



TO: Ms. Laurie Halligan
Governor's Office of Health Policy and Finance
15 State House Station
Augusta, ME 04333

FROM: CAHC Coalition and Maine Equal Justice Partners

RE: Written Comments on Draft 2010-12 State Health Plan

DATE: June 18, 2010

Thank you for the opportunity to provide these written comments as a supplement to our oral testimony delivered at the public hearing on June 9, 2010 (attached).

For over 20 years Consumers for Affordable Health Care Coalition has worked to protect the rights of health care consumers in Maine. We are a nonprofit, nonpartisan, research and advocacy organization committed to helping all Maine people obtain quality, affordable health care. We represent a diverse, broad-based coalition of approximately 40 members, including individuals, faith-based groups, small businesses, and other advocacy organizations.

OVERVIEW

We would like to offer some general recommendations as to tone and content. We offer the following comments and suggestions for that purpose.

First and foremost, we firmly believe that health care is a human right. Regardless of income, race, ethnicity, age, disability, residency, orientation, or gender, every person is entitled to receive comprehensive, coordinated, quality health care in a system that is transparent, efficient, and accountable to the people it serves. This mission should be the frame through which all decisions about public health, health care access, and delivery and payment systems are analyzed and developed. We support inclusion of such a statement in the State Health Plan, and this may fit within the principles listed on page 13 as noted below.

The Plan highlights Maine's leadership in health reform and success in reducing the number of uninsured. We must not, however, rest on our laurels. While it is commendable that our health status has improved from 16th to 9th since 2003, we should still strive to be first in the nation. To help us get there, the Plan should recognize the correlation between health care coverage and health status; without health insurance, a person is more likely to delay or forego necessary care, and often need more expensive care later. Some Maine residents will die because they lack health insurance. The State Health Plan should include language that protects coverage gains that Maine has already achieved as we move forward through implementation. Maine should be ensuring that people who are currently covered are not placed at risk of losing coverage, especially coverage for critically important primary care and prevention that will help them stay

healthy and help reduce the need for more expensive medical interventions in the future. Thus, we support the Plan's inclusion of the need to expand access to primary care and prevention. A statement recognizing this connection may be appropriate in Section V.

We also support the goals of eliminating waste and inefficiencies in our health care system in order to help contain costs. Cost containment is critical to bringing down the skyrocketing costs of premiums for private insurance so that those seeking health insurance in the individual market are able to afford quality coverage, especially those at moderate income levels.

The plan acknowledges that achieving many of its goals will require additional data. One example that bears emphasizing is that health disparities among various populations are largely undocumented in Maine. This is because the necessary racial and ethnic data, including language, are not currently being collected in a systematic way. In addition, the racial and ethnic categories that are used are not standardized, posing significant problems for determining accurate trends and/or needs. We strongly encourage including a goal to address this issue in the final version of the plan.

Although the word "citizen" was removed on page 4 per Ed Miller's suggestion, it appears multiple times throughout the remainder of the Plan, (i.e. pp. 7, 12, 14, 17, 22, 33 – this list is an example and does not purport to be exhaustive) and should be changed in order to be as inclusive as possible for all Maine people.

We welcome and support the renewed commitment to working with Maine's tribes. We are hopeful that a truly collaborative approach will be taken in order to expand access to primary and preventive care. Such an approach is critical to reducing disparities.

Another piece of the data issue also recognized by the plan and worth emphasizing is the need for greater transparency. As part of the continued effort towards more transparency the information currently provided to the public through various state and private websites needs to be more accessible, coordinated, and user-friendly.

DETAIL REVIEW

Section III “Where We’re Going”

- Page 13: We would encourage the Council to add another principle that recognizes the correlation between increasing health coverage and improving health status.
- Page 13: There are two references to documenting “measurable savings or return on investment” as we reform our health care system. We suggest that there be a statement added that recognizes that those savings and returns should be shared with the ultimate payers of all health care costs (consumers) and reinvested into improving the system, not simply added to profit lines.
- Page 13: We strongly recommend that another principle be added stating that health care is a human right.

Section IV – “Reduce Inefficient Practices and Waste”

- We agree with the comments made by Peter Kraut, Maine Primary Care Association, at the June 9th Public Hearing, that this section be amended to “Strengthen Primary Care and Reduce . . .” We agree that greater emphasis on primary care is needed as we work toward the goal of ensuring that every person in Maine has access to comprehensive and coordinated care. We also support the inclusion of a goal that calls on the legislature, Governor’s office, Maine Primary Care Association and Congressional delegation to work together to bid for the competitive funding for Community Health Centers in the Patient Protection and Affordable Care Act. This may be best delegated as a task under Goal IV.1.
- Page 14, 3rd bullet: Please provide a link to the “statewide plan for reducing the incidence of healthcare-associated infections” that is mentioned in this bullet.
- Page 16, 2nd bullet: In light of the data included in this bullet, we urge the inclusion of goals and tasks that seek to reduce the spending associated with these categories without eliminating services that would lead to worse health outcomes. One goal could be to convene a meeting of interested parties to create a pilot project that would address the unique needs of these populations. Tasks could include identifying best practices of delivering care by reviewing available data, some of which might stem from the current Schaller Anderson care coordination initiative.
- Page 17, Goal IV.1: We would encourage that a definition of “patient centered medical home” be added to this goal.
- Page 18, Goal IV.2: We applaud the inclusion of this goal, yet we urge stronger action be taken to ensure that this goal is achieved within the next two years.
 - Task 1, Bullet 1: There should be an open and transparent process for reviewing the data regarding “savings resulting from reduced emergency room” and which payors benefit from the savings and how those saving are reallocated within the system.

- Task 1, Bullet 2: Undertaking a second emergency room study between now and 2012 seems premature. The creation and implementation of a 24/7 call system, evening and weekend hours and consistent and standard follow up practices after discharge should be the immediate focus. Perhaps after such processes are in place for two years a second study would be warranted.
 - Task 4: We do not have a specific recommendation to offer at this time, but implore you to integrate systematic opportunities for consumer input as you address this task.
- Page 18-19, Goal IV.3: We applaud the inclusion of this goal as an effective and efficient means of delivering health care services in areas of Maine where physicians and specialists in particular are scarce. We urge the Council, however, to include language that clearly states that telehealth should supplement a patient's medical home rather than becoming the exclusive means of care. Additionally, use of out-of-state providers must be addressed. Use of these providers can present both an access and cost advantage, however, we must be sure that such providers are appropriately certified and that there are no obstacles to their reimbursement.
 - Page 20, Goal IV.4: We applaud this goal and believe that it is essential if Maine is to contain costs within our health care "system". The Tasks, however, should include making the data accessible to the public and making it transparent. Also, we would urge the inclusion of real targets, similar to those in Goal IV.5, i.e. reduce unnecessary or duplicative laboratory tests and advanced imaging by x% by 2012.
 - Page 20, Goal IV.5: This is a critical issue and we are pleased to see it addressed.
 - Task 1, Bullets 3 and 4: We request that any public reporting be coordinated in both location and format with other cost and quality reporting initiatives to create greater ease of use for the consumer (e.g. report in the same location and fashion as data required per PL 2009, Ch. 350).

Section V – "Strengthen Public Health and Prevention"

- Page 22: There is a need for increased accountability within the Healthy Maine Partnerships (HMPs). It is essential that explicit models and performance measures be developed to hold the individual partnerships accountable. We firmly believe that the HMPs have the opportunity to be very effective but we are concerned that resources aren't being used as efficiently as possible.
- Page 26, Goal V.3:
 - Although gathering population health indicators for the four federally recognized tribes in Maine is long over due, we would strongly encourage that this goal be expanded to include all of Maine's racially and ethnically diverse populations.
 - The second bullet under the Tasks for this Goal provides "Work to develop actionable strategies to address the identified priorities." We would encourage the Council to change this to "Develop actionable strategies to address the identified priorities." As

a state we need to develop strategies to stem and resolve the health disparities that exist in Maine sooner rather than later.

- Page 27, Goal V.4: We recommend adjusting this goal and its tasks to better incorporate mental health along with substance abuse. Additionally, please consider including a representative from NAMI or another advocacy group for the mentally ill on the Task Force contemplated in bullet 1.
- Page 27, Goal V.5: We enthusiastically endorse inclusion of this task and recommend that the Council consider creation of a consumer assistance program, (i.e. as potentially funded by the federal Patient Protection and Affordable Care Act), to help educate patients about access programs, community resources, and disease management. The state should also explore developing something akin to a medical desk reference for the consumer, written in plain English that lists a variety of non-acute conditions, their symptoms, and how to treat them, along with a list of resources (e.g. public health, disease management support groups, coverage programs, etc.) to complement the assistance program. In addition, we encourage the Council to recognize the critical link between health care coverage and patient engagement and interface with the health system. Finally, we recommend increased models of care coordination, as emphasized in the Plan's section on Payment Reform, to support patients' ability to access their health information, risk assessment, professional assistance, and treatment plans in ways that are user-friendly and transparent.

Section VI – “Pay for What Matters”

- Page 29, Major Findings, 2nd Bullet: We strongly encourage you to pursue the strategy of “Payments for coordinating the care of patients with complex or chronic conditions to prevent complications of disease and reduce costs by reducing the need for costly interventions related to those complications” (p. 30 3rd bullet) as one of several utilized in payment reform activities. We must create a payment system that incentivizes higher quality, better patient outcomes and experience, and greater efficiency. We believe that starting with our most vulnerable populations, e.g. older adults and those living with multiple chronic conditions, is critical to achieving our payment reform goals.
- Page 31-32, Goal VI.1 and VI.2: The addition of a professional consumer advocate on both the Advisory Council and the Payment Reform Sub-Committee is necessary to best represent consumer interests and ensure transparency. Payment reform will have a profound impact on how health care is delivered in our State. It is imperative that the ultimate payor - the consumer - is represented in these discussions. We wholeheartedly endorse the two primary goals of payment reform: Controlling unnecessary spending and promoting positive outcomes. Achieving both of these goals will require a delicate balancing of priorities and buy-in from consumers/patients. We strongly believe that including consumer input is necessary to strike the appropriate balance.
- Page 32, Desired Outcomes: We do not believe any of the five outcomes listed meet one of the two primary goals (“Promoting positive outcomes”) and thus ask that you add:

“Ensure that our health care system provides the comprehensive, coordinated, patient-centered care that individuals want and need.”

Section VII – “Align Policies and Systems”

- Page 36, VII.1, Task 6: We applaud inclusion of this task as it is an integral component of the aforementioned goal of reducing disparities. We would encourage the Council to include a strategy that develops and utilizes a consumer assistance program (as potentially funded through the Patient Protection and Affordable Care Act) to provide navigation resources, i.e. interpreters and translators, to enhance access.
- Page. 37-39, Goal VII.2 and VII.3: We applaud the Council’s recognition of oral health as a vital and integral part of overall health care and for addressing tasks to improve the delivery of and access to oral health services in Maine. The second Task under Goal VII.3 is critical to successfully improving the oral health of Maine people. In light of the fact that there are new, emerging models for mid-level practice, the Council may want to include a “report back” on what the models are, how they were achieved and current obstacles, if any, that are being encountered.
- Page 38, Goal VII.2: We would also encourage the Council to explore other barriers to access beyond the shortage of providers in rural areas. Specifically, like many other preventive services, access to oral health care, i.e. dental exams, x-rays, and regular cleanings, is often hindered by issues with transportation, cost-sharing, and long waiting times to secure an appointment.
- Page 41, Goal VII.5: We applaud you for acknowledging that although population specific data on race and ethnicity is required by federal law, it isn’t currently being done in Maine on a consistent basis. We also encourage you to consider means to enforce the collection of data, specifically recommending legislation to ensure that responsible parties comply with the law to make the data more reliable in an effort to be more effective in reducing disparities. As suggested below, we believe requiring consistent data collection as a condition of CON approval may also assist with this goal.
- Page 43, second bullet: We would encourage the Council to expand the second bullet to say “Improved coordination of care and communication among providers and patients across all health delivery systems”.
- Page 44: We would encourage the Council to add “Improved transparency through assessment and reporting of quality of care, patient experience, and health outcomes” to the system improvements realized through health information.
- Page 45, Goal VII.6 Tasks: We ask that consumer engagement be made a priority in the pursuit of this task. Consumers have a vested interest in the privacy and security of their medical records and should be consulted at every opportunity. Specifically, we recommend that you convene a consumer advisory working group to ensure that consumers from diverse backgrounds whose coverage spans a variety of sources (e.g.

MaineCare, private insurance, Medicare, etc.) have input. The MaineCare HIT discussion, for instance, had significant consumer input that was invaluable to that discussion. This working group should have the authority to make recommendations to the Legislature in the same way the Legal Working Group has.

- Page 47, last paragraph: Please correct reference to CIF being determined “annually” as it is now on a 3 year schedule.
- Page 48-49, Goal VII.6 (HISS Program):
 - In item #2, bullet #1, please add a clarifying statement that the two references to payors include consumers.
 - In item #2, bullet #2, please specify that reports regarding the “savings” be transparent and available to the public.
 - In item #3, please provide clarification that the comment solicited will be a public comment session.
 - We would like to see the HISS program robustly evaluated in a transparent manner to determine its effect on cost containment goals of the CON/CIF process. Thus, we would like to see a 6th item added to this section to outline an evaluation process.
- Page 50, Goal VII.7: As a general comment, adding a requirement that a CON applicant demonstrate consistent collection of racial and ethnic data before obtaining CON approval may help the state obtain more reliable data and better address health disparities.
 - In item #1, please consider adding language that would encourage projects to focus on integrating services that address significant health challenges but that may not be considered health care services or public health services, per se (i.e. transportation services, housing services, social supports, etc.).
 - In item #1, bullet 4, please specify that the applicant’s data collection and reporting be publically available.
 - In item #3, please specify that the patient safety and quality improvement plan be publically available.

Section VIII – “Implement Federal Health Reform”

We applaud the inclusion of this section as part of the State Health Plan. The passage of the federal Patient Protection and Affordable Care Act of 2010 (PPACA) presents game changing opportunities for improving health care in the United States. Beginning a public transparent process for making needed implementation decisions will ensure that the Act is carried out in the spirit in which it was passed.

We wholeheartedly agree that Maine’s long history of health reform positions us well to be a leader to the nation in mapping out the implementation steps. We are encouraged by the coverage gains we have achieved since the last State Health Plan and have high hopes for the

greater gains our state will achieve as a result of the PPACA and swift implementation at the state level.

Below we offer a few specific comments for your consideration; however, as are many other stakeholder groups, we are still analyzing many portions and options under the PPACA and have not developed consumer positions on many topics. Thus, as a general request, we ask you to insert into any tasks or action items that you will solicit stakeholder input and feedback as the state makes policy decisions for implementation.

Background:

- Page 55 contains two errors:
 - Our understanding of the HRSA program is that Dirigo will not be operating like an exchange. Each participant will enroll in their eligible employer’s plan; Dirigo will not create a marketplace for them to purchase insurance.
 - “[H]ealth status to thirteenth best in the nation in 2009 (up from 25th in 2003)” should be changed to “ninth best in the nation in 2009 (up from 16th in 2003)”.

Major Policy Options:

- Page 59, Who Administers the Exchange: State or not-for-profit: An additional factor to consider is that it has been our experience that consumers are often denied access to due process when non governmental organization takes over certain functions. This concern can be addressed; however, if an RFP contains appropriate due process standards.
- Page 60, Funding to Support Development of the Exchange: We agree that the state should take advantage of funding opportunities as soon as possible – timelines throughout this section will need to be aligned with these opportunities.
- Page 60, Eligibility Determinations: This work will need to be done to bring Maine systems in line with federal eligibility standards. We also need to assess the DHHS integrated system and existing Dirigo system to see if both are needed and if so, how would they work together. It should be noted that there will no longer be an asset test.
- Page 61, Longer Term Decisions: These longer term decisions should be catalogued and fleshed out so that decisions made now do not limit our options later.
- Page 62, Goal VIII.1 Task 1: We agree with the need to create option papers and encourage the inclusion of more than just the named groups in the process. In fact, we point to the model used to develop this state health plan e.g. making drafts publically available, public hearings and the inclusion of relevant constituencies, as a path to create these option papers.

Dirigo and the Federal Financing of Reform

- Page 63: A correction should be made to the first full paragraph on the page - not all DirigoChoice enrollees will be eligible for the new tax credits, only those currently receiving subsidies and a subset of those not currently eligible for subsidies.
- Page 63: We think it is premature to consider the future of the Dirigo assessment. We do not yet have a complete picture of the costs of implementing these reforms. For example, one gap in funding may be for the inclusion of state mandates within the exchange when the mandated benefit is not part of the essential health plan.
- Page 64, “Public Option”: We would urge a thorough review of the benefits of developing a basic health program before dismissing it as a viable option for coverage. Establishing a basic health plan does not necessarily mean that Maine will have three different health care programs. With the State moving to Medicaid Managed Care, it might be possible and cost effective to place adults with income between 133 and 200% of the FPL into the same plans, and thereby protect this group from excessive cost sharing. Doing so would eliminate any unnecessary confusion, because adults with incomes between 0 and 200% would have access to the same coverage, similar to coverage for children through Medicaid and CHIP. In addition, parents from 133 to 200% would maintain access to the same plans as their children on MaineCare.
- Page 65, Goal VIII.1 Task 2: We would encourage delay in creating a list of options with respect to assessment until there is more information on additional costs that may accrue to the state (12/31/2011). There should be implementation of earlier steps to address the creation of a basic health program, to include a thorough review of all options.
- Page 68, footnote 16: Maine covers pregnant women up to 200% of FPL, not 185%.
- Page 69, first paragraph, about midway down: There is an assertion that Maine will have to pay some state money for childless adults between 100 and 133% of FPL starting in 2017 because Maine is an expansion state. We believe this statement is inaccurate. Maine, like all states, will have to start expending some funds for newly eligibles beginning in 2017, regardless of whether the state is an expansion state or not.
- Page 69, third bullet: We are aware that this bullet is trying to outline possibilities, however, including this bullet, which if implemented would result in thousands of low-income parents losing health care coverage contradicts the desired outcomes of the State Health Plan. Stripping away coverage from this population will not improve their overall health or contain costs within our system as they will likely forego inexpensive preventive care and present with more acute, costly conditions. In addition, there is research that indicates children whose parents have health coverage are more likely to see the doctor than those whose parents don't have coverage. Protecting coverage that Maine currently has should be a priority for the ACHSD and the 2010-2012 State Health Plan.
- Page 72, Task 6: We reiterate our recommendation that the Advisory Council add a seat for a professional consumer advocate to its membership. Decisions regarding implementation will forever change the way Maine does business and it is essential that consumers have a seat at

the table. Overall, the Council should continue to conduct its hearings in a transparent manner.

- Page 73, Task 7: We ask that the agencies' work plans be made available to the public.
- Page 73, Task 8: We ask that the Council provide adequate notice of these meetings to the public and continue to maintain transparency by having all materials such as the progress reports easily available to the public.

Within the matrix of key issues and activities identified, we are in complete agreement with the concept, and suggest stating even more strongly, that the state agencies need to work closely with the legislature and stakeholders to have an informed and open discussion.

CONCLUSION

We look forward to working with you to ensure that all Mainers have access to quality and affordable health care coverage so that we can achieve the healthiest Maine possible. In the short term, we look forward to working together to ensure further development of a robust State Health Plan to help lead us there.