

**State of Maine
130th Legislature
Joint Standing Committee on Health and Human Services**

Testimony of Charles F. Dingman

On behalf of the Maine Primary Care Association

***Supporting*
LD 1867, “An Act To Codify MaineCare Rate System Reform”**

Sponsored by Representative Michele Meyer

February 2, 2022

Senator Claxton, Representative Meyer, and members of the Joint Standing Committee on Health and Human Services, I am Charlie Dingman, a lawyer with the firm of Kozak & Gayer, and I am here today on behalf of the Maine Primary Care Association (MPCA). MPCA is a membership association that includes all of Maine's 20 Community Health Centers (CHCs).

Maine's CHCs provide comprehensive primary and preventive care for approximately 1 in 6 Maine people. Community Health Centers make up the largest primary care network in the state, and they provide high quality, wide-ranging health care services. They are at the forefront of delivering care to underserved communities in our State, without regard to patients' ability to pay.

The Maine Primary Care Association supports LD 1867, the Department's proposal to introduce a systematic structure for ongoing review and updating of provider rates paid by MaineCare for the wide range of services that the program covers. Establishing a clear framework for rate setting development and maintenance is an important step toward recognizing that access to quality health care requires that MaineCare payments to providers of that care must keep pace with changes in costs, workforce challenges, and treatment modalities. FQHCs, as pioneers in integrating care, addressing the social determinants of health, and providing access to all regardless of ability to pay, welcome the Department's initiative to give ongoing attention to how its payments can best meet these goals. Redesign of payment to invest resources where they will yield the highest value for patients is a building block for a reformed health care system that can deliver equitable access to better health care.

As you consider this bill and put it in final form for enactment, MPCA also urges you to consider building on the Department's proposal to ensure that the rate reform framework you create is both flexible and inclusive enough to achieve the Department's important goals. To this end, we hope that the Department and the Committee will consider several modifications to the bill as printed. Several suggestions are outlined below.

First, we have learned from the Department's initial efforts to undertake a comprehensive review of rates that the selection of comparisons for benchmarking can be difficult and potentially misleading, if attention is not given to the comparability of the systems for which payment is being made in different states, the total bundle of compensation made from different

sources in another state, or the differing objectives of payors other than MaineCare.¹ It is vital to consider the entire payment made for a bundle of services in a given state rather than making “apples and oranges” comparisons where payments may be structured differently. Benchmarking will only become more difficult as innovative, value-based methods of compensation are expanded both in Maine and elsewhere. We applaud the bill’s references to using benchmarking only where “appropriate” and to selecting “at least 5 comparison states” plus Maine commercial insurers in periodic benchmarking reports, and the requirement of rate studies where benchmarking would be inconsistent with achieving efficient, economy, quality, and access. We urge that the Department extend the public input provisions to provide for input from providers and patients on whether benchmarking meets these standards for a given service, i.e. the periodic development of benchmarks, and the decision about when they are appropriate, should be subject to public comment opportunities like those described in paragraph G for rate studies, modified as proposed below.

Second, the public comment opportunities described in paragraph G can be read as mirroring the rulemaking process required by the Maine APA. That process, as implemented by the Department over the years, is insufficient to allow the Department to engage in constructive dialogue with affected parties, including providers and MaineCare members, as rates and payment systems are formulated. We recommend that the final enactment make it clear that a period for exposure of drafts and discussion and interaction with interested persons about those drafts should precede the issuance of a proposed rule for public comment. This might be inferred from the reference to “public presentation of drafts for comment,” but we recommend that it be crystal clear (1) that this is a preliminary step prior to rulemaking and (2) that dialogue rather than passive reception of comments is contemplated. For example, a new subparagraph (G)(5) might read:

(5) An opportunity for substantive dialogue among the department, any consultants or contractors engaged by the department, and affected persons including members and providers regarding concerns identified in public comments;

followed by renumbering of existing subparagraph (5) to (6).

Third, the requirement of cost-of-living adjustments is critically important and marks an important codification of recent trends in the Department’s approach to provider rates. However, the statute should not bias the selection of inflation measures to focus on “minimum wage laws” as suggested in subparagraph (H)(2). The realities of workforce shortages in the health care sector demand that minimum wages changes be factored in but that labor supply and competitive wage pressures beyond population-wide minimums also be considered.

Fourth, the Technical Advisory Panel established in subsection 4 should not be composed entirely of government officials as proposed here. It should also include representatives of both

¹ Attached for ease of reference are comments submitted by MPCA in December 2020, responding to the problems it identified in the Department’s initial effort to develop a comprehensive rate system evaluation. LD 1867 already contains important safeguards against repetition of some of these problems, but additional refinements informed by this prior experience are suggested in this testimony. MPCA would welcome the opportunity to discuss these concerns with the Department prior to the work session on this bill.

MaineCare members and providers, with a cross-section of provider types that should include primary care, community behavioral health care, dental care, long term care, and acute institutional care. The expertise sought from this panel will not be fully informed if it excludes the experience of MaineCare members or that of various provider types.

Finally, this framework should not impede the prompt development and implementation of urgently needed rate reforms that are otherwise under way or that the Legislature directs the Department to undertake. We think this is clear from the context of the printed bill, but care should be taken that this is explicit in the final enactment.

Thank you for your time during the hearing and for your attention to this somewhat more detailed written testimony. I would be pleased to respond to any questions via the contact information provided below.

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Maine Primary Care Association Comments MaineCare Comprehensive Rate System Evaluation - Phase 2 December 11, 2020

We appreciate the opportunity to comment on MaineCare's Comprehensive Rate System Evaluation Phase 2. However, as also noted in our Phase 1 comments, the condensed timeframe has not afforded us the necessary time to have robust conversations with our 20 Community Health Center members (also known as CHCs, or FQHCs) who serve over 210,000 Mainers. As the largest primary care network in Maine, we believe more time for discussion and deliberation would undoubtedly provide the Department and the Legislature with far richer information on which to base their conclusions; we strongly encourage the Department to find ways to continue this vital dialogue beyond the submission of the report.

Fair and adequate rates constitute the foundation of sustainability for vital health care services, which are in turn the key to access to life-saving services for MaineCare members. High-quality primary care - medical, behavioral, and dental - located in rural and underserved communities provides not only for the physical wellbeing of health center patients, but also contributes to the health of the whole community. This is the significant value of Maine's Community Health Centers, who also serve as an economic driver and linchpin of economic development in every Maine county. Community Health Centers are key safety net providers in Maine. As the most rural state in the country our providers manage services over vast areas; for example, one provider serves 12,000 people living in an area of over 2,160 sparsely populated square miles.

Maine Primary Care Association and its members stand ready to work with the Office of MaineCare services to address the issue of adequate rate structure, as well as any other issues pertaining to the health and wellbeing of Maine residents. In reviewing the findings from the assessment, we want to highlight significant concerns with the lack of context and comprehensiveness in the initial findings. Specifically, we wish to point out the following:

1. Limitations of the comparisons impacting the results:

- Five states were selected for geographic and other similarities
 - Three of those states do not publish 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.

2. Scope of Services: Maine and Connecticut comparison

- Connecticut has a separate PPS rate for Behavior Health (BH), while the Maine PPS rate is inclusive of BH, Medical *and* Dental. This is a profound difference in payment methodology.
- The Connecticut BH rate is about 1.5 times higher than the medical PPS rate, which changes the average PPS payment to FQHCs. This reality is reflected nowhere in the initial findings.
- The Connecticut Change in Scope process, which drives FQHC rate calculation, is not a well-functioning process. The flawed process has kept PPS rates there artificially low, as there has been almost no rate adjustment for close to 20 years as a result the PPS medical rates are one of the lowest in the country.

- Connecticut has a modified APM for intensive case management with 50% FQHC participation.
3. 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 \$55,425².
 - Maine has 20.6% of the population over 65- the highest in the nation while Connecticut ranks 14th with 17.2%.³
 - 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.⁴
 - Becker's Hospital Review found that Maine had a 13% uninsured rate, while CT was 10%⁵
 - 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.⁶
 - According to Statistical Atlas, Maine has a population density of 40 per square mile while Connecticut 630 per square mile.⁷

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.⁸

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.

Recommendations:

Community Health Centers are an essential part of Maine's public health infrastructure, providing critical primary, behavioral, and dental care at more than 70 service sites across the state. CHCs are on the front lines of the state's COVID-19 response and will continue to play a vital role in recovery from this deadly disease. As noted in Governor Mills' Nov. 2020 Economic Recovery Report, the eight transformational recommendations of the committee cannot be realized without bringing the virus under control and maintaining a strong public health

¹ <https://www.census.gov/quickfacts/CT>

² <https://www.census.gov/quickfacts/fact/table/ME/IPE120219#IPE120219>

³ <https://www.prb.org/which-us-states-are-the-oldest/>

⁴ <https://2020scorecard.commonwealthfund.org/rankings>

⁵ <https://www.beckershospitalreview.com/rankings-and-ratings/states-ranked-by-uninsured-rates.html>

⁶ <https://stacker.com/stories/2779/states-biggest-rural-populations?page=5>

⁷ <https://statisticalatlas.com/division/New-England/Population>

⁸ <https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities>

infrastructure: *“This new report comes at a time when the virus is spreading like wildfire, making a strong public health infrastructure critical to social stability and an economic recovery”*.⁹

To assure the strength and viability of the Maine Community Health Center network, we recommend that the Office of MaineCare Services partner with the Maine Primary Care Association (MPCA) to carefully evaluate the rates for FQHCs with consideration of the unique geographic, demographic and service delivery models they represent, especially in light of the collective impact that CHCs have on both individual health and wellness as well as economic recovery and growth.

In addition, to maintain a viable dental safety net we recommend that the Office of MaineCare Services convene a stakeholder group to explore the viability of Alternative Payment Methods (APM) as part of the immediate goal but also as part of larger goal of Valued Based Payment/Care (VBP).

Thank you for considering our comments, and we look forward to continuing the dialogue on this important issue.

⁹ https://www.maine.gov/future/sites/maine.gov.future/files/inline-files/Maine%20ERC%20Report_FINAL_11242020.pdf