



Testimony of Vanessa Santarelli, CEO

Maine Primary Care Association

**In Opposition to the Department of Health and Human Services' Proposed Section 1115
Demonstration Waiver, MaineCare Reform**

Thursday, May 18, 2017

Office of MaineCare Services (OMS) Director Nadeau, the Maine Primary Care Association (MPCA), whose members include all 20 of Maine's Federally Qualified Health Centers (FQHCs/Health Centers), appreciates the opportunity to submit comments on the OMS' proposed Section 1115 Demonstration Waiver on MaineCare Reform. Collectively, Maine's FQHCs provide comprehensive, affordable, high quality primary and preventive health care services to approximately 210,000 Mainers, have over 2040 employees, and contributed over \$311 million to the state's economy last year (Capital Link Report, 2017).

We are opposed to the significant changes included in the Department's 1115 waiver application because, if approved and implemented, they will lead to such adverse consequences as: a further loss of health coverage for thousands of Mainers in need, greater financial fragility among essential health care providers, such as FQHCs, hospitals, and nursing homes, and no marked reduction of inappropriate Emergency Department utilization, or reductions in bad debt and charity care. We also question the timing of this waiver application, which comes on the heels of the Administration's biennial budget proposal which seeks to eliminate MaineCare coverage for all 19 and 20 year olds, as well as lowering parental eligibility from 100% federal poverty to 40%. These policy initiatives are not in keeping with the goals of the Medicaid Program, nor the purpose and intent of the section 1115 Demonstration waivers.

Our comments focus primarily on the following provisions of the 1115 MaineCare Reform waiver application, however, we are opposed to it in its entirety: The imposition of monthly premiums for patients with health insurance coverage through MaineCare; the elimination of retroactive Medicaid eligibility; charging elderly and low income Mainers \$20 for "non-emergency" use of the Emergency Department; and allowing providers to charge those who have health coverage through MaineCare for missed appointments.

Monthly Premium Payments for Continued Coverage:

For MaineCare members who do not currently pay premiums, the Department is proposing to require monthly premiums of \$14 for those with incomes between 0-100% FPL; \$43 for those with incomes between 101%-200% FPL and \$66 for those with incomes of 201% FPL and above. For many of these individuals, the proposed premiums represent over 2% of their family's income, which is unaffordable, and will virtually guarantee that thousands will be dropped from their coverage through no fault of their own.

As Carol Carew, CEO from Bucksport Regional Health Center explained: *“MaineCare eligible patients struggle to meet daily expenses for basic necessities. Imposing a monthly premium payment would stop MaineCare patients from being able to visit their health care providers.....the result of patients who lose coverage as a result of not being able to afford their premiums will be an increase in ED visits, and a loss of revenue for FQHCs because many patients will stop scheduling appointments for preventive care, which will in turn lead to more serious illnesses from a lack of early detection and treatment. The cost to the State will also increase.”*

Ann Tucker, CFO from Greater Portland Health echoes this concern: *“Many of our patients struggle to provide food, shelter and the basic necessities for themselves and their families. In many cases, patients don’t have the money to pay the \$3 copay.....adding additional financial barriers to receiving medical care may drive patients away from making appointments. Patients will wait until their medical issues become serious and end up hospitalized.”*

By way of example, please consider the experience with our FQHCs’ current MaineCare patients who are subject to a \$3 copay, and who cannot afford it. DFD Russell Medical Centers with sites in Monmouth, Leeds and Turner reports that “for the 10 year period since being on their Electronic Health Record, Centricity, they came up with \$23,079 in MaineCare copay adjustments which translates into 7,693 visits where the \$3 copay was withheld from their rate payment and was not paid by the patient.” If MaineCare patients are unable to afford a \$3 copay for care, how can the State expect them to pay over 4 times that amount (\$14) at the lowest tiered level?

It would be helpful to know what factors the Department considered in deciding to proceed with this approach:

- What has the Department’s experience been with the collection of other premiums?
- What is the rate of non-payment currently?
- What is the percentage of those that were subject to paying a premium but either could not afford to pay or chose not to?
- How many MaineCare members does the Department expect will be removed for non-compliance?
- The Department is projecting \$8million in revenue from premiums and Emergency Department cost-sharing, and notes that it is not included in the cost-neutrality. As such, will the Department please share how it plans to use those funds? And, does that represent the total impact (state and federal) or is that just the impact to the state?

If our Health Centers’ experiences are any indication as to what would occur if this monthly premium policy was implemented, than the majority of those subject to it, would lose their health insurance coverage through MaineCare very quickly.

Elimination of Retroactive Medicaid Eligibility

Maine’s FQHCs provide access to all individuals who reside in their service areas, regardless of insurance status or ability to pay.....however, because the federal and state funding they receive is insufficient to keep their doors open to all, they must to rely on a patchwork of funding,

including reimbursement from private insurers, Medicare and MaineCare to remain financially sustainable. The bundled reimbursement that FQHCs receive, (otherwise known as the Prospective Payment System (PPS) rate of reimbursement), is the fairest rate of payment they receive for the broader range of services they are required to provide to their patients by law. Eliminating retroactive Medicaid eligibility will adversely impact our FQHCs' ability to receive adequate payment for services rendered, and will further erode the resources they have available to devote to patient care.

“Enrollment assisters” are employed by our Health Center members and are trained to sign uninsured individuals up for health insurance on the Marketplace, as well as programs like Medicare and MaineCare that they are eligible for. In some cases, there is a delay between when they sign up and have an appointment, and get approved for their coverage.

The following example provided by the Maine Mobile Health Program (MMHP) illustrates another situation that some of their patients have found themselves in: *“When they receive mail in English regarding their MaineCare and don't understand what it says, they can't read it with their Community Health Worker (CHW) until their scheduled appointment with them. In at least a few occasions, a patient's renewal papers came and the renewal date passed before their visit with their CHW. The current 90 day retroactive window allows these workers to renew their MaineCare without a gap in coverage....two of the patients who experienced this situation were receiving some form of cancer treatment, so not only would a gap in coverage be expensive for them, it would hinder their seamless ability to access cancer treatment.”*

Neither our Health Centers, nor their patients should be unfairly penalized or denied payment for services rendered in the way that they are currently and appropriately receiving reimbursement for.

\$20 Charges for “Non-Emergency” Use of the Emergency Department:

“The Department is proposing to send a bill in the amount of \$20 to non-dually eligible MaineCare members for each “non-emergency use of the Emergency Department- (visits that do not require an inpatient admission). The bill will include a breakdown of the costs associated with their visit to provide information to members regarding the cost of their care to the taxpayers of Maine.....(p.9 of the MaineCare 1115 waiver application).”

While we share the Department's goal of reducing non-emergency use of Emergency Departments, the majority of our FQHCs believe this approach is misguided and won't achieve the desired outcome. Maine's FQHCs have made significant strides over the years to inform and educate their patients about the importance of using their Health/Medical Home (primary care setting) as a first option for non-emergent needs.

Most of our Health Center members have weekend, evening hours, and/or walk in care, as well as 24 hour on-call service to answer patient questions when the office is closed. They also provide case management and chronic disease management to follow up on patient visits for such conditions as diabetes, COPD, asthma, and depression, as well as ensure that medications are being taken properly so as to avoid adverse interactions. Additionally, several Health Centers are using innovative technology, such as HealthInfoNet to monitor ED use among their patients so they can follow up with them to learn about why they went there instead of the Health Center

first. If during those conversations, the Health Centers' staff determine that their health issue could have been more suitably addressed in the primary care setting, they will inform and educate the patient as to why they should call them first in the future for similar or related circumstances. Jim Davis, the CEO at Pines Health Services with sites in Caribou and Presque Isle partners with their local hospital, Cary Medical Center, and *"receives daily information on ED visits and hospital admits to enable follow up by pre-visit planners, nurses and care coordinators."*

Despite all of our efforts to address the over-utilization of Emergency Departments for acute and other primary care-related needs, there are circumstances where such visits cannot or should not be avoided.

One such example provided by Holly Gartmayer-DeYoung, CEO at Eastport Health Care, which serves high percentages of low-income, and elderly patients, as well as fisherman and others who work in high-injury risk occupations: *"Sometimes EHC refers patients to the ED as part of the treatment option for an acute issue, i.e-exacerbation of COPD (chest x-ray and IV meds may be necessary to stabilize the patient); an acute injury that might require setting a fracture or suturing a wound. EHC makes every effort to have patients use their Primary Care Provider (PCP) for all non-emergency related health issues "Call EHC first." However, we have patients that consistently don't comply because they have dementia and don't remember, or a developmental disability. Supporting a case management/Health Home model is an ideal way to address this issue as opposed to charging for the ED visit."*

Addie Carter, the CEO of East Grand Health Center noted that: *"Our Health Center is closed on the weekends and we don't open until 8:30am. I can see this posing a problem in the winter months as well when we are closed due to inclement weather and also during observed holidays."*

The lack of reliable, affordable, and publicly available transportation remains is one of, if not the biggest barrier that our Health Centers' patients face in accessing care. For some of our most rural and frontier areas, the situation is even more dire. At Harrington Family Health Center, some patients who reside on the outer borders of their service area, have admitted to going to the local hospital because it was closer and they didn't have transportation that would get them back and forth to their appointment at the Health Center. If improvements were made to increase access to public transportation in communities where there is none, we would potentially see a corresponding decrease in missed primary care appointments as well as fewer non-emergency ED visits.

We welcome the opportunity and stand ready to continue working with the Department on strategies and approaches that will further reduce non-emergency ED utilization. However, given the barriers faced by those who lack transportation in rural areas, chronic diseases such as dementia that can affect a patient's ability to remember to see their primary care provider before going to the ED, and the difficulty low income patients already have in making a copayment of \$3 for primary care visits, the notion of charging \$20 per ED visit doesn't seem like a viable solution to this problem.

Allow Providers to Charge MaineCare Recipients for Missed Appointments:

The majority of Maine's FQHCs have policies concerning patients who miss appointments, commonly referred to as "no call, no show (NCNS)." Several Health Centers have a process in place whereby a letter is sent to the patient upon each instance of NCNS, with a discharge from the practice after 3 successive instances. Other members have a policy to call a patient to find out why they missed their appointment and if it is transportation-related, they identify ways to assist them in making their next visit.

While a couple of our Health Center members said they would be open to this policy change, the majority said they are not--and will not charge their MaineCare patients for missed appointments even if they are permitted to do so. The latter does not believe that doing so will increase revenue--in fact, they think it might actually add costs, or increase bad debt, in addition to being administratively burdensome.

Fish River Rural Health with sites in Fort Kent and Eagle Lake: *"We are opposed to this policy change as there is too much "gray" area involved in determining whether or not the patient should be charged for a missed appointment. Also, we believe the charge would eventually have to be written off to "bad debt." Transportation barriers are also a factor as well as the unpredictable weather...especially with long winters and short amounts of daylight."*

Lisa Tapert from the Maine Mobile Health Program agrees: *"Charging patients for missed appointments seems especially unfair when the MaineCare rides system that provides transportation to MaineCare clients free of charge routinely arrives late or not at all to pick them up. We have had practices threaten to drop patients because of missed appointments, when the reason the patients missed the appointment was because the MaineCare rides system was either so late in picking them up they already missed their appointment or never showed up at all. This is particularly a problem in the Greater Lewiston Area where some of our patients have stopped using the MaineCare rides system because it is so inconsistent and unreliable. Charging patients for those missed appointments feels like a double punishment."*

Jim Davis, CEO at Pines Health Services offers an additional perspective: *"Transportation barriers are considerable for our rural service area. Public transportation might as well be non-existent. Logisticare is no help unless you are able to schedule an appointment or determine the need for a visit more than 48 hours in advance. If not, you dial 911 and wait for the ambulance to provide at least one way "free" transportation."*

We understand and appreciate the Department's intent to address providers' concerns related to the frequency of missed appointments, but as several of our Health Centers noted, there are additional factors to consider in terms of why this occurs.

Additional Questions:

We would greatly appreciate the Department's response to the following additional questions concerning the Community Engagement and Work Requirements sections of the waiver application:

- How many MaineCare members are within each identified “able-bodied” eligibility group? And, what do they each constitute as a percentage of the total MaineCare population?
- How many of those members are not currently meeting the proposed Community Engagement and work requirements? Percent of the total “able-bodied” population?
- What percentage is the Department assuming for non-compliance? In other words, how many MaineCare members are expected to be dropped from MaineCare coverage for non-compliance?
- How is this information currently collected, if at all? If it currently isn’t collected, how will it be and by whom?
- The proposal references that MaineCare members will be assessed to determine whether or not they meet the work requirements. How will those assessments be conducted? And, by whom will those assessments be conducted?
- If health care providers are going to be asked or expected to conduct the assessments, how will those services be reimbursed?

The Department’s three main goals of this 1115 Demonstration are:

1. To preserve limited financial resources for the state’s most needy individuals and ensure long-term fiscal sustainability;
2. To promote financial independence and transitions to employer-sponsored or other commercial health insurance; and
3. To encourage individual responsibility for one’s health and health care costs.

Unfortunately, the changes proposed under its application do nothing to further those objectives. To the contrary, they undermine the intent and purpose of the federal Medicaid Act altogether. The more Mainers dropped from the MaineCare Program, the fewer federal matching dollars our State will be able to draw down to care for our most vulnerable, like children, the elderly and those with a disability. It is also important to note that individuals have a better chance of becoming financially independent when they have health insurance, as well as affordable access to high quality health care services-like those provided at Maine’s FQHCs. Many employers in Maine, particularly smaller businesses are finding it increasingly difficult to provide their employees with health benefits.....and most private health insurance plans, including those on the Marketplace, are unaffordable for low income earners. The notion that the State would terminate someone’s health coverage if they are too poor to afford a monthly premium isn’t sound policy nor is it consistent with our values as Mainers.

Maine’s FQHCs serve as a model of how integrated, high quality, primary and preventive medical, behavioral health and dental services should be delivered, and we are proud of our work which has earned us that reputation. However, we will only be able to continue serving our communities if we have adequate and sustainable funding to support our staffing, services and operations. For these reasons and those noted above, we respectfully urge the Department to withdraw its 1115 waiver application. Thank you.