January 12, 2021

Ms. Michelle Probert
Director of MaineCare Services
Office of MaineCare Services
Department of Health and Human Services
109 Capitol Street
11 State House Station
Augusta, Maine 04333

Dear Ms. Probert,

I'm writing on behalf of the MaineCare Advisory Committee (MAC) Rate Subcommittee members to share the concerns that our subcommittee outlined at the January 5, 2021 MAC meeting regarding the Myers and Stauffer Benchmark Report and the Rate System Evaluation Stakeholder Sessions held last month (12/4/20 -12/9/20).

We appreciate that the Department has taken on a significant project to determine how best to create transparent, consistent, and viable rates, and know that there is additional work being done before key findings are shared on January 15, and the final Rate System Evaluation report is released in February.

As committee members who represent a large network of diverse MaineCare providers we welcomed the opportunity to give input into as well as participate in, the Stakeholder Sessions. We were however disappointed to have less than two weeks (which fell within the Thanksgiving holiday and during another surge of COVID-19 in our state) to review the report and accompanying tables. We moreover remain deeply concerned that the report itself is currently limited to a comparison of rate amounts (where available) from other states. Without key data points such as the minimum wage in these states, or rate components for each service, policymakers could be led to believe that Maine may be paying too much or in some cases, too little for services.

Key factors that that should be included in a final report include:

- **Minimum wage for each state.** The wage component of a rate represents a significant amount of each rate. At $12.15/hr., Maine has the highest minimum wage among the 5 states chosen for comparison. A minimum wage table should be included.

- **Provider Tax for each state.** The Maine provider tax is applied to the overwhelming majority of MaineCare services. If a provider tax is applied in other states, it should be noted for each state.

- **Rate components and methodology for each state's service rates.** A truer state to state comparison would show how each rate is built in each state and which components are included in each service being compared.
    - Three of the five states used in the report do not publish a majority of their rates- New Hampshire, Montana, and North Carolina. This suggests a woefully inadequate amount of data for comparison.
    - As noted in the "Key Points," Vermont has an entirely different payment system and does not seem a good comparison to Maine for that reason. Therefore, Maine is only

being compared to Connecticut, which, while located in New England is vastly different from Maine.
    - Demographic Maine and Connecticut comparison – these two states are dramatically different from one another and as such CT does not hold as a comparable state: CT has a median household income of $76,1061 while Maine has a median income of $55,425.
    - Maine has 20.6% of the population over 65- the highest in the nation while Connecticut ranks 14th with 17.2%.

- **State demographics including age and population density and income disparity**
    - The Commonwealth Fund, in its 2020 Scorecard on Health System Performance, ranked Maine the lowest in New England overall and specifically on Income Disparity, Access, and Affordability, Prevention and Treatment, Healthy Lives.
    - Becker's Hospital Review found that Maine had a 13% uninsured rate, while CT was 10%
    - 2010 Census data- the most recently available- ranks Maine as the most rural state in the US with 61.3% of the population living in rural areas and Connecticut as 40th with only 12% of the population in rural areas.
    - According to Statistical Atlas, Maine has a population density of 40 per square mile while Connecticut 630 per square mile.
    - These statistics are defining factors for health quality and outcomes. Numerous studies have clearly shown the linkage between rurality and health status and access to healthcare. From chronic conditions, dangerous natural resource work, to the prevalence of substance and alcohol misuse—the health status of rural Americans is more challenged than that of their urban/suburban counterparts. Factors that create those disparities are a complex web.
    - Maine residents accessing health care are further challenged by seasonal weather, road conditions, and unreliable cell phone coverage. Distance and time to get to health care are very different calculations and are significantly impacted by weather and road conditions. A 25-mile trip on good roads, daytime, and in the summer may be between 30 and 45 minutes. A 25-mile journey in winter, on winding back roads, in a blizzard could be as long as 2 hours and a matter of life and death.

- **Deinstitutionalization.** Maine has chosen a community-based model to support people with serious and persistent mental illness as well as for people with intellectual and developmental disabilities. Rate comparisons should factor the cost of community-based services versus the large institutional treatment facilities and residential facilities in other states.

- **Other funding sources for services.** Many states fund services through county authorities, regional mental health authorities, and state grants or general funds, that augment their Medicaid rates. Information showing what other funding streams that state and county may employ to offset the costs of providing that service should be considered.

- **Access to services.** Under §1902(a)(30)(A) of the Social Security Act, state Medicaid programs must ensure that provider payments are "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers" to provide access to care and services. Information regarding the number of closures or rate of reduction among service providers, Department waitlists for services, and timeframes to secure an initial appointment or assessment should be included to highlight services that do not provide adequacy of network to assure access.

- **Balanced "outlier rates".** Currently, in the report, MaineCare rates that were *more than* 20% of the comparison rate are perceived to be outliers on the "high" side, but those *less than* 40% of the comparison rate are on the "low" side. This on the face of it appears to be a lopsided balance with the "low outlier" as an exceptionally low comparison, as opposed to being 80% of the comparison rate. This was discussed at the meeting and noted as statistically viable presentation as many of the state's rates were much lower than 20% of the average. Please consider providing additional information regarding this point and use of "outlier rates."

We appreciate the opportunity to provide this feedback and remain available to answer any questions that you or members of your team may have.

Sincerely,

Laura Cordes
Chair, MAC Rate Subcommittee

cc: Jeanne Lambrew, Commissioner, DHHS
MaineCare Advisory Committee (MAC) Members