



September 14, 2017

The Honorable Thomas Price, Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Re: MaineCare 1115 Demonstration Project Application

Dear Secretary Price:

The Maine Primary Care Association (MPCA), whose members include all 20 of Maine’s Federally Qualified Health Centers (referred throughout our comments as both FQHCs and Health Centers), respectfully submits the following comments on the Maine Department of Health and Human Services’ (Maine DHHS) Section 1115 Demonstration Waiver. Collectively, Maine’s FQHCs provide comprehensive, affordable, high quality primary and preventive health services to approximately 210,000 Mainers (1 in 6 Maine people); additionally, health centers employ over 2,000 individuals and last year contributed over \$311 million to the state’s economy (Capital Link Report, 2017).

Given the FQHCs’ strong ties to the communities they serve—and the relationships they work so hard to sustain within those communities—we oppose the considerable changes contemplated in Maine DHHS’ 1115 waiver application. If approved and implemented, the changes will lead to:

- **Further erosion of health care coverage and access for thousands of vulnerable Mainers in need.** At one of Maine’s largest FQHCs, for example, roughly 18,000 to 26,000 of the health center patients stand to lose coverage if they cannot meet the work requirements that the state lays out. At a smaller CHC in one of Maine’s most impoverished regions, the impact is just as significant—that CHC estimates that nearly 3% of their entire patient panel would be at risk for losing coverage. Ironically, given the emphasis in the 1115 Waiver application on a work mandate, this erosion of coverage presents a problem in terms of ongoing labor force participation. Without access to health care that keeps people healthy, we do not understand how DHHS can achieve its stated goal of “transitioning working-aged, able-bodied adults to employment and financial

independence.” In fact, access to health care through programs like Medicaid can often facilitate an individual’s ability to gain and maintain employment. For recent research on the links between labor market participation and Medicaid, see Jean Hall et al., “Effect of Medicaid Expansion on Workforce Participation for People With Disabilities,” *American Journal of Public Health*, Feb. 2017, or Rachel Garfield & Robin Rudowitz, “Understanding the Intersection of Medicaid and Work,” *Kaiser Family Foundation*, Feb. 15, 2017.) See also the initial findings of a new study on this issue from the Maine Center for Economic Policy: <https://www.mecep.org/decline-in-health-tied-to-decline-in-workforce/> (Accessed 9/14/17).

- **Increased financial strain for essential health care providers.** FQHCs, hospitals, and nursing homes—among other safety net providers—stand to lose patients, which in turn leads to further losses to already-stretched bottom lines. Maine’s 1115 Waiver application does not offer a legitimate way to offset inappropriate Emergency Department utilization, or to reduce bad debt and charity care. Many of our CHCs report, in fact, that when their patients lose health care coverage, they eventually seek treatment at the local ED. These adverse consequences are compounded by the fact that Maine has increasing rates of poverty (including 16.6 % of children living in poverty), and is a non-expansion state, so access to health care is already a challenge for many Maine people, especially in the state’s most rural areas.

Additionally, the 1115 Waiver application, as submitted, stands in stark contrast to the stated goals of the Medicaid Program. The key provisions of work requirements, co-payments, premium sharing, and asset testing do not meet the stated intent of the section 1115 Demonstration Waiver program itself. CMS lists on its website its four key criteria for evaluating section 1115 waivers (<https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>; accessed 8/31/17): 1). Increase and strengthen overall coverage of low-income individuals in the state; 2). Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state; 3). Improve health outcomes for Medicaid and other low-income populations in the state; and 4). Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

From our perspective, the 1115 Waiver application from Maine’s Department of Health and Human Services fails to demonstrate how it meets any of these criteria. As it is written, the application instead does the following: 1). It **threatens to further decrease and weaken overall coverage** for low-income individuals who cannot meet work requirements or who are unable to pay co-pays—these individuals are part of a growing vulnerable population in Maine; and 2). It **subverts provider networks** by adding both administrative and financial burdens, and impacting the stability of referral relationships as well as continuity of care at the local and regional level.

Furthermore, by disrupting life-saving treatment and prevention efforts, the proposed limits to eligibility worsen already declining public health outcomes (which is very problematic in a state that lacks public health infrastructure, as noted in a July 2017 editorial on Maine’s public health status: <http://www.pressherald.com/2017/07/29/maine-voices-states-ill-advised-to-neglect-its-responsibilities-for-public-health/>.) For more on Maine’s already-declining health outcomes, see America’s Health Rankings: <https://www.americashealthrankings.org/explore/2016-annual-report/state/ME>. Finally, in our view, none of the elements in the 1115 Waiver application from Maine DHHS are transformative in a way that would improve the efficiency of the MaineCare program—in fact, the provisions set forth in the application create additional operational challenges that Maine DHHS does not explain how it will address.

While our comments below are focused on key provisions within the Waiver application, we want to be clear that we oppose the 1115 Waiver in its entirety.

Key Provision: Work Requirements

For MaineCare members who are between the ages of 19-64 and so-called “able bodied,” the Department proposes a minimum of 20 hours per week of work, or other approved activities (i.e., volunteering). Failure to engage in these activities will result in termination of Medicaid after three months. While there are some exemptions to this requirement, we oppose the work requirement on several grounds:

- 1). Any gap in coverage has the potential to create additional burdens on both individuals as well as the health care system. Imagine a diabetic patient who has just stabilized as a result of obtaining treatment with a new PCP because she has Medicaid coverage. She has a part time job but her hours are reduced suddenly to below the 20 hours per week threshold and she cannot get additional hours. She loses Medicaid coverage and stops treatment, and is now unable to pay for her maintenance medication. As a result, she ends up in the ED repeatedly and costs the system more money than if she’d had continuous coverage.
- 2). It is unclear the level to which the work requirement will be monitored and what role providers, such as FQHCs, will have in “policing” this requirement. Anything that could detract from patient care—such as additional check-ins to determine if a patient is meeting this requirement—is a waste of resources and certainly does not contribute to the “transformation of service delivery networks.”
- 3). As mentioned above, there is evidence suggesting that health care access is a key way for people to participate in the labor market.
- 4). Maine is a state with a high proportion of seasonal jobs such as fishing. This industry and others like it may suffer disproportionately, as the nature of the work means there will be months when individuals are not employed. The Waiver does not clearly address how seasonal workers will be treated.

Key Provision: Monthly Premium Payments for Continued Coverage

The Department proposes to require monthly premiums for so-called “able-bodied” adults. Premiums range from \$10-\$40 per month, depending on income level. For many individuals on MaineCare, the proposed premiums represent a significant amount of their family’s income. As one FQHC CEO put it: *“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 and the result is that patients who lose coverage as a result of not being able to afford their premiums will go to the ED for visits. This also means 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.”*

Another FQHC leader echoed 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 current \$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.”*

Consider the experience of one FQHC in central Maine, which reports that for the 10 years since being on an Electronic Health Record, there were \$23,079 in MaineCare co-pay adjustments made, which translates into 7,693 visits where the \$3 copay was withheld from 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 3 times that amount (\$10) at the lowest premium level?

Similarly, one of Maine’s largest health centers added that “if our patients are not paying their \$3 co-pays now, the probability of them paying a MaineCare premium is quite slim.” In fact, this FQHC estimates that up to 53% of their Medicaid patients would lose coverage as a result of inability to pay. The health centers’ collective experiences strongly suggest that the majority of those subject to premium requirements would lose their Medicaid coverage very quickly.

Key Provision: Elimination of Retroactive Medicaid Eligibility

Eliminating retroactive Medicaid eligibility will impact adversely the FQHCs’ ability to receive adequate payment for services already rendered, and it will further eat away at the scant resources they have available to devote to patient care. The Department argues in its application that “providers should determine whether or not they wish to deliver a service based on insurance status of the individual at the time of service, not based on the potential for future retroactive coverage” (see page 11 of the state’s application). This argument presents a dilemma that is especially challenging to FQHCs, which by law must 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 does not cover operating costs, they must—in order to remain financially sustainable—rely on a patchwork of funding, including

reimbursement from private insurers, Medicare, and Medicaid (according to 2016 UDS data, 23% of health center patients in Maine had Medicaid as their coverage source.)

The following example illustrates the challenges of limiting retroactive coverage in another way: *“When patients receive mail 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 patients to renew their MaineCare without a gap in coverage [and] 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 ability to access seamless cancer treatment.”*

Key Provision: Charges for “Non-Emergency” Use of the Emergency Department:

The Department proposes to charge patients with Medicaid \$10 for each non-emergency use of the Emergency Department. This assessment is based on visits that are attached to specific ICD-10 codes, many of which would meet a “prudent person standard” for presentation at an Emergency Room. The Department failed to explain adequately their justification for specific codes as opposed to others. For example, if a child has an acute and serious asthma attack, it appears that this provision would penalize a parent who brings their child in for treatment. In many cases, serious asthma attacks do not lead to inpatient admission, but a MaineCare parent would be punished for doing what any good parent would do if their child were having difficulty breathing.

While we share the Department’s goal of reducing non-emergency use of Emergency Departments, the majority of FQHCs believe this approach will not achieve the desired outcome. Maine’s FQHCs have made significant strides over the years to educate their patients about the importance of using a Health/Medical Home (primary care setting) as a first option for non-emergent needs. In fact, most of our Health Centers 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. These sites 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.

Despite all of these efforts to address 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 is provided by a CEO at a remote health center in Washington County, Maine: *“Sometimes we refer 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. We make every effort to have patients use their Primary Care Provider (PCP) for all non-emergency related health issues. 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/ home health model is an ideal way to address this issue as opposed to charging for the ED visit.”

Additionally, the lack of reliable and affordable transportation remains is one of, if not the biggest, barrier that Health Center patients face in accessing care. For some of our most rural and frontier areas, the transportation situation is dire. At a remote Washington County health center, for example, 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 did not 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 likely would see a corresponding decrease in missed primary care appointments as well as fewer non-emergency ED visits.

We 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 \$10 per ED visit is not a viable solution to this problem.

Conclusion

The Department’s stated 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 disabilities. Additionally, as we have pointed out throughout our comments, 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, such as 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 suggestion to terminate someone’s health coverage if they are too poor to afford a monthly premium does not make sound policy.

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 the work that has garnered us such a reputation. However, we can continue to serve Maine communities only if we have adequate and sustainable funding to support the required operations that make those services feasible. For these reasons and those noted above, we respectfully urge CMS to ask Maine to withdraw its 1115 Waiver application, or to re-work the application to meet the spirit and intent of the 1115 Demonstration program.

If you require additional information, please feel free to contact Darcy Shargo at the Maine Primary Care Association (dshargo@mepca.org) or at 207-621-0677. Thank you for considering our comments.