Testimony in Opposition to LD 390: "An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund or Other Funds and Changing Certain Provisions of Law Necessary to the Proper Operations of State Government for Fiscal Years Ending June 30, 2018 and June 30, 2019," and specific to the Provisions Related to Proposed Cuts to MaineCare coverage."

From: DFD Russell Medical Centers delivered by Amanda Comeau Patient Board Member

February 21, 2017

Senators Hamper and Brakey, Representatives Gattine and Hymanson and Distinguished Members of the Joint Standing Committees on Appropriations and Financial Affairs and Health and Human Services, my name is Amanda Comeau and I am a Board Member and patient of DFD Russell Medical Center (DFDRMC), a Federally Qualified Health Center with three sites in Leeds, Monmouth and Turner. DFDRMC was founded in 1976 and for over 40 years has provided high quality, cost effective primary care to these underserved rural areas. In response to community needs, DFDRMC has built a comprehensive array of services including adult primary and pediatric care, 340b discounted pharmacy program, integrated behavioral health counseling and chronic care management. We serve over 8,000 patients and last year more than 30% of our patients were below 200% of the federal poverty guidelines.

The Governor's proposed budget cuts more than $65 Million dollars from anti-poverty programs that provide health care, food and shelter. This proposed budget comes on top of deep cuts made in recent years that have caused more than 35,000 Mainers to lose health care.

While DFDRMC and its Board of Directors oppose all cuts to programs affecting low income Mainers, I will address two that directly impact our patients.

First the Administration is proposing a reduction in MaineCare Parent Eligibility from incomes at or below 100% Federal Poverty Level (FPL) to incomes at or below 40% FPL effective July 1, 2018. For a parent and one child, eligibility would be reduced from an income of about $1,402 per month to $561 per month. For a family of 3 people, eligibility would be reduced from about $1,764 per month to $706 per month. **At DFD Russell more than 478 patients who average 4.88 visits per year for acute, primary preventative and behavioral health services would lose coverage under this proposed cut.**

DFDRMC offers outreach and enrollment services to ensure patients receive healthcare coverage and other supporting services for which they qualify. While the Affordable Care Act (ACA) has provisions to expand public coverage options for adults these parents are in the "coverage gap" which means that they will not have access to Affordable Care Act subsidies on the Exchange.

Many studies have shown a direct correlation between child and parent coverage and how improved continuity for parents impacts coverage continuity for their children. Specifically, Jennifer E. DeVoe et al in an article entitled "The Association Between Medicaid Coverage for Children and Parents Persists: 2002–2010" described how "a lack of insurance for parents led to delayed care and the inability to stay healthy, which interfered with their ability to provide for their children. Many parents made reference to how a parent's serious illness could negatively impact the family. For example, a sick parent would not be able to work and therefore not have enough income to pay for rent, utilities, or food."

A provision of the Medicaid program, called Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), ensures that children in Medicaid receive regular health screenings, and when problems are diagnosed, treatment services are provided. Well-child check ups are a component of the EPSDT program. This early investment in children can save money by enabling children to maximize their development and educational attainment—minimizing the need to receive life-long services.

Some of the care coordination activities under EPSDT include: information about the program and outreach to eligible populations and ensuring patient/parent compliance with the periodic screening schedule through assistance with appointments, missed appointment follow-ups and referral coordination and follow-up.

An example of coordination of care provided at DFDRMC, where we treat the entire family, was highlighted when a mother brought her four month old in for her EPSDT well-child visit and indicated that she was experiencing postpartum depression. In addition to the physical examination and immunizations for the baby, the mother was counseled by the PCP both on appropriate care and follow up visits for the child as well as appropriate self-care, which in this case involved an antidepressant and behavioral health counseling.

Elimination of MaineCare eligibility for 19 and 20 year olds cuts approximately 5,800 young adults from the MaineCare program including **68 patients served at DFDRMC.**

DFDR employs 54 individuals among the three sites, including three mental health providers whose case load primarily consists of MaineCare patients which are referred by our primary care providers. This coordination of care between primary and behavioral health providers is critical in avoiding unnecessary hospitalizations. Emergency department use increases when healthcare coverage decreases costing the system more annually than preventative care.

When considering the reduction in healthcare coverage for patients you must also consider the increasing financial deficits that exist among the state's Federally Qualified

Health Centers as revenue sources do not keep pace with the costs of providing care to rising numbers of the uninsured and underinsured populations. MaineCare, as a revenue source, is no exception, in March of 2003, Maine implemented the prospective payment system (PPS) of reimbursement for FQHCs. This reimbursement methodology is based on the averaged costs of providing care in 1999 and 2000 and is only increased by the Medicare Economic Index released annually.

It is widely accepted that the MEI, as an inflationary factor, does not adequately compensate for the rising costs of providing comprehensive, coordinated health care services which contributes to the health centers continuing to fall further behind each year. While we should be in a position of at least covering costs as we expand preventive and primary health care to meet the needs of our growing medically underserved populations, particularly in light of the Governor's health policies, we find ourselves unable to financially match the intensifying needs of the patient population.

Contrary to what may have been relayed by the Department, FQHCs do not receive increasing grant funds to care for increasing numbers of uninsured populations. If we do not received adequate reimbursement we will be unable to sustain services and locations of care.

We respectfully request that both of these proposed cuts be withdrawn to ensure uninterrupted access to high quality primary care for parents and children and to maintain the continued viability of the primary care safety net in Maine.

Respectfully Submitted by
Amanda Comeau
Board Member and Patient
DFD Russell Medical Centers