Proposed Committee Amendment to LD 1487
An Act to Implement Managed Care in the MaineCare Program
From Senator Roger Katz, February 25, 2014

Amend the bill by striking the title and inserting a new title to read: “An Act to Provide Fiscal Predictability to the MaineCare Program and Health Security to Maine People.”

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

PART A

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

§ 3174-WW. Patient-centered MaineCare reform

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

A. “Department” means the Maine Department of Health and Human Services.

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

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

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

A. The following members must be enrolled in year one of the implementation of managed care and in each year thereafter: persons who are eligible for MaineCare under section 3174-G, subsection 1, paragraphs A, E, G, H and I, and nondisabled children who are eligible under section 3174-G, subsection 1, paragraphs B or D.

B. All of the remaining eligibility groups under section 3174-G may be required to enroll in the managed care program after the first year of implementation and in subsequent years after the department has sought stakeholder input, approval from the federal Department of Health and Human Services, Centers for Medicare and

Medicaid Services and after major substantive rulemaking.

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

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

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

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

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

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

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

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

(1) Accreditation by a nationally recognized accrediting body;

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

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

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

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

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

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

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

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

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

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

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

(1) That the managed care plan participate in and coordinate with departmental efforts in health care payment reform including value based purchasing; quality improvement; delivery system improvement; improvement in patients' experience of care; participation in other departmental initiatives, including the State Innovation Model grant initiative; and participation in the Maine Primary Care Medical Home initiative, including the financial support of qualifying Primary Care Medical Homes. The department may require the managed care plan to participate in initiatives regarding compensation for physicians for coordination of care; management of chronic disease; and avoidance of the need for more costly services; Managed care plans must

(2) That each approved plan meet a minimum medical loss ratio of at least 85% as defined in rules adopted by the department. Rules adopted pursuant to this subdivision are major substantive as defined in Title 5, chapter 375, subchapter 2-A. In adopting rules pursuant to this subdivision the department must be guided by Section 2718 of the Public Health Service Act and its implementing regulations and must seek input from the stakeholder group convened to provide input on capitated managed care.

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

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

(a) A list of contracted providers, including whether the provider is currently accepting new MaineCare patients as of the most recent information made available to the managed care plan and, to the extent available to the managed care plan, information about licensure or registration, locations and hours of operation and specialty credentials and other certifications that allows comparison of providers to network adequacy standards and that accepts and displays feedback from patients satisfaction information;

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

(6) That the managed care plan establish and maintain an encounter data system to

collect, process, store and report to the department for all MaineCare members enrolled in the plan;

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

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

(b) A managed care plan must be accredited by a nationally recognized accrediting body, or have initiated the accreditation process, within one year after the contract with the department is executed and must meet the requirements for external quality review.

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

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

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

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

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

(13) That, during a transition period to be determined by the department with stakeholder input, a managed care plan must contract with any existing and qualified provider willing to accept the terms, conditions and rates associated with the Medicaid managed care plan. After the transition period, the standards must allow managed care plans to limit providers in their networks based on credentials, quality indicators, and price provided that no limitation permitted by this subparagraph may be construed to modify or excuse noncompliance with the access standards established pursuant to 5(B)(3), including without limitation access to family planning and family planning related services. In addition, after the transition period, the managed care plan must contract with any willing and qualified provider who is a federally qualified health center, rural health clinics, school-based health clinics, and a provider who serves high-risk populations or specialize in conditions that require costly treatment. The department shall adopt rules to implement this subdivision. Rules adopted pursuant to this subdivision are major substantive rules as defined by Title 5, chapter 375, subchapter 2-A.

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

(15) That a managed care plan must provide that the commissioner and the medical director of MaineCare program have the authority to override any denial of care by the managed care on the basis of medical necessity;

(16) That a managed care plan must provide that MaineCare members enrolled in the plan and providers be third party beneficiaries under any contract between the plan and the department;

(17) That a managed care plan must be subject to financial consequences, backed by a

performance bond or similar guarantee, for failure to meet quality standards, access standards, patient satisfaction standards and other requirements of law or rule or of the contract between the department and the managed care plan;

(18) That a managed care plan is subject to the jurisdiction and oversight of the Maine
Bureau of Insurance and must comply with provisions of title 24-A, including Chapter 56-A;

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

(20) That a managed care plan may allow for cost sharing in accordance with the provisions of 42 United States Code § 1396o.

(21) That a managed care plan must provide a reasonable contribution to pay for the funding of the ombudsman program under subsection 7.

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

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

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

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

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

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

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

(1) The plan does not cover a service the member seeks due to religious or moral objections;

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

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

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

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

7. Ombudsman program. The department shall ensure the establishment of an external and independent ombudsman who is not within the control of the managed care plans. The ombudsperson shall identify and report to the department and the committee of jurisdiction within the Legislature on systemic issues and possible solutions to those issues and be able to assist MaineCare members and providers with grievances and appeals either within the ombudsman program or under contract with an external entity. The department and any plan that provides services to MaineCare members must provide de-identified data to the ombudsperson as necessary for the ombudsperson to carry out the functions of the position required by this paragraph.

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

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

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

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

Sec. A-2. Stakeholder group on capitated managed care in the MaineCare program. By August 1, 2014 the Commissioner of Health and Human Services shall convene a stakeholders group to design and plan for the implementation of a capitated managed care program for MaineCare enrollees. The stakeholder group shall make recommendations to the department regarding the implementation of 22 MRSA section 3174-WW, including, but not limited to, the following issues: the development of the selection and phase-in process; consumer choice and access to providers and network adequacy; accountability and transparency; incentives to encourage and reward health behaviors; alignment with existing efforts related to payment reform and care coordination; establishment of clear quality metrics and quality improvements; comprehensive and coordinated data analytics and access to data; usage and payment of emergency department services; and consumer protections. The stakeholder group shall include but not be limited to representatives of the following: MaineCare members and advocates representing MaineCare members; consumer advocates,

representatives of health insurance carriers; primary health care providers; acute care and critical access hospitals; behavioral health providers, including substance abuse providers; academics with a concentration in health care policy; pharmacy benefits managers, the Department of Health and Human Services; the Bureau of Insurance and representatives of the State Innovation Model grant process. The stakeholder group shall work until managed care implementation and the phase in of all mandatory populations is fully complete. The stakeholder group shall provide input on the implementation of Title 22 Maine Revised Statutes, section 3174-WW.

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

Sec. A-4. Report to the Legislature. By March 1, 2015, the Department of Health and Human Services shall report to the Joint Standing Committee on Health and Human Services on the status of implementation of managed care pursuant to 22 MRSA section 3174-WW, each of the areas addressed by the stakeholders group, the specific recommendations of the stakeholder group, the department's value based purchasing initiative, including accountable care. The report must include actual and projected cost savings and the structure of managed care program. Beginning April 1, 2015 the department shall provide a report every month to the Joint Standing Committee on Health and Human Services on the implementation of managed care.

Sec. A-5. Rulemaking Required. The following rulemaking requirements apply to the implementation of managed care in the Maine Care program by the Department of Health and Human Services pursuant to 22 MRSA section 3174-WW.

(a) By May 1, 2015, the department shall propose major substantive rules to implement managed care based on the recommendations of the stakeholder group.

(b) By September 1, 2015, the department shall provisionally adopt a managed care rule and provide copies of the rule to the Executive Director of the Legislative Council and the in accordance with the provisions of 5 MRSA 8072 (3) and (4).

(c) By January 15, 2016, the Joint Standing Committee on Health and Human Services shall make its recommendation to the full legislature on the managed care major substantive rule in accordance with 5 MRSA 8072 (5).

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

(e) Within 6 months of awarding of the request for proposals the department shall start implementation of managed care.

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

PART B

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Reduction in enhanced Federal Medical Assistance Percentage effective. The reduction in the enhanced Federal Medical Assistance Percentage described in subsection 1 has taken effect; and

3. Legislative session of at least 30 days. After the reduction of the enhanced Federal Medical Assistance Percentage as described in subsections 1 and 2, the Legislature has convened and conducted a session of at least 30 calendar days.

Sec. B-5. Repeal. The Maine Revised Statutes, Title 22, section 3174-G, subsection 1, paragraphs H and I are repealed December 31, 2016.

PART C

Sec. C-1. Research organization evaluation. The Office of Fiscal and Program Review shall contract with a nonpartisan research organization to study the impact of the MaineCare expansion authorized in Part B on programs and services that do not currently receive Federal Medical Assistance Percentage matching funds or do not qualify for enhanced Federal Medical Assistance Percentage matching funds under the federal Patient Protection and Affordable Care Act, 42 United States Code, Section 18001, et seq., with the goal of identifying and maximizing General Fund savings. The Commissioner of Health and Human Services, the Commissioner of

Corrections and the Executive Director of the State Board of Corrections shall provide to the research organization information and assistance requested for preparation of the evaluation. In evaluating the programs and services under this Part, the research organization shall at a minimum evaluate the impact on the following programs and services: the state-funded Mental Health Services - Community, Office of Substance Abuse and General Assistance - Reimbursement to Cities and Towns programs; the elderly low-cost drug program under the Maine Revised Statutes, Title 22, section 254D; services provided for individuals 21 to 64 years of age who are currently eligible for MaineCare under medically needy, spend-down criteria; services provided under the Maine HIV/AIDS Section 1115 Demonstration Waiver; services provided for parents participating in family reunification activities; services provided for disabled individuals 21 to 64 years of age with incomes below 139% of the federal poverty level; services provided to individuals awaiting a MaineCare disability determination for whom the applications are subsequently granted; services provided to individuals who would have been considered eligible on the basis of a disability but for whom the full determination process was not completed; medical services provided to persons in the care and custody of the Department of Corrections or a county correctional facility; and the amount of payment for services that hospitals received during fiscal years 2014-15 and 2015-16 as a result of the expansion of MaineCare eligibility pursuant to Part B. In addition, the research organization shall evaluate any savings and the impact on health outcomes achieved through initiatives implemented pursuant to the State Innovation Models Initiative grant.

Sec. C-2. Health Insurance Marketplace report. The Office of Fiscal and Program Review shall contract with a nonpartisan research organization to examine the financial feasibility of providing health care coverage to newly eligible MaineCare members through the Health Insurance Marketplace modeled after Medicaid expansion coverage in Arkansas or Iowa. The Office of Fiscal and Program Review shall report by February 15, 2015 to the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding the feasibility of providing health care coverage to newly eligible MaineCare members through the Health Insurance Marketplace modeled after Medicaid expansion coverage in Arkansas or Iowa.

Sec. C-3. Report. The research organization that conducts the evaluation under section 1 shall report no later than February 15, 2015 and February 15, 2016 to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over criminal justice and public safety matters on the amount of General Fund savings resulting from the MaineCare expansion authorized in Part A and identified in section 1. The reports must include the amount of savings expected and realized during fiscal years 2014-15 and 2015-16 by service area or program, the amount deposited in the MaineCare Stabilization Fund pursuant to section 3 and the amount of savings projected to be achieved through state fiscal year 2020-21 by service area or program.

Sec. C-4. Calculation and transfer. Notwithstanding any other provision of law, the State Budget Officer shall calculate the amount of savings identified in this Part that applies against each General Fund account statewide as a result of the expansion of MaineCare eligibility authorized in Part B and shall transfer the amounts up to the amounts specified in section 6 by financial order upon the approval of the Governor. These transfers are

considered adjustments to appropriations in fiscal year 2014-15. The State Controller shall transfer any amounts identified under this Part greater than the amounts specified in section 6 to the MaineCare Stabilization Fund established under the Maine Revised Statutes, Title 22, section 3174-KK. The State Budget Officer shall provide a report of the transferred amounts to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs no later than June 30, 2015 for fiscal year 2014-15 and no later than June 30, 2016 for fiscal year 2015-16.

Sec. C-5. Review and responsibility. Following receipt of the reports from the research organization as required under section 3, the joint standing committee of the Legislature having jurisdiction over health and human services matters shall review the information provided in the reports and shall determine if the net cost to the General Fund of providing coverage under the MaineCare program to individuals pursuant to Title 22 Maine Revised Statutes section 3174-G, subsection 1, paragraphs H and I exceeds the savings to the General Fund, including any amount deposited in the MaineCare Stabilization Fund pursuant to section 4, due to the expansion of coverage for those individuals. Following its review of the report received on February 15, 2016, the joint standing committee may report out a bill to the 127th Legislature regarding its determinations and conclusions.

Sec. C-6. Appropriations and allocations. The following appropriations and allocations are made.

(To be written by OFPR)

PART D

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

(To be written by OFPR)

PART E

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

1. Primary care provider. The department shall provide notice to the member that the member is required to sign up as a patient with a primary health care provider promptly after enrolling in the MaineCare program; and

2. Benefit termination. The department shall provide written notice to the member that the member's MaineCare coverage will end on December 31, 2016 unless a law is passed to extend coverage past that date.

PART F

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

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

A. Three members of the Senate appointed by the President of the Senate, including 2 members of the party holding the largest number of seats in the Senate and 1 member of the party holding the second largest number of seats in the Senate; and

B. Five members of the House of Representatives appointed by the Speaker of the House, including 3 members of the party holding the largest number of seats in the House and 2 members of the party holding the second largest number of seats in the House.

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

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

4. Duties. The task force shall meet up to 4 times in order to identify any policies in MaineCare that penalize or create a disincentive for members to increase hours of employment or earnings. The task force shall make recommendations to eliminate any such barriers and shall propose new policies that support and promote stable and lasting employment. In performing its work, the task force shall examine current rules related to MaineCare Transitional Assistance and any opportunities to further reduce the "cliff effect" impacting working families that lose eligibility for MaineCare. The task force shall consider solutions that provide continuity of care and minimize persons' moving on and off of the MaineCare program.

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

6. Report. The task force shall submit a report that includes its findings and

recommendations for presentation to the Joint Standing Committee on Health and Human Services by November 4, 2014.

PART G

Sec. G-1. Implement reforms in programs for adults with intellectual disabilities. The Department of Health and Human Services shall implement forthwith the reforms identified in this section and shall transfer all savings resulting from those reforms and adjust reimbursement rates for providers of services as necessary to develop the funds that will reduce waiting lists for services under the MaineCare program Sections 21 and 29 services for adults with intellectual disabilities and autism to less than 6 months by January 15, 2015.

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

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

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

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

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

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

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

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

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

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

B. The department shall carry out the directives and proceed to implement the initiatives contained in the following resolves:

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

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

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

C. The department shall move forward to accomplish the following reforms that were identified during the work of the MaineCare Redesign Task Force that was convened pursuant to Public Law 2011, chapter 657, part T:

1. Decrease the cost of health care to persons with intellectual disabilities by implementing care management in long term support service providers;

2. Increase the census of very small home support residential programs in all cases where it can be done without encountering behavioral impediments. In many cases, homes are established with only 1 or 2 occupants when 3 or 4 might well be accommodated;

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

4. Add monitoring technology to replace on site staffing during low activity periods pursuant to waivers the department was directed to obtain in Public Law 2013, chapter 368, part SS;

5. Substitute foster homes for hourly staff model care in those situations where individuals require long term or permanent living arrangements for daily support; and

6. Accelerate the teaching of independent living skills with focus on populations transitioning from school to adult living.

Sec. G-2. Savings from reforms. The savings generated by reforming the MaineCare services for adults with intellectual disabilities and autism cited in section 1 must be used to serve those on the waiting list for MaineCare Section 21 and 29 programs. The department shall develop a plan with clear steps and a timeline to ensure that current and future waiting lists for services under Sections 21 and 29 do not exceed 6 months by January 15, 2015, and shall present its plan to the Legislature by June 30, 2014.

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

PART H

Sec. H-1. Fraud investigation. The Department of the Attorney General shall undertake an initiative to strengthen fraud investigation in the MaineCare program. The Department of the Attorney General shall establish 2 new positions within the Health Care Crimes Unit to investigate allegations of misuse of public funds in the MaineCare program and to aid the Attorney General in the prosecution of crimes and other legal actions related to misuse of public funds.

Sec. H-2. Appropriation and allocation

(To be written by OFPR)

SUMMARY

This amendment replaces the bill. It strikes the title and inserts a new title to read: "An Act to Provide Fiscal Predictability to the MaineCare Program and Health Security to Maine People." The amendment contains the following provisions.

Part A establishes managed care in the MaineCare program. Part A includes requirements for managed care plans and for contracting by the Department of Health and Human Services for managed care services. Part A specifies how MaineCare members enroll in managed care plans.

Part B expands medical coverage under the MaineCare program to adults who qualify under federal law with incomes up to 133% of the nonfarm income official poverty line, with the 5% federal income adjustment for family size, and qualifies Maine to receive federal funding for 100% of the cost of coverage for members who enroll under the expansion. Adults who will be eligible are those 21 to 64 years of age effective July 1, 2014 and adults 19 and 20 years of age beginning October 1, 2019. The expansion of Medicaid eligibility contained in this Part is repealed if 3 circumstances occur: the enhanced Federal Medical Assistance Percentage for calendar years 2014 through 2020 is reduced below certain stated levels; the reduced enhanced Federal Medical Assistance Percentage has taken effect; and after the occurrence of the reduction of the enhanced Federal Medical Assistance Percentage the Legislature has convened and conducted a session of at least 30 calendar days. This bill repeals the expansion of medical coverage under the MaineCare program on December 31, 2016.

Part C requires the Office of Fiscal and Program Review to contract with a nonpartisan research organization to evaluate the financial feasibility of providing health care coverage to newly eligible MaineCare members through the Health Insurance Marketplace modeled after Medicaid expansion coverage in Arkansas or Iowa and to report the findings of the evaluation to the joint standing committee on health and human services by February 15, 2015. Part C directs the Office of Fiscal and Program Review to contract for an examination of the impact of the MaineCare expansion on programs and services that do not currently receive Federal Medical Assistance Percentage matching funds or do not qualify for enhanced Federal Medical Assistance Percentage matching funds under the federal Patient Protection and Affordable Care Act, 42 United States Code, Section 18001, et seq., with the goal of identifying and maximizing General Fund savings. Part C requires a report by February 15, 2015 and February 15, 2016 to the joint

standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over criminal justice and public safety matters on the amount of General Fund savings resulting from the MaineCare expansion. The report must include the amount of savings expected and realized during fiscal years 2014-15 and 2015-2016 by service area or program. Part C requires the State Budget Officer to calculate the amount of savings that applies against each General Fund account for all departments and agencies from savings associated with the MaineCare expansion and to transfer the amounts by financial order upon the approval of the Governor. It requires the State Controller to transfer any remaining savings to the MaineCare Stabilization Fund. Part C requires the State Budget Officer to provide a report of the transferred amounts to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs no later than June 30, 2015 for fiscal year 2014-15 and no later than June 30, 2016 for fiscal year 2015-16.

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

Part E requires the Department of Health and Human Services, when enrolling a MaineCare member who is eligible under Title 22 Maine Revised Statutes section 3174-G, subsection 1, paragraphs H or I, to provide written notice that is readable at the 6th grade reading level to the member of the requirement to sign up as a patient with a primary health care provider promptly after enrolling in the and that the member's MaineCare coverage will end on December 31, 2016 unless a law is passed to extend coverage past that date.

Part F establishes the Task Force to Create Opportunities for Stable Employment for MaineCare Members. The task force is directed meet up to 4 times in order to identify any policies in MaineCare that penalize or create a disincentive for members to increase hours of employment or earnings, to make recommendations to eliminate barriers and to propose new policies that support and promote stable and lasting employment, to examine current rules related to MaineCare Transitional Assistance and any opportunities to further reduce the "cliff effect" impacting working families that lose eligibility for MaineCare and to consider solutions that provide continuity of care and minimize persons' moving on and off of the MaineCare program. The task force is directed to submit a report to the Joint Standing Committee on Health and Human Services by November 4, 2014.

Part G directs the Department of Health and Human Services to implement reforms specified in Public Law 2013, chapter 368, Section SS-4, to carry out the directives and proceed to implement the initiatives contained in Resolve 2013, chapter 24 and chapter 368, sections NN and ss-1 and to move forward to accomplish 6 reforms identified as part of the work of the MaineCare Redesign Task Force that was convened pursuant to Public Law 2011, chapter 657, part T. This Part requires that savings resulting from accomplishing the required reforms be used to serve persons on the waiting lists for MaineCare Sections 21 and 29 services. This Part directs the department to develop a plan with clear steps and a timeline to ensure that current and future

waiting lists for services under Sections 21 and 29 do not exceed 6 months by January 15, 2015, and to present the plan to the Legislature by June 30, 2014. This Part authorizes the department to adopt emergency rules to accomplish the duties contained in the law.

Part H directs the Department of the Attorney General shall undertake an initiative to strengthen fraud investigation in the MaineCare program. The Department of the Attorney General shall establish 2 new positions within the Health Care Crimes Unit to investigate allegations of misuse of public funds in the MaineCare program and to aid the Attorney General in the prosecution of crimes and other legal actions related to misuse of public funds.