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MEMORANDUM

TO: Joint Standing Committee on Health and Human Services
FROM: Department of Health and Human Services
DATE: March 19, 2019
RE: Responding to questions re: Budget Group D

MAINECARE (EXCLUDING NFs)

Update on the correct numbers for CHIP FMAP on lines 295-6.
We are working on this, but do not have an updated number for you at this time.

Information about the drug rebate program – how it works, who participates, which drugs are included?
Overview - The drug rebate program includes CMS, state Medicaid agencies, and participating drug manufacturers. It aims to offset the federal and state costs of most outpatient prescription drugs dispensed to Medicaid beneficiaries. Approximately 600 drug manufacturers currently participate in this program. This program requires a drug manufacturer to enter into, and have in effect, a national rebate agreement with CMS. Each calendar quarter, a rebate invoice is created and mailed to each manufacturer whose product was paid for with Medicaid funds. The invoices are based upon the quantities of drugs dispensed by pharmacies and medical providers to eligible MaineCare members, and paid for by MaineCare. The information is processed in real-time through an online point-of-sale system known as MEPOPS. MaineCare receives significant rebates from manufacturers of outpatient drugs and some medical supplies. Rebates are obtained through two separate, but related, programs – the National Medicaid Drug Rebate Program and the State Supplemental Rebate Program.

National Medicaid Drug Rebate Program
The National Medicaid Drug Rebate Program (MDRP), administered by CMS, is authorized by Section 1927 of the Social Security Act. It requires that pharmaceutical manufacturers pay statutorily calculated rebates to Medicaid programs in order for their drug products to be covered. These rebates include an inflation component that requires manufacturers to pay additional rebates when their price increases exceed the rate of inflation. For many products that have had excessive price increases, the rebate can be over 100%, making the drug free for the state. In addition, this rebate includes a Best Price provision that requires manufacturers to rebate their drug products down to the best price offered to nearly all purchasers in the country. Through this program, MaineCare receives more than 50% of its gross outpatient drug expenditures back from manufacturers in the form of rebates.

State Supplemental Rebate Program

MaineCare collects additional rebates through its Supplemental Rebate Program. Through this program, manufacturers contract directly with the state to pay rebates for covered outpatient drugs and for certain medical supplies (most commonly, those used in management of diabetes). Generally, manufacturers contract for these rebates in exchange for preferred positioning on MaineCare's Preferred Drug List (PDL) or Preferred Product List.

Sovereign States Drug Consortium (SSDC)

MaineCare is a charter member of the Sovereign States Drug Consortium (SSDC), a group of 12 state Medicaid programs that leverage their collective five million covered lives to obtain significant supplemental rebates from manufacturers. The SSDC is the only multistate Medicaid pool that is organized and governed by the participating states and that enables states to contract directly with manufacturers rather than through an outside vendor. While the member states collaborate on strategy and best practices, each state maintains full independence and flexibility in the operation of its pharmacy benefit. The SSDC contracts with Change Healthcare to administer the rebate solicitation, negotiation and evaluation process at the direction of the member states.

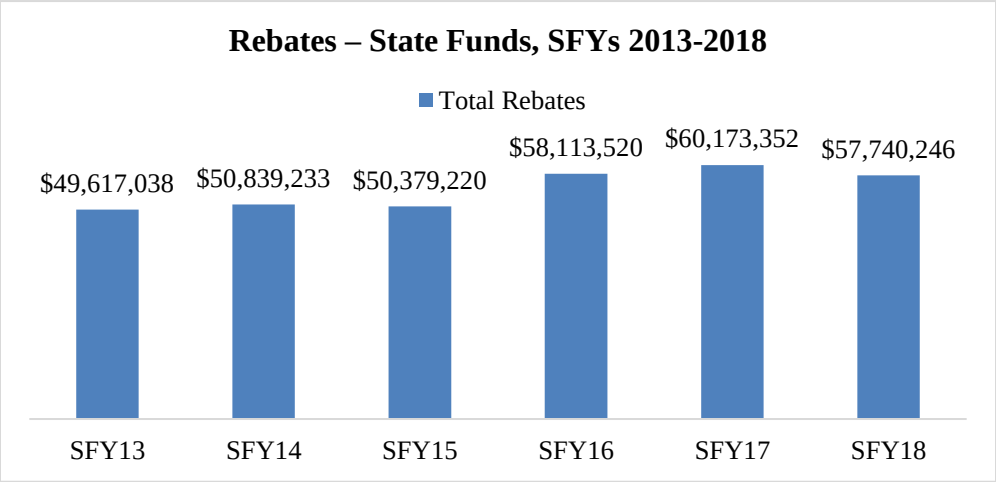
SSDC member states include: Delaware, Iowa, Maine, Mississippi, North Dakota, Ohio, Oklahoma, Oregon, Utah, Vermont, West Virginia, and Wyoming. States that belong to the SSDC:

- Use Preferred Drug Lists or Product Based Prior Authorization programs to direct utilization to drug and DME products that provide the greatest value.
- Leverage their collective covered lives to negotiate for drug and DME discounts from manufacturers.
- Collaborate and share best practices in other areas of Medicaid pharmacy administration and management.

As with the National Medicaid Drug Rebate Program, State Supplemental Rebates are paid by the manufacturer directly to the state, ensuring complete transparency. Additionally, both rebates are shared with the federal government in accordance with the state's FMAP.

Pharmacy Overview (SFYs 2013-2018)

State Fiscal Year	Average # Rx Filled/Year	Annual Spend
2013	6,653,725	$225,925,078
2014	5,035,593	$230,517,990
2015	4,486,476	$248,512,412
2016	4,292,613	$277,519,228
2017	4,002,265	$267,325,211
2018	3,714,145	$271,192,159



Detailed timeline and assumptions for Medicaid expansion – assumptions for full enrollment, enrollment ramp-up, need, claims assumptions? How do DHHS assumptions and estimates differ from recent ones (DHHS in last administration, Manatt, OFPR)?
Enrollment/Ramp Up - Manatt's report from February 2018, on the basis of data from other states' expansion experiences, assumed: 1) that of the total possibly eligible population, 55% would ultimately enroll and, 2) that there would be a ramp-up period lasting until SFY 2021. Both assumptions do not appear to have anticipated a delayed implementation. The current administration included similar estimates about enrollment and a ramp-up, albeit with a somewhat quicker ramp-up with full enrollment expected within SFY 2020.

Consistent with its standard practice for such estimates, the prior administration assumed full enrollment as of the first day. In early 2018, the prior administration and OFPR (in October 2016) also assumed that significantly higher percentages of the total potentially eligible expansion population would enroll.

Claims - Manatt mirrored the prior administration's 6% year-over-year per-member-per-month (PMPM) growth rate in its claims/cost assumption, but noted that it was high relative to other states' experiences. Both Manatt and the previous administration assumed that 19- and 20-year-olds falling into the expansion category would receive the regular (lower) federal matching rate, whereas the current administration has assumed that they will receive the higher rate, based on guidance from CMS.

Manatt also assumed that expansion would extend to certain populations who would have been otherwise covered by state funds, leading to savings. The prior administration did not include such assumptions.

The primary difference in PMPM is that Manatt and the prior administration applied a higher annual cost increase rate than the current administration did to the PMPM we had for childless adults from when they were previously covered in Maine. It is based on either a four or six percent increase each year since 2013, whereas ours was based on the Medical CPI. That varied each year, from as low as 1.97% in 2018 to as high as 3.79% in 2016.

Information about claims history by April 1st. Projected and actual enrollment at certain periods and claims in the future. What is the appropriate frequency for providing information to the committees that is useful?
Please see attached sheets on caseloads and claims totals per year, including forecasting.

The Department conducts spending forecasts twice per year – in May and December, on average. The forecasts are based on historical spending loaded into a modeling algorithm and adjusted for known events, such as 500 people coming off the Section 21 waitlist. Historical caseload is also available, but the Department has not generally forecasted enrollment.

Are there any trends available about those that have signed up for MaineCare that are not in the 90% eligible category? Trends in nonexpansion group?
It is too early in the claims process to have sufficient data to analyze trends related to claims for either the whole or any subset of the expansion population.

Attached is a case load report with quarter-end counts over the last few State Fiscal Years. In general, the trend has been decreasing or enrollment has been flat. The exceptions are children (foster care/adoption assistance children and the CHIP program), and members with the Limited Family Planning benefit.

What is the total amount of federal funds received for Medicaid? Expansion funding from the federal government is approximately what percentage of the whole?
Federal funds for expanded MaineCare are anticipated to be approximately 18.1% of the total amount of federal funding received for the program, annually. (This figure was derived by taking the full actual federal expenditure for MaineCare in the last full federal fiscal year ($1,872,692,677 for FFY 2018) and factoring in the estimated federal share of expanded Medicaid for the first full state fiscal year in which expansion is established ($413,372,187 for SFY 2020)).

FFY 2018	$1,872,692,677
SFY 2020 Expansion	$413,372,187
Total	$2,286,064,864
Expansion as a % of Total	18.1%

Please provide the approved SPA information when it is available so that the Legislature understands the retroactivity part.
The Department has not yet received final approval for the MaineCare Expansion State Plan Amendment, so cannot provide it at this time.

Information about the Program Integrity Unit – history, number of cases, funding amounts
Overview - States that participate in Medicaid are required to, among other things, adopt policies and procedures to prevent fraud, abuse, unnecessary utilization and excess payments in the Medicaid program. See 42 CFR 455.1, 42 CFR 456.3, 42 CFR 456.23.

The Program Integrity Unit performs numerous functions to protect against fraud, waste or abuse. Its functions include, but are not limited to, analyzing MaineCare claims to detect trends that may indicate fraud, abuse, or inappropriate utilization patterns. It also receives referrals or complaints from numerous sources, such as other state and federal agencies, healthcare providers, members, or third parties. Based on these sources of information, Program Integrity may perform post-payment reviews of providers to validate any suspicions or allegations of fraud, waste, or inappropriate utilization. If Program Integrity's work uncovers suspected fraud, the matter would be referred to the Medicaid Fraud Control Unit (MFCU) for further investigation and potential criminal prosecution. Program Integrity staff works closely with MFCU to aid in investigations.

Number of Cases - In CY 2017, the PI unit opened 368 cases and closed 349 cases. In CY 2018, the PI unit opened 401 cases and closed 390 cases. Cases can originate from multiple sources including data mining, complaints from members or third-parties, requests from management or other DHHS offices, etc. A case is closed when PI is finished with its review and any appeals are concluded – so some can drag out.

Below, is recent data on collections resulting from overpayments established/identified by Program Integrity's work:

2015: $650,488
2016: $1,381,115
2017: $1,739,224

Funding Amounts - Program Integrity staff are state employees funded in the last biennial state budget. At that time, the unit was housed within the Department of Health and Human Services' Division of Audit. In March 2018, it transferred over to the Office of MaineCare Services, and the budgetary funding provisions should be amended accordingly in the upcoming budget.

Additional Questions from Rep. O'Connor:

Number of individuals qualifying for the highest reimbursement rate & current FMAP. There are currently 9,721 adults enrolled in the Expansion group who qualify for enhanced FMAP. There are 738 individuals enrolled in the Expansion group who qualify for the current FMAP – these are parents who otherwise wouldn't have been eligible for Medicaid, and our estimates took this type of expanded eligibility into account.

A determination whether enrollees' coverage is retroactive to July 2; if so, healthcare providers may submit all bills incurred by an enrollee back to that date for payment. The Department is reconsidering all previously denied coverage where expansion should have been available. For those reconsidered cases, coverage may be retroactive back to July 2, depending on the date of application (because eligibility typically begins in the month of application) and/or whether retroactive coverage was requested and appropriate (rules for retroactivity allow coverage to pre-date the month of application by as much as three months, if requested and if eligibility criteria are met in those retro months). Providers are well aware that Maine is working to expand Medicaid and that the SPA approval is still pending.

The types of services enrollees are accessing; for example, the percentage of individuals accessing rehabilitation services for opioid use.
This information is not available at this time, but the Department is working to pull data like this and publish a dashboard on the OMS website with these types of details.

Financial details regarding the number of providers that have submitted claims as of July 2, the total cost incurred for those services, and the types of services.
This information is not available at this time.

Whether providers are being notified that enrollees' prior and even current costs may not be eligible for the federal match because the SPA has not yet been approved.
They are not, because the extent of federal match does not impact providers directly.

The number of individuals who have given up private health insurance (either employer-provided or purchased by the individual) prior to enrolling in Medicaid expansion.
OFI does not collect data on previously held private or employer-sponsored health insurance for MaineCare applicants.

The number of new enrollees who did or would have qualified for subsidies on the exchange and what their monthly cost would have been if they had not enrolled in Medicaid expansion.
OFI is unable to provide an estimate on the number of new enrollees who may have qualified for Marketplace coverage, and what the cost of that coverage may have been.

HOSPITALS

Will the department be promulgating rules pursuant to PL 2017, c. 454 (reimbursement to hospitals for patients awaiting placement)? There is funding in the budget but hospitals are not being reimbursed because the rules have not been amended.
The Department has finished the public notice process and will be submitting a State Plan Amendment for these changes in the next few weeks. Also, MaineCare has consulted the Office of the Attorney General and will be proposing the rule changes in the next few weeks. The changes will be effective retroactively to January 1st, 2019. While the language changes to the rule will be fairly simple, there were some system changes that needed to be made before the rulemaking could go forward.

FUND FOR A HEALTHY MAINE

A-271: why are federal funds for plumbing source being replaced with FHM funding – Is federal funding ending?
The two positions in question are Radon Program positions, not "plumbing source." It is anticipated the federal grant funding will end. Also, this past year's grant funding awarded to Maine totaled only $75,000, an insufficient amount to currently fund two positions.

Additional questions were answered within Group A memo.

MAINECARE SPENDING SUMMARY
SFYs 2015-2018 Actual, SFYs 2019-2021 Forecast
Excludes ADMIN and DISPROPORTIONATE SHARE

CLAIMS SYTEM:	2015 ACTUALS	2016 ACTUALS	2017 ACTUALS	2018 ACTUALS	2019 FORECAST	2020 FORECAST	2021 FORECAST
BEHAVIORAL HEALTH SERVICES	211,036,749	216,939,983	180,068,684	166,324,047	156,443,355	159,402,110	162,420,037
CASE MANAGEMENT	46,446,903	46,775,046	40,523,663	37,254,725	38,414,415	38,120,330	38,479,927
CLINIC	52,479,282	56,922,465	52,180,807	52,932,385	51,394,843	51,544,288	51,701,327
DED & CO-INS FOR DUALS	96,995,470	95,243,597	94,058,111	97,487,436	93,355,001	93,687,643	94,105,990
DENTISTRY	28,642,847	28,825,221	26,547,663	24,275,663	25,061,575	25,078,717	25,082,222
DEVICES AND SUPPLIES	23,262,362	24,951,540	25,085,493	26,640,624	27,679,040	27,665,033	27,687,711
HCBS WAIVERS	355,178,997	381,065,415	402,939,755	437,119,637	533,057,215	591,859,640	611,411,407
HEALTH HOMES	14,668,172	20,800,946	44,741,599	62,242,656	76,754,266	86,200,189	97,654,053
HOME HEALTH	9,266,934	8,897,917	10,826,122	15,212,856	17,535,501	18,775,717	19,590,260
HOSPITALS	539,145,605	536,286,669	562,709,704	612,311,639	577,242,540	587,863,415	605,652,855
INSURANCE	1,720,816	1,667,916	1,623,168	1,745,571	1,642,330	1,687,284	1,687,284
LABORTORY SERVICES	12,832,013	13,222,090	9,119,577	9,883,660	9,768,864	9,768,863	9,768,861
MEDICAL PROFESSIONALS	133,464,531	139,143,671	129,019,596	133,856,002	131,940,015	134,094,620	134,094,619
OTHER	5,808,237	5,953,338	7,216,145	7,210,721	8,069,493	8,195,905	8,471,474
PHARMACY	233,728,084	260,243,013	251,120,713	254,563,471	261,106,758	267,681,662	275,712,111
REHAB SERVICES	67,901,389	64,677,988	66,007,215	66,134,516	66,988,158	66,890,378	67,003,334
RESIDENTIAL	548,764,730	589,493,101	601,469,812	626,377,707	692,828,720	698,893,332	716,964,026
SCHOOL BASED SERVICES	44,359,135	44,166,972	49,572,834	51,775,961	53,090,007	55,299,769	57,740,358
TRANSPORTATION	50,278,708	49,658,218	49,796,267	49,714,211	46,797,316	48,231,218	49,912,391
TOTAL CLAIMS SYSTEM	$ 2,475,980,965	$ 2,585,713,606	$ 2,605,379,647	$ 2,733,172,779	$ 2,869,169,412	$ 2,970,940,113	$ 3,055,140,249
NONCLAIMS SYSTEM:							
DRUG REBATE EXPENDITURE TRANSFERS	(82,287,103)	(98,450,970)	(110,352,507)	(104,016,440)	(107,568,540)	(84,156,411)	(83,502,367)
EXPENDITURE TRANSFERS	(1,765,095)	(1,670,661)	(1,658,413)	(1,751,465)	(1,922,882)	(1,905,890)	(1,905,891)
HOSPITAL MATCH PAYMENT	75,172,193	74,441,139	74,514,682	80,881,638	80,881,638	80,010,262	80,010,262
MEDICARE A,B,D	152,344,357	166,768,098	183,916,692	199,440,331	190,728,008	200,030,861	205,303,036
MISCELLANEOUS TRANSACTIONS	(2,377,183)	(5,726,123)	(1,175,578)	(4,641,036)	0	-	-
ONE TIME PAID	226,457	0	(2,877,645)	6,443,231	7,888,918	300,000	300,000
ONE TIME RECOVERY OF FUNDS	(313,987)	(153,609)	(686)	(38,099)	-	-	-
RECOVERY OF FUNDS	(89,974,588)	(70,578,994)	(93,864,429)	(82,848,961)	(61,680,784)	(68,317,981)	(67,978,279)
TOTAL NON CLAIMS SYSTEM	$ 51,025,050	$ 64,630,371	$ 48,384,742	$ 93,527,581	$ 108,326,357	$ 125,960,841	$ 132,226,762
TOTAL MAINECARE	**$ 2,527,006,015**	**$ 2,650,343,977**	**$ 2,653,764,388**	**$ 2,826,700,360**	**$ 2,977,495,769**	**$ 3,096,900,954**	**$ 3,187,367,011**