to any **private, local, regional or countybased assistance, state or federal assistance**, housing, employment, **unemployment benefits** or food assistance program that the applicant is receiving or immediately eligible to receive. Available resources also include services, commodities or facilities made available by private organizations when the services, commodities or facilities are available and offered at no cost to the applicant.

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Current law only addresses the forfeiture or abandonment of a public resource. Hence the law is interpreted in such a way that private resources are excluded. The result is that an applicant, initial or repeat, who forfeits or causes a reduction in benefits from a private source, **particularly Unemployment Insurance**, is not held accountable. **GA cannot use the forfeited or reduced Unemployment Insurance benefits in determining eligibility as we can with TANF and other public benefits.**

What is fair about penalizing a TANF recipient for forfeiting or causing a reduction in benefits, and not penalizing an individual who forfeits or causes a reduction in benefits? from a private program, particularly Unemployment Insurance?

You will hear testimony opposing this bill as some mistakenly believe that GA will use the Federal Food Supplement as an available resource and because of that applicants will be denied food assistance from GA. We are restricted from using the Federal Food Supplement as a resource and this proposal will not change that; if an applicant has a deficit after GA assists with rent and utilities, the applicant is entitled to receive food assistance and is not referred to a food bank to replace the deficit

You will hear testimony opposing this bill as some mistakenly believe that applicants will be referred to shelters instead of GA assisting with stable housing. If an applicant is eligible for GA, s/he is advised to find affordable housing; referrals to shelters are made in emergency situations and are not intended to be long term solutions. This proposal will not change this procedure.

You will hear the argument that it is unfair to penalize initial applicants for something they did prior to applying for GA, and had no way of knowing how that would impact their eligibility for GA. Why is it fair for an initial applicant to be disqualified for quitting or being terminated from a job, but it is not fair for an initial applicant to be disqualified for forfeiting or causing a reduction in benefits, or for abandoning or refusing to use a resource? Penalizing an initial applicant for abandoning a resource without just cause is fair—it is common sense.

You will hear that poverty causes people to sometimes act in certain ways. The consequences of poverty are many, but it is a disservice to low income people to insinuate that they have a lesser ability than others to use common sense. Just cause does not equate to a lack of common sense.

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This proposal would affect the new applicant who left a subsidized apartment in Maine or out of state (the same penalty applies to residents and non-residents) without "good cause." It would also affect the repeat applicant who left a subsidized apartment without "good cause." It would affect the new applicant who leaves a treatment program against medical advice. Without treatment the probability of the applicant remaining on GA for an extended period of time is very high. It would not affect the applicant who can show good cause.

You will hear concerns regarding GA not being administered uniformly across the state. You will hear that some of the GA administrators do not have the ability to determine "good cause," and that some of the administrators are not in compliance with GA law. Ignoring accountability, which results in increased state and municipal expenses, is not going to address the uniformity and compliance issues. That is not to say that we take the uniformity and compliance concerns lightly, we take them very seriously and we continue to extend our assistance in collaborating with DHHS, the GA administrators and the full time advocates to ensure the program is administered as intended. Since GA is intended to be the last resort, replacing an abandoned or forfeited resource with GA, disregards the intent of the program and is fiscally irresponsible.

On behalf of the City of Lewiston, I thank you for this opportunity to share our comments regarding the general assistance proposals in LD 539. The City of Lewiston requests that you seriously consider what the GA program is intended to be□a safety net for our most vulnerable residents who are unable through no fault of their own to provide basic necessities for themselves or their families. The program is not intended to assist applicants who intentionally violate program rules or abandon resources without just cause. It is imperative that accountability be built into the GA program and that the program be administered in a fiscally responsible manner.

SUMMARY

This bill makes both initial and repeat applicants for general assistance who voluntarily voluntarily abandon government or private resources without just cause ineligible to receive general assistance to replace the abandoned assistance for a period of 120 days from the date the applicant abandons the resource. The bill also makes an applicant who forfeits government or private resources due to fraud, misrepresentation or intentional violation or refusal to comply with program rules without just cause ineligible to receive general assistance to replace the forfeited assistance for the duration of the forfeiture or 120 days, whichever is greater. Current law provides that an applicant who forfeits government resources is ineligible to receive general assistance for the duration of the forfeiture.

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Orbeton, Jane

From: Meredith Strang Burgess <msblegislature@maine.rr.com>
Sent: Wednesday, January 18, 2012 4:21 PM
To: Nadeau, Stefanie; Orbeton, Jane
Cc: earlmccormick
Subject: LD 1055
Attachments: cf124-LD-1055.pdf; ATT141218.htm

Hi Stephanie and Jane,

Per our conversation today, I would like to propose that perhaps instead of, or if the MOE is not granted, that the state consider implementation parts of my bill, LD 1055 from the 124th Legislature. It related to the creation of co-pays with certain restrictions on the various medical services offered to MaineCare recipients. You will see that the bill also proposed a pharmacy co-pay, but hopefully we have dealt with this issue in a proactive way with the passage of LD 346 in the first session of the 125th....if we can ever get that implemented!

Attached is the official file from LD 1055. You may find some parts of the testimonies of interest. Note that there is a Fiscal note on page 59.....but I will add that the department at that time was not "motivated" to make this idea to seem at all interesting and I believe low balled the projected savings.....and the projected savings that would come from a huge behavior shift is also not accounted for. There are some interesting charts from MEJP as well on page 45/46.

Thanks!!

Meredith

Representative Meredith Strang Burgess

House District 108

Cumberland, Chebeague Island, Long Island, and part of North Yarmouth

House Chair of the Joint Standing Committee on Health and Human Services

HOUSE OF REPRESENTATIVES

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RepMeredith.StrangBurgess@legislature.maine.gov

www.meredithformaine.com

BUSINESS

124th MAINE LEGISLATURE

FIRST REGULAR SESSION-2009

Legislative Document **No. 1055**

H.P. 730 House of Representatives, March 17, 2009

An Act To Alter MaineCare Benefits as Allowed by the Federal Deficit Reduction Act of 2005

Reference to the Committee on Health and Human Services suggested and ordered printed.

Millicent M. MacFarland

MILLICENT M. MacFARLAND
Clerk

Presented by Representative STRANG BURGESS of Cumberland.
Cosponsored by Senator MILLS of Somerset and
Representatives: CURTIS of Madison, LEWIN of Eliot, MILLETT of Waterford, NUTTING of Oakland, RICHARDSON of Carmel, TARDY of Newport, Senators: COURTNEY of York, ROSEN of Hancock.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §3173-C, as amended by PL 2007, c. 240, Pt. GGG, §1, is further amended to read:

§3173-C. Copayments

1. Authorization required. The department may not require any MaineCare member, referred to in this section "member," to make any payment toward the cost of a MaineCare service unless that payment is specifically authorized by this section, except that any copayment or premium expressly approved by the federal Secretary of the Department of Health and Human Services as part of a waiver must be implemented.

2. Prescription drug services. Except as provided in subsections 3 and 4, a payment of $3.00 for each drug is to be collected from the ~~MaineCare~~ member for each drug prescription that is an approved MaineCare service. Copayments must be capped at $30 per month per member. If a member is prescribed a drug in a quantity specifically intended by the provider or pharmacist, for the recipient's health and welfare, to last less than one month, only one payment for that drug for that month is required.

3. Exemptions. No copayment may be imposed with respect to the following services:

A. Family planning services;

B. Services furnished to individuals under 21 years of age;

C. Services furnished to any individual who is an inpatient in a hospital, nursing facility or other institution, if that individual is required, as a condition of receiving services in that institution, to spend for costs of care all but a minimal amount of income required for personal needs;

D. Services furnished to pregnant women, and services furnished during the post-partum phase of maternity care to the extent permitted by federal law;

E. ~~Emergency~~ Except as applied to nonemergency use of emergency services, emergency services, as defined by the department;

F. Services furnished to an individual by a Health Maintenance Organization, as defined in the United States Social Security Act, Section 1903(m), in which ~~he~~ the individual is enrolled; and

G. Any other service or services required to be exempt under the provisions of the United States Social Security Act, Title XIX and successors to it.

4. Persons in state custody. Any copayment imposed on a Medicaid recipient in the custody of the State is to be collected from the state agency having custody of the recipient.

~~**7. Copayments.** Notwithstanding any other provision of law, the following copayments per service per day are imposed and reimbursements are reduced, or both, to the following levels:~~

~~A. Outpatient hospital services, $3;~~

~~B. Home health services, $3;~~

~~C. Durable medical equipment services, $3;~~

~~D. Private duty nursing and personal care services, $5 per month;~~

~~E. Ambulance services, $3;~~

~~F. Physical therapy services, $2;~~

~~G. Occupational therapy services, $2;~~

~~H. Speech therapy services, $2;~~

~~I. Podiatry services, $2;~~

~~J. Psychologist services, $2;~~

~~K. Chiropractic services, $2;~~

~~L. Laboratory and x-ray services, $1;~~

~~M. Optical services, $2;~~

~~N. Optometric services, $3;~~

~~O. Mental health clinic services, $2;~~

~~P. Substance abuse services, $2;~~

~~Q. Hospital inpatient services, $3 per patient day;~~

~~R. Federally qualified health center services, $3 per patient day, effective July 1, 2004; and~~

~~S. Rural health center services, $3 per patient day.~~

~~The department may adopt rules to adjust the copayments set forth in this subsection. The rules may adjust amounts to ensure that copayments are deemed nominal in amount and may include monthly limits or exclusions per service category. The need to maintain provider participation in the Medicaid program to the extent required by 42 United States Code, Section 1392(a)(30)(A) or any successor provision of law must be considered in any reduction in reimbursement to providers or imposition of copayments.~~

8. Copayments. Notwithstanding any other provision of law, copayments to be paid by members are subject to the provisions of this subsection. In accordance with this subsection a provider may charge a copayment to a member and, if the member does not pay the copayment, the provider may refuse to provide the service or item for which the copayment was charged.

A. Copayments may not be charged to the following populations:

(1) Children who have not attained 6 years of age whose family incomes are below 133% of the nonfarm income official poverty line;

(2) Children 6 years of age and older and under 19 years of age whose family incomes are below 100% of the nonfarm income official poverty line;

(3) Pregnant women and women who are within 60 days of having delivered a child;

(4) Recipients of federal supplemental security income benefits;

(5) Women being treated for breast or cervical cancer;

(6) Children in foster care and adoption assistance programs under chapter 1071; and

(7) Members who reside in licensed residential facilities run by or contracted for by the State in which the residents are subject to a personal needs allowance under rules adopted by the department.

B. Copayments may not be charged for pregnancy-related services, family planning services, hospice care or preventive services for children who have not attained 18 years of age.

C. For members whose income is below 100% of the nonfarm income official poverty line, copayments are limited to nominal amounts as determined by rule adopted by the department and may not be required in order for the member to receive the service or item.

D. Except as otherwise provided in this paragraph, copayments must be charged by providers of services and items, and reimbursements are reduced as follows.

(1) For members whose income is between 100% and 150% of the nonfarm income official poverty line, except as otherwise provided in this subparagraph, copayments are set at 10% of the cost of the service or item. For nonemergency use of emergency services, copayments are set at twice the amount otherwise applicable to the emergency service. The hospital must screen the member for the purposes of determining the member's health condition prior to requiring payment of the nonemergency use copayment. The hospital must inform the member of the increased copayment applicable to the member's nonemergency use of emergency services and must provide information about nonemergency providers who could provide appropriate health care services to the member.

(2) For members whose income is above 150% of the nonfarm income official poverty line, except as otherwise provided in this subparagraph, copayments are set at 20% of the cost of the service or item. For nonemergency use of emergency services, copayments are set by rule adopted by the department. The hospital must screen the member for the purposes of determining the member's health condition prior to requiring payment of the nonemergency use copayment. The hospital must inform the member of the increased copayment applicable to the member's nonemergency use of emergency services and must provide information about nonemergency providers who could provide appropriate health care services to the member.

E. Copayments for prescription and over-the-counter drugs that are subject to the formulary standards of section 3174-M, subsection 1-A are subject to the provisions of this subsection.

(1) For all members, copayments for preferred drugs are limited to the amounts determined by rule adopted by the department.

(2) For members whose family income is below 150% of the nonfarm income official poverty line, copayments for drugs are limited to nominal amounts.

(3) For members whose family income is at or above 150% of the nonfarm income official poverty line, copayments for drugs are set at 20% of the cost of nonpreferred drugs and 10% of the cost of preferred drugs.

(4) For all members, copayments at the higher rate applicable to nonpreferred drugs must be waived when the prescribing health care practitioner determines that the preferred drug is less effective for the member or will have an adverse health impact on the member and informs the department of that determination.

F. For all members, copayments and premiums are limited to an aggregate limit of 5% of family income over a 3-month period.

9. Premiums. Premiums for health coverage are subject to the provisions of this subsection.

A. Premiums may not be charged to the following populations:

(1) Children who have not attained 6 years of age whose family incomes are below 133% of the nonfarm income official poverty line;

(2) Children 6 years of age and older and under 19 years of age whose family incomes are below 100% of the nonfarm income official poverty line;

(3) Pregnant women and women who are within 60 days of having delivered a child;

(4) Recipients of federal supplemental security income benefits;

(5) Women being treated for breast or cervical cancer;

(6) Children in foster care and adoption assistance programs under chapter 1071;

(7) Members who reside in licensed residential facilities run by or contracted for by the State in which the residents are subject to a personal needs allowance under rules adopted by the department; and

(8) Members whose family income is below 150% of the nonfarm income official poverty line.

B. For members whose family income is at or above 150% of the nonfarm income official poverty line, premiums are set at amounts to be determined by the department by rule.

C. For all members, copayments and premiums are limited to an aggregate limit of 5% of family income over a 3-month period.

D. The department shall suspend coverage for a member who is more than 60 days in arrears in the payment of premiums required by this subsection.

10. Nonemergency use of emergency services. As used in this section, "nonemergency use of emergency services" means use of emergency services in a

hospital for care or treatment other than for an emergency medical condition, as defined in the federal Balanced Budget Act of 1997, Public Law 105-33, 111 Stat. 251.

11. Rulemaking. The department shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 2. Rulemaking. By January 1, 2010, the Department of Health and Human Services shall adopt rules to implement this Act.

Sec. 3. Effective date. This Act takes effect October 1, 2009.

SUMMARY

This bill imposes cost sharing in the form of premiums and copayments for services, items and prescription drugs in the MaineCare program consistent with the provisions of the federal Deficit Reduction Act of 2005.

Suggestions for DHHS savings.

1. Move MaineCare to payor of last resort. Employees of companies which offer group insurance must accept and enroll in that program and can not remain on MaineCare - or pay a buy in.

2. REQUALIFY ME Care members every 3 yrs on a staggered basis

3. Reevaluate the efficacy of our methadone program. Payments to providers for counseling must reflect the effort. Group counseling reimbursements must be much less than individual counseling rates. We should be looking at dosage patterns, as Southern Me institutions provide much higher dosages and do not even entertain the notion of tapering.

Furthermore

4. Establish equal reimbursements to providers based on acuity to mental health counselors.

Submitted By Rep Malaby

Orbeton, Jane

From: Meredith Strang Burgess <msblegislature@maine.rr.com>
Sent: Wednesday, January 18, 2012 5:07 PM
To: Orbeton, Jane
Subject: My ideas for cost savings

Hi Jane,

Here are my ideas for potential cost savings to the state:

1) Implement Co-pays to the max allowed for all MaineCare medical services. (LD 1055)

2) Implement/expand Targeted Case Management immediately to the top 5% of MC users.

3) Research other innovative ways to save healthcare costs through other management ideas.....such as the study under way in New York state on the savings from TCM around palliative care.
See: **http://blogs.wsj.com/health/2011/03/08/study-palliative-care-for-medicaid-patients-reduces-their-hospital-costs/**

And lastly.....I can't resist the chance to also add my bill LD 1226 from the first session of the 125th legislature which proposes to "equalize" the tax on raw tobacco and other related products that up to this point are not taxed the same as cigarettes. Thus creating an unfair competitive advantage. Tobacco creates huge healthcare costs and it seems appropriate to equalize the tax and use it towards the cost of healthcare or prevention. It was estimated that this tax change could generate up to 4 million or more per year.

Thanks!!

Meredith

Representative Meredith Strang Burgess

House District 108

Cumberland, Chebeague Island, Long Island, and part of North Yarmouth

House Chair of the Joint Standing Committee on Health and Human Services

HOUSE OF REPRESENTATIVES

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