# MAINE STATE LEGISLATURE

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# POLICY LEADERS ACADEMY

MAINE DEVELOPMENT FOUNDATION

UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service

***Presents***

# Legislative Policy Forum on Health Care

***Friday, January 30, 2009***
***Augusta Civic Center***

# Issue Briefs

**Sponsored by:**

*Strategic solutions for Maine's health care needs*

# MAINE DEVELOPMENT FOUNDATION

February 6, 2009

TO: Legislators Unable to Attend PLA Health Care Forum

FROM: Laurie Lachance, President & CEO

RE: Issue Briefs Notebooks

We're sorry that you were unable to join us last Friday at the Policy Leaders Academy Health Care Policy Forum. The event was very well attended and the feedback has been extremely positive. All Legislators who attended the forum were given a handbook containing a great deal of information that, we believe, will be extremely useful to you as you face the myriad of legislation dealing with this critical policy area (your copy is attached). Each notebook includes:

- "An Overview of Health Care in Maine" - a Power Point presentation by Dr. Wendy Wolf, President of the Maine Health Access Foundation,
- 14 Issue Briefs on topics covered in the break-out sessions (including Dirigo, Medicaid, Prescription Drugs and Aging), and
- A complete resource list of speakers and panelists with their contact information.

The Issue Briefs were commissioned by the Maine Health Access Foundation and researched and written, primarily, by Maine's leading academic experts from the Muskie School of Public Service and the Margaret Chase Smith Policy Center. Each of these briefs were prepared in an easy-to-read format and are 4-6 pages long. They present a very balanced overview of the issues and the key policy considerations. Our hope is that this notebook will serve as a "Primer", enabling you to come up to speed fairly quickly on these diverse and complex topics.

Although you were unable to attend, we would welcome your feedback on the Issue Briefs and the other materials so that we can ensure that future publications are as useful as possible.

Best wishes in your important work in this and other policy areas.

LGL:dh
Enclosure

295 Water Street, Suite 5, Augusta, Maine 04330
Tel: 207/622-6345 Fax: 207/622-6346
E-mail: mdf@mdf.org www.mdf.org

Margaret Chase Smith POLICY CENTER
The University of Maine

MAINE DEVELOPMENT FOUNDATION
POLICY LEADERS ACADEMY

UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service

# LEGISLATIVE POLICY FORUM ON HEALTH CARE

## Friday, January 30, 2009
**Augusta Civic Center, Augusta**

## AGENDA

**8:30** **Registration, Networking & Continental Breakfast**

**9:00** **Welcome (MDF and Legislative Leadership)**
- Honorable Elizabeth Mitchell, President, Maine State Senate
- Honorable Hannah Pingree, Speaker, Maine House of Representatives
- Laurie Lachance, President & CEO, Maine Development Foundation

**9:20** **Overview of Maine's Health System**
- Erik Steele, Vice President & Chief Medical Officer, Eastern Maine Healthcare Systems

**9:55** **Breakout Sessions I**

a. **Innovations in State Health Reform**
***Moderator:*** Elizabeth Kilbreth, Associate Research Professor, Muskie School of Public Service
***Panelists:***
Neva Kaye, Senior Program Director, National Academy for State Health Policy
Kala Ladenheim, Public Health Consultant

b. **Medicaid**
***Moderator:*** Kimberley Fox, Senior Policy Analyst, Muskie School of Public Service
***Panelists:***
Brenda Harvey, Commissioner, Dept. of Health & Human Services
Erik Steele, Vice President & Chief Medical Officer, Eastern Maine Healthcare Systems

c. **Prescription Drugs**
***Moderator:*** Marcella Sorg, Director, Rural Drug & Alcohol Research Program, Margaret Chase Smith Policy Center
***Panelists:***
Jim Clair, CEO, Goold Health Systems Inc.
Nancy Kelleher, State Director, AARP Maine

d. **An Overview of Maine's Health Care System**
This session is not a panel. It is an educational session for all legislators.
***Presenter:*** Wendy Wolf, President & CEO, Maine Health Access Foundation

**e. Hospitals**
***Moderator:*** John Gale, Research Associate, Muskie School of Public Service
***Panelists:***
Scott Bullock, CEO, MaineGeneral Health
John Welsh, President, Rumford Hospital

**11:00 Break**

**11:10 Breakout Sessions II**

**a. Medicaid** – ***repeat of breakout session I-b***

**b. Health IT**
***Moderator:*** Joshua Cutler, Director, Maine Quality Forum
***Panelists:***
Devore Culver, Executive Director, HealthInfoNet
David Howes, President & CMO, Martin's Point Health Care

**c. Medical Transportation**
***Moderator:*** Ann Acheson, Research Associate, Margaret Chase Smith Policy Center
***Panelists:***
Norman Dinerman, Medical Director, LifeFlight of Maine
Marcia Larkin, Director of Community Support Department, Penquis

**d. Long-Term Care**
***Moderator:*** Elise Bolda, Associate Professor of Health Policy & Management, Muskie School of Public Service
***Panelists:***
Anthony Forgione, President & CEO, Seventy Five State Street
Diana Scully, Director, Office of Elder Services, Dept. of Health & Human Services

**e. Health Care Workforce**
***Moderator:*** M. Michelle Hood, President & CEO, Eastern Maine Healthcare Systems
***Panelists:***
William Beardsley, President & CEO, Husson University
Danielle Ripich, President, University of New England

**12:15 Lunch and Keynote Presentation**

**Charlene Rydell Memorial Lectureship**
*"Why National Health Reform is an Oxymoron"*
***Speaker:*** Alan Weil, Executive Director, National Academy for State Health Policy

**1:45** **Breakout Sessions III**

a. **Innovations in State Health Reform** – ***repeat of breakout session I-a***

b. **Children's Health**
***Moderator:*** Glenn Beamer, Director, Margaret Chase Smith Policy Center
***Panelists:***
Steve Meister, Pediatrician, Edmund Ervin Pediatric Center
Jonathan Shenkin, CEO & Pediatric Dentist, Penobscot Children's Dentistry Associates

c. **Mental Health/Behavioral**
***Moderator:*** David Lambert, Associate Research Professor, Muskie School of Public Service
***Panelists:***
Wesley Davidson, CEO, Aroostook Mental Health Center
Dennis King, CEO, Spring Harbor Hospital/Maine Mental Health Partners

d. **Health Care Workforce** - ***repeat of breakout session II-e***

e. **Opportunities for Health Insurance Reform**
***Moderator:*** Gino Nalli, Assistant Professor, Muskie School of Public Service
***Panelists:***
John Benoit, President, Employee Benefits Solutions, Inc.
Andrew Coburn, Director, Institute for Health Policy, Muskie School of Public Service

**2:50** **Closing Remarks**

**3:00** **Adjourn**

*Strategic solutions for Maine's health care needs*

## Policy Leaders Academy Partners:

MAINE DEVELOPMENT FOUNDATION

Maine Development Foundation
295 Water Street
Suite 5
Augusta ME 04330
Phone: 207-622-6345
Fax: 207-622-6346
Web: www.mdf.org

UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service

Muskie School of Public Service
University of Southern Maine
PO Box 9300
Portland, Maine 04104-9300
Phone: 207-780-4430
Fax: 207-780-4417
Web: www.muskie.usm.maine.edu

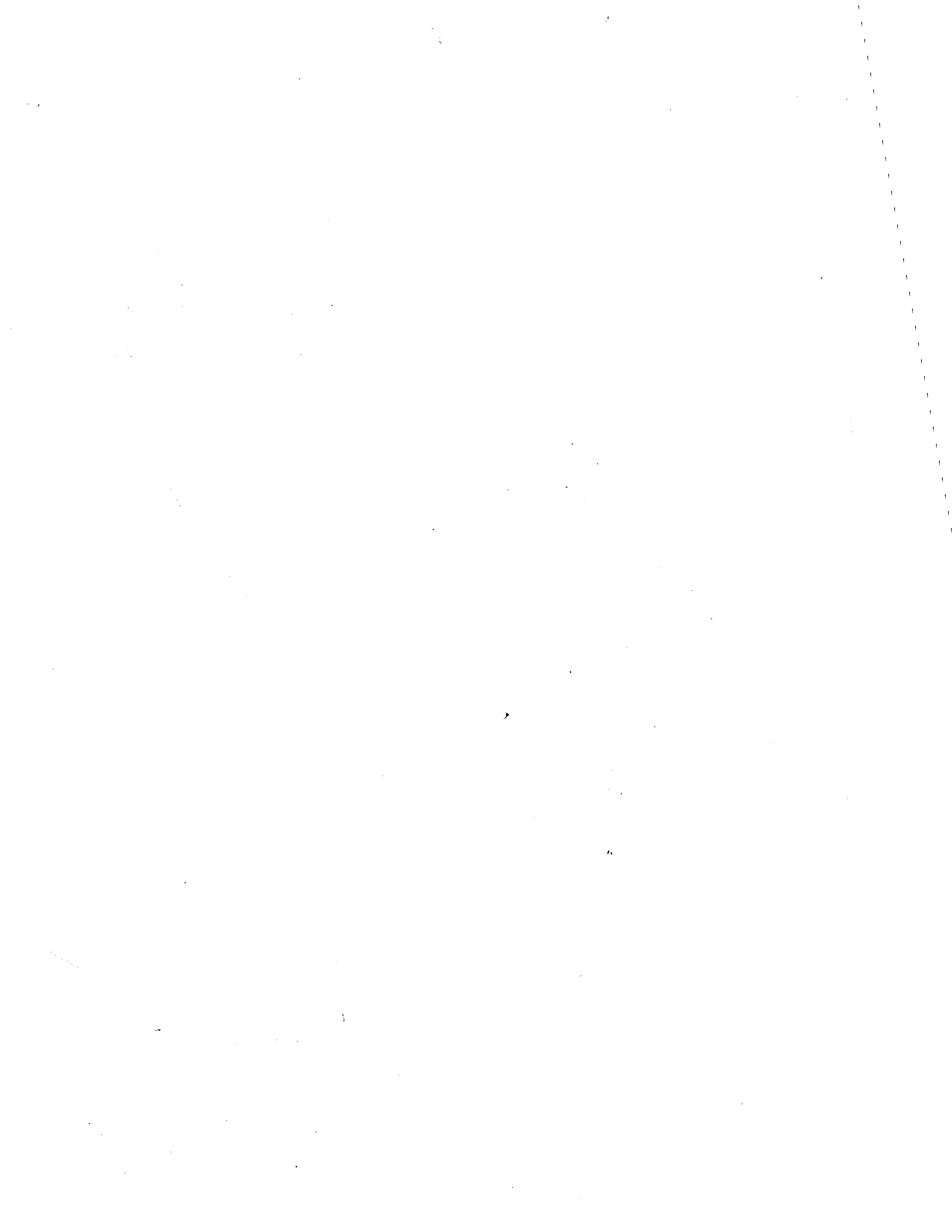
Margaret Chase Smith Policy Center
The University of Maine
5784 York Complex, Bldg #4
Orono, ME 04469-5715
Phone: 207-581-1648
Fax: 207-581-1266
Web: www.umaine.edu/mcsc

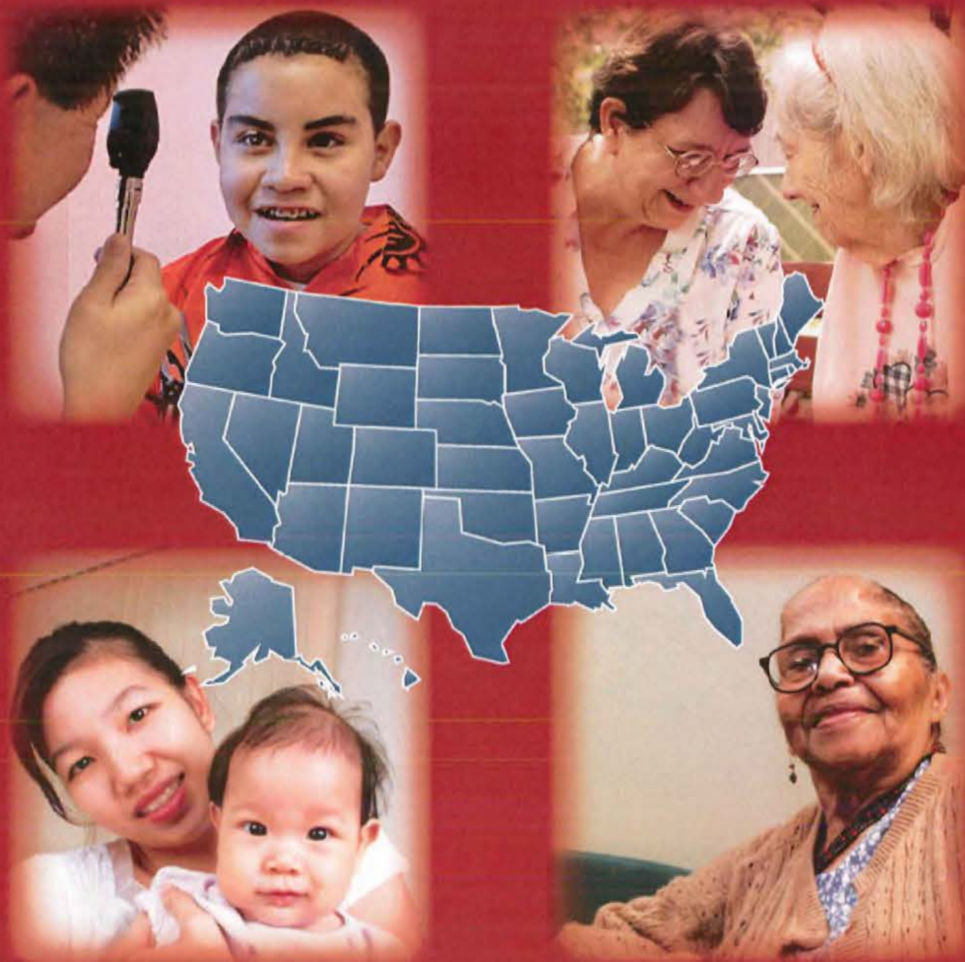
## Legislative Policy Forum on Health Care Sponsor:

*Strategic solutions for Maine's health care needs*

Maine Health Access Foundation
150 Capitol Street
Suite 4
Augusta, Maine 04330
Phone: 866-848-9210
Fax: 207-620-8269
Web: www.mehaf.org

Keynote





*Executive Summary*

# Aiming Higher

*Results from a State Scorecard on Health System Performance*

THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

JUNE 2007

## THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

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*Senior Policy Director*
The Commonwealth Fund

**Cathy Schoen**
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*Program Associate*
The Commonwealth Fund

## THE COMMONWEALTH FUND

The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good.

The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

COVER PHOTOS
TOP LEFT: ROGER CARR
TOP RIGHT: MARTIN DIXON
BOTTOM LEFT: PAULA PHOTOGRAPHIC
BOTTOM RIGHT: ROGER CARR

# Executive Summary

## *Aiming Higher*

### RESULTS FROM A STATE SCORECARD ON HEALTH SYSTEM PERFORMANCE

Joel C. Cantor and Dina Belloff
Rutgers University Center for State Health Policy

Cathy Schoen, Sabrina K. H. How, and
Douglas McCarthy
The Commonwealth Fund

**On behalf of the Commonwealth Fund Commission on a High Performance Health System**

June 2007

ABSTRACT: Developed to follow the *National Scorecard on U.S. Health System Performance*, published in 2006, the *State Scorecard* assesses state variation across key dimensions of health system performance: access, quality, avoidable hospital use and costs, equity, and healthy lives. The findings document wide variation among states and the potential for substantial improvement—in terms of access, quality, costs, and lives—if all states approached levels achieved by the top states. Leading states outperform lagging states on multiple indicators and dimensions; yet, all states have room to improve. The report presents state performance on 32 indicators, with overall rankings as well as ranks on each dimension. The findings underscore the need for federal and state action in key areas to move all states to higher levels of performance and value.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff, or of The Commonwealth Fund Commission on a High Performance Health System or its members. This report, related state tables, and other Fund publications are available online at www.commonwealthfund.org. To learn about new publications when they become available, visit the Fund Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 1030.

# Preface

The Commonwealth Fund Commission on a High Performance Health System is pleased to sponsor this first *State Scorecard on Health System Performance* in the hope that it will help meet the growing need for comparative state health system performance information and contribute to positive action among the states.

In the U.S. federal system, the states maintain significant authority over many health and regulatory policies that influence health system performance and health outcomes. States organize and deliver population health services, regulate health insurance markets, provide Medicaid coverage for the poor and State Children's Health Insurance Program (SCHIP) coverage for low-income children, purchase coverage for their employees and retirees, license and monitor health care providers, and finance charity care for the uninsured. Given these activities and levers, state policymakers across the country are realizing the tremendous opportunity they have to shape and improve health care at the local level for their populations.

In 2006, the Commission published *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* to comprehensively assess how well the U.S. health system is performing across key indicators of health care outcomes, quality, access, efficiency, and equity. Findings of the *National Scorecard* indicate that America's health system falls far short of achievable benchmarks, especially given the resources the nation invests. Based on these and other data, the Commission believes that transformation of the U.S. health system is urgently needed to achieve optimal health care for all Americans while improving value for society's investment in health care. States and their health delivery systems vary and include models and centers of excellence. In many instances even top-performing states do not reach as high a level as should be achievable—and all have substantial room to improve. Nonetheless, focusing on how top-performing states and organizations achieve high levels of performance will enable the entire country to improve. The *State Scorecard* underscores the need for national as well as state action in key areas to move all states to higher levels of performance and value.

**James J. Mongan, M.D.**
Chairman

**Stephen C. Schoenbaum, M.D.**
Executive Director

The Commonwealth Fund Commission on
a High Performance Health System

## *Executive Summary*

The rich geographical diversity of the United States is part of its appeal. The diverse performance of the health care system across the U.S., however, is not. People in the United States, regardless of where they live, deserve the best of American health care. The *State Scorecard* is intended to assist states in identifying opportunities to better meet their residents' current and future health needs and enable them to live long and healthy lives. With rising health costs squeezing the budgets of businesses, families, and public programs, there is a pressing need to improve performance and reap greater value from the health system.

The *State Scorecard* offers a framework through which policymakers and other stakeholders can gauge efforts to ensure affordable access to high-quality, efficient, and equitable care. With a goal of focusing on opportunities to improve, the analysis assesses performance relative to what is achievable, based on benchmarks drawn from the range of state health system performance.

Currently, where you live in the United States matters for quality and care experiences. The widely varying performance across states and sharp differences between top and bottom state rates on the 32 indicators included in the *State Scorecard* highlight broad opportunities to improve. If all states approached levels achieved by the top states, the cumulative result would be substantial improvement in terms of access to care, health care quality, reduced costs, and healthier lives.

> Note: This report summarizes results of the *State Scorecard* and presents overall state rankings and rankings on each of the five dimensions of health system performance. Appendices present state-level data for all indicators. *State Scorecard Data Tables* with data and state rankings on the 32 health system indicators and data for all equity comparisons can be downloaded from the Commonwealth Fund Web site at www.commonwealthfund.org. The Web site also provides individual state performance profiles that compare the state to the top state, top five states, and state median rates on all indicators. Also available on the Web site is an analysis of the impact on access, costs, and lives for each state if it were to achieve the top level of performance on each of 11 key indicators. State-specific profiles can be downloaded from the Web site.

The analysis of the range of state performance points to five cross-cutting findings:

- There is wide variation among states. This means that the potential exists for the country to do much better.
- Leading states consistently outperform lagging states. The patterns indicate that federal and state policies and local and regional health systems make a difference.
- Across states, better access is closely associated with better quality.
- There are significant opportunities to reduce costs as well as improve access to and quality of care. Higher quality is not associated with higher costs across states.
- All states have substantial room to improve.

### HIGHLIGHTS AND KEY FINDINGS

#### Health care access, quality, cost, and efficiency vary widely across the United States.

The range of performance is often wide across states, with a two- to threefold or greater spread from top to bottom. The variability extends to many of the 32 indicators across five dimensions of health system performance: access; quality; potentially avoidable use of hospitals and costs of care; equity; and the ability to live long and healthy lives (referred to as "healthy lives") (Exhibit 1). Improving performance across the nation to rates achieved by the leading states could save thousands of lives, improve quality of life for millions, and enhance the value gained from our substantial investment in health care.

If all states could approach the low levels of mortality from conditions amenable to care achieved by the top state, nearly 90,000 fewer deaths before the age of 75 would occur annually. If insurance rates nationwide reached that of the top states, the uninsured population would be halved. Matching the performance of the best states on chronic care would enable close to four million more diabetics across the nation to receive basic recommended care and avoid preventable complications, such as renal failure or limb amputation. By matching levels

EXHIBIT 1

**List of 32 Indicators in State Scorecard on Health System Performance**

| Access | Year | All States Median | Range of State Performance (Bottom – Top) | Top State |
|---|---|---|---|---|
| 1. Adults under age 65 insured | 2004–2005 | 81.5 | 69.6 – 89.0 | MN |
| 2. Children insured | 2004–2005 | 91.1 | 79.8 – 94.9 | VT |
| 3. Adults visited a doctor in past two years | 2000 | 83.4 | 73.9 – 91.5 | DC |
| 4. Adults without a time when they needed to see a doctor but could not because of cost | 2004 | 87.2 | 80.1 – 96.6 | HI |
| **Quality** | | | | |
| 5. Adults age 50 and older received recommended screening and preventive care | 2004 | 39.7 | 32.6 – 50.1 | MN |
| 6. Adult diabetics received recommended preventive care | 2004 | 42.4 | 28.7 – 65.4 | HI |
| 7. Children ages 19–35 months received all recommended doses of five key vaccines | 2005 | 81.6 | 66.7 – 93.5 | MA |
| 8. Children with both medical and dental preventive care visits | 2003 | 59.2 | 45.7 – 74.9 | MA |
| 9. Children with emotional, behavioral, or developmental problems received mental health care | 2003 | 61.9 | 43.4 – 77.2 | WY |
| 10. Hospitalized patients received recommended care for acute myocardial infarction, congestive heart failure, and pneumonia | 2004 | 83.4 | 79.0 – 88.4 | RI |
| 11. Surgical patients received appropriate timing of antibiotics to prevent infections | 2004–2005 | 69.5 | 50.0 – 90.0 | CT |
| 12. Adults with a usual source of care | 2004 | 81.1 | 66.3 – 89.4 | DE |
| 13. Children with a medical home | 2003 | 47.6 | 33.8 – 61.0 | NH |
| 14. Heart failure patients given written instructions at discharge | 2004–2005 | 49 | 14 – 67 | NJ |
| 15. Medicare patients whose health care provider always listens, explains, shows respect, and spends enough time with them | 2003 | 68.7 | 63.1 – 74.9 | VT |
| 16. Medicare patients giving a best rating for health care received | 2003 | 70.2 | 61.2 – 74.4 | MT |
| 17. High-risk nursing home residents with pressure sores | 2004 | 13.2 | 19.3 – 7.6 | ND |
| 18. Nursing home residents who were physically restrained | 2004 | 6.2 | 15.9 – 1.9 | NE |
| **Potentially Avoidable Use of Hospitals & Costs of Care** | | | | |
| 19. Hospital admissions for pediatric asthma per 100,000 children | 2002 | 176.7 | 314.2 – 54.9 | VT |
| 20. Asthmatics with an emergency room or urgent care visit | 2001–2004 | 15.5 | 29.4 – 9.1 | IA |
| 21. Medicare hospital admissions for ambulatory care sensitive conditions per 100,000 beneficiaries | 2003 | 7,278 | 11,537 – 4,069 | HI |
| 22. Medicare 30-day hospital readmission rates | 2003 | 17.6 | 23.8 – 13.2 | VT |
| 23. Long-stay nursing home residents with a hospital admission | 2000 | 16.1 | 24.9 – 8.3 | UT |
| 24. Nursing home residents with a hospital readmission within three months | 2000 | 11.7 | 17.5 – 6.7 | OR |
| 25. Home health patients with a hospital admission | 2004 | 26.9 | 46.4 – 18.3 | UT |
| 26. Total single premium per enrolled employee at private-sector establishments that offer health insurance | 2004 | $3,706 | $4,379 – 3,034 | UT |
| 27. Total Medicare (Parts A & B) reimbursements per enrollee | 2003 | $6,070 | $8,076 – 4,530 | HI |
| **Healthy Lives** | | | | |
| 28. Mortality amenable to health care, deaths per 100,000 population | 2002 | 96.9 | 160.0 – 70.2 | MN |
| 29. Infant mortality, deaths per 1,000 live births | 2002 | 7.1 | 11.0 – 4.3 | ME |
| 30. Breast cancer deaths per 100,000 female population | 2002 | 25.3 | 34.1 – 16.2 | HI |
| 31. Colorectal cancer deaths per 100,000 population | 2002 | 20.0 | 24.6 – 15.3 | UT |
| 32. Adults under age 65 limited in any activities because of physical, mental, or emotional problems | 2004 | 15.3 | 22.8 – 10.8 | DC |

*Note: All values are expressed as percentages unless labeled otherwise. See Appendices B1 and B2 for data source and definition of each indicator.*

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

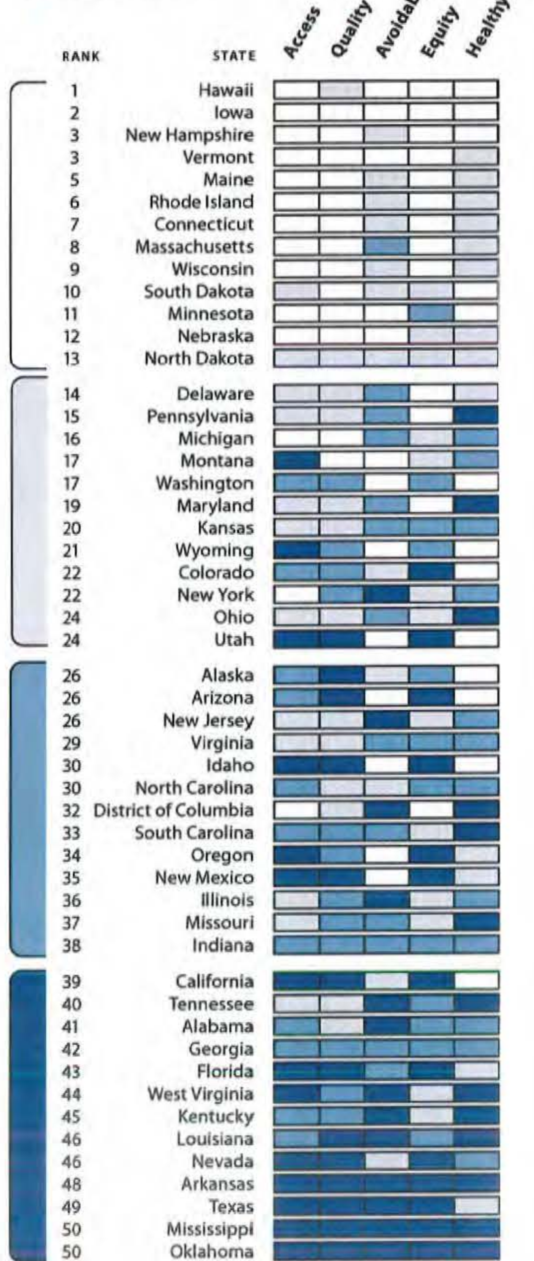



EXHIBIT 2

**State Scorecard Summary of Health System Performance Across Dimensions**

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

achieved in the best-performing states, the nation could save billions of dollars a year by reducing potentially preventable hospitalizations or readmissions, and by improving care for frail nursing home residents. If annual per-person costs for Medicare in higher-cost states came down to median rates or those achieved in the lowest quartile of states, the nation would save $22 billion to $38 billion per year. While some savings would be offset by the costs of interventions and insurance coverage expansions, there would be a net gain in value from a higher-performing health care system.

### Leading states consistently outperform lagging states on multiple indicators and dimensions.

Thirteen states—Hawaii, Iowa, New Hampshire, Vermont, Maine, Rhode Island, Connecticut, Massachusetts, Wisconsin, South Dakota, Minnesota, Nebraska, and North Dakota—emerge at the top quartile of the overall performance rankings (Exhibit 2). These states generally ranked high on multiple indicators in each of the five dimensions assessed by the *State Scorecard.* Many have been leaders in reforming and improving their health systems and have among the lowest uninsured rates in the nation.

Conversely, the 13 states at the bottom quartile of the overall performance ranking—California, Tennessee, Alabama, Georgia, Florida, West Virginia, Kentucky, Louisiana, Nevada, Arkansas, Texas, Mississippi, and Oklahoma—lag well behind their peers on multiple indicators across dimensions. Uninsured rates for adults and children in these states are well above national averages and more than double those in the quartile of states with the lowest rates. The rates for receipt of recommended preventive care are generally low, and mortality rates from conditions amenable to health care often high.

Health system performance often varies regionally. Across dimensions, states in the Upper Midwest and Northeast often rank in the highest quartile of performance, with those in the lowest quartile concentrated in the South.

States can look to each other for evidence of effective policies and strategies associated with higher performance. For example, in 1974,

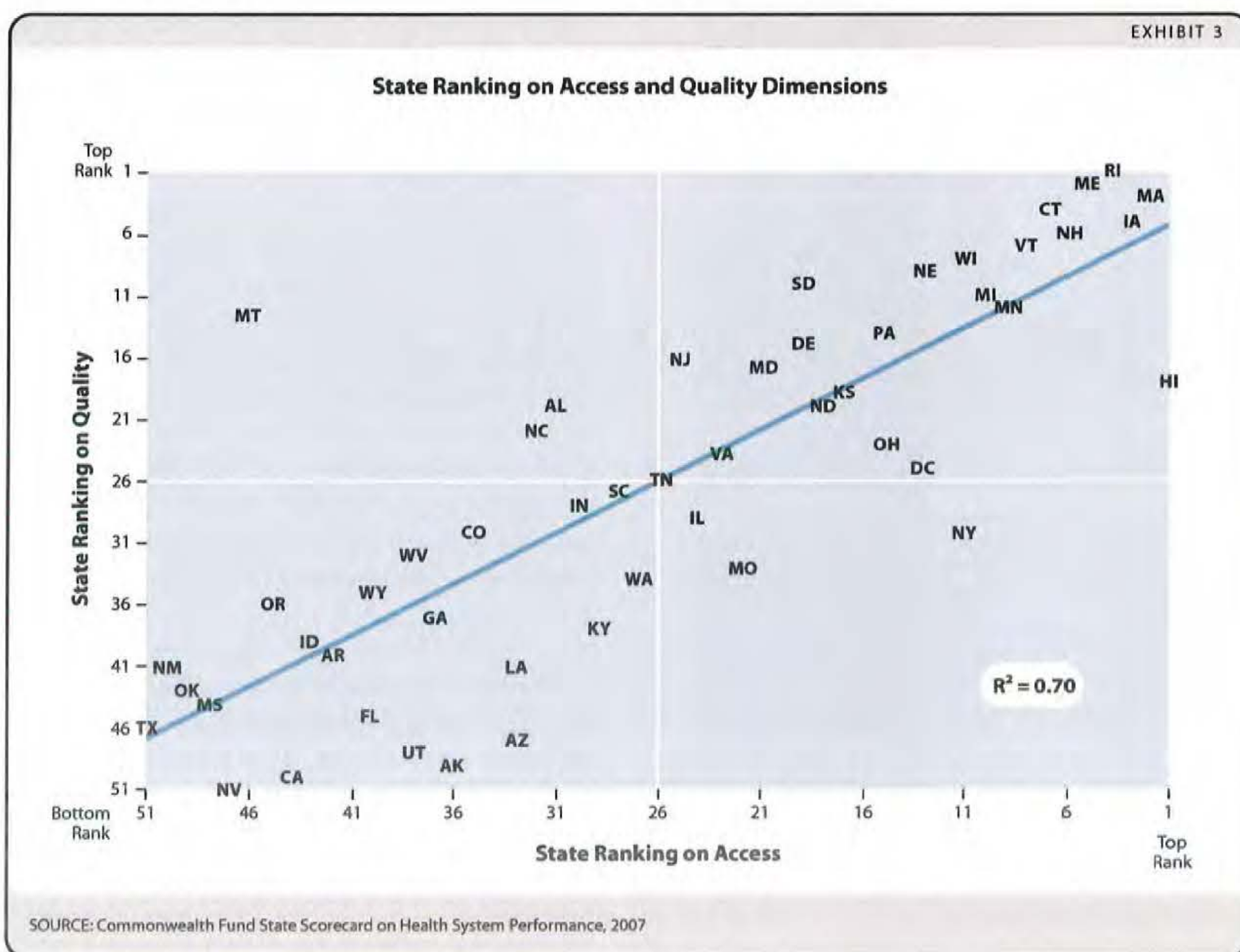
Hawaii became the first state to enact legislation requiring employers to provide health insurance to full-time workers; it now ranks first in terms of access to care. For the past decade, Rhode Island has provided incentive payments to Medicaid managed care plans that reach quality targets; it now ranks first on measures of the quality of care. Maine, Massachusetts, and Vermont lead in providing equitable health systems; the three states are recognized for their innovation and leadership on expanding health insurance coverage and benchmarking for quality.

The patterns indicate that federal and state policies plus local and regional health care systems make a difference. Leading states outperform lagging states on multiple indicators that span the dimensions of access, quality, cost, equity, and healthy lives.

**Better access is associated with better quality across states; insurance matters.**

Across states, better access to care and higher rates of insurance are closely associated with better quality (Exhibit 3). States with the lowest rates of uninsured residents tend to score highest on measures of preventive and chronic disease care, as well as other quality indicators.

Four of the five leading states in the access dimension—Massachusetts, Iowa, Rhode Island, and Maine—also rank among the top five states in terms of quality. Moreover, states with low quality rankings tend to have high rates of uninsured. This cross-state pattern points to the importance of affordable access as a first step to ensure that patients obtain essential care and receive care that is well coordinated and patient-centered. In states where more people are insured, adults and children are more likely



to have a medical home and receive recommended preventive and chronic care. Identifying care system practices as well as state policies that promote access to care is essential to improving quality and lowering costs.

The number of uninsured children has declined following enactment of federal Medicaid and State Children's Health Insurance Program (SCHIP) expansions for children. Yet, the high and rising rates of uninsured adults put states and the nation at risk as adults lose affordable access and financial security. The deterioration in coverage and the relationship between better coverage and better care point to a pressing need for national action to expand insurance coverage and ensure access to care.

#### Higher quality does not mean higher costs.

Annual costs of care vary widely across states, with no systematic relationship to insurance coverage or ability to pay as measured by median incomes. Moreover, there is no systematic relationship between the cost of care and quality across states. Some states achieve high quality at lower costs.

States with higher medical costs tend to have higher rates of potentially preventable hospital use, including high rates of readmission within 30 days of discharge and high rates of admission for complications of diabetes, asthma, and other chronic conditions. Reducing the use of expensive hospital care by preventing complications, controlling chronic conditions, and providing effective transitional care following discharge has the potential to improve outcomes and lower costs.

#### There is room to improve in all states.

All states have substantial room to improve. On some indicators, even the top rates are well below what should be achievable. There are also substantial variations in performance within states.

Among the top-ranked states, each had some indicators in the bottom quartile or bottom half of the performance distribution. Understanding how underlying care system features and population factors contribute to performance variations will help inform efforts to improve.

### STATE VARIATION: HIGHLIGHTS BY DIMENSION

#### Access

- The percent of adults under age 65 who were uninsured in 2004–2005 ranges from a low of 11 percent in Minnesota to a high of 30 percent in Texas. The percent of uninsured children varies fourfold, from 5 percent in Vermont to 20 percent in Texas.
- Over the past five years, the number of states with more than 16 percent of children uninsured declined from 10 to three. In contrast, the number of states with 23 percent or more of adults uninsured increased from four to 12.
- In all but six states, the percent of adults uninsured increased. Notable exceptions include Maine and New York, which have both expanded programs to insure low-income adults.
- Across states, three of four uninsured adults age 50 or older did not receive basic preventive care, including cancer screening. The percent of adults who reported going without care because of costs is up to five times greater in states with high rates of uninsured adults than in states with the lowest uninsured rates.
- The nation would insure 22 million more adults and children if all states moved to the level of coverage provided in the top-performing states.

#### Quality

- Even in the best states, performance falls far short of optimal standards. The percent of adults age 50 or older receiving all recommended preventive care ranges from a high of 50 percent in Minnesota to 33 percent in Idaho. The percent of diabetics receiving basic preventive care services varies from 65 percent in Hawaii to 29 percent in Mississippi.
- Childhood immunization rates range from 94 percent in Massachusetts to less than 75 percent in the bottom five states. The percent of children with a medical home that helps coordinate care ranges from a high of 61 percent in New Hampshire to less than 40 percent in the bottom 10 states.
- Discharge planning varies markedly. The percent of congestive heart failure patients receiving

complete hospital discharge instructions ranges from 33 percent or less in the bottom five states to 67 percent in New Jersey.

- If all states reached the levels achieved among the top-ranked states, almost nine million more older adults would receive recommended preventive care, and almost four million more diabetics would receive care to help prevent disease complications. Likewise, about 33 million more adults and children would have a usual source of care or medical home to help coordinate care.

**Potentially Avoidable Use of Hospitals and Costs of Care**

- State rates of hospital admission for childhood asthma range from a low of 55 per 100,000 children in Vermont to more than 300 per 100,000 in South Carolina.
- Rates of potentially preventable hospital admission among Medicare beneficiaries range from more than 10,000 per 100,000 beneficiaries in the five states with the highest rates to less than 5,000 per 100,000 in the five with the lowest rates (Hawaii, Utah, Washington, Alaska, and Oregon).
- Similarly, there is a twofold variation in rates of hospital readmission within 30 days among Medicare beneficiaries (from 24 percent in Louisiana and Nevada to only 13 percent in Vermont and Wyoming) and a threefold range in rates of hospital admission among nursing home residents, from 25 percent (Louisiana) to only 8 percent (Utah).
- High rates of potentially avoidable hospital use and repeat admissions are closely correlated with high costs of care. States with the highest rates of readmission have annual Medicare costs per person 38 percent higher than states with the lowest rates.
- If all states reached the low levels of potentially preventable admissions and readmissions, hospitalizations could be reduced by 30 to 47 percent and save Medicare $2 billion to $5 billion each year. Potential savings would be still greater if the interventions applied to all patients.
- Improving care and developing more efficient care systems have the potential to generate major savings. If annual per-person costs for Medicare in higher-cost states came down to median rates or the lowest quartile, the nation would save $22 billion to $38 billion per year.

**Equity**

- Equity gaps by income and insurance status on quality indicators exist in most states. The gaps are widest in states that perform poorly overall on quality and access indicators.
- On average, 78 percent of uninsured and 71 percent of low-income adults age 50 and older *did not* receive recommended preventive services. By comparison, 59 percent of insured adults and 54 percent of higher-income adults failed to receive such care.
- The pattern extends to diabetics. On average, 67 percent of low-income diabetics *did not* receive basic care according to guidelines for their condition.
- In some states, equity rankings were low as a result of large disparities among minority groups that comprise relatively small shares of the state population. For example, in Minnesota, indicators of health care quality were often low for a group that included Asian Americans and Native Americans. A focus on these groups would have a high return in reducing health disparities.

**Healthy Lives**

- There is a twofold range across states in the rate of deaths before age 75 from conditions that might have been prevented with timely and appropriate health care. Potentially preventable death rates in the states with the lowest mortality (Minnesota, Utah, Vermont, Wyoming, and Alaska) are 50 percent below rates in the District of Columbia and states with the highest rates (Tennessee, Arkansas, Louisiana, and Mississippi).
- There are wide differences in this dimension among racial groups. For example, age-standardized death rates for conditions amenable to health care are twice as high for blacks as for whites nationwide (194 versus 94 per 100,000 population). Southern states and some states in the Midwest with large black populations have the greatest racial disparities, with more

than 100 additional deaths per 100,000 black residents above the overall national average. Yet, racial disparities exist even in states with narrower gaps.

- Potentially preventable mortality rates for whites also vary significantly across states, ranging from a low of 67.6 per 100,000 population (Minnesota) to a high of 118.3 (West Virginia). In general, white rates are highest in states with high overall rates.
- If death rates in all states improved to levels achieved by the best state (Minnesota, with 70.2 deaths per 100,000), about 90,000 fewer premature deaths would occur annually.
- Health system performance is only one of many forces that shape health status and longevity. Family history and immigration status can affect state-level population health indicators. Risk factors, such as smoking and obesity, vary across states. Public health policies, including workplace and environmental regulations, are thus critical components for long and healthy lives. The indicators in this dimension are likely to be sensitive to health system performance broadly defined, modifiable through both improved care and public health policies.

## SUMMARY AND IMPLICATIONS

The view of health system performance across the nation reveals startlingly wide gaps between leading and lagging states on multiple indicators. The gaps represent illnesses that could have been prevented or better managed, as well as costs that could have been saved or reinvested to improve population health. The *State Scorecard* indicates that we have much to gain as a nation by aiming higher with a coherent set of national and state policies that respond to the urgent need for action.

States play many roles in the health system—as purchasers of public coverage and coverage for their employees, regulators of providers and insurers, advocates for the public health, and, increasingly, conveners and collaborators with other stakeholders. States also can provide a source of public reports on quality and costs. These roles provide potential leverage points to promote better access and quality and to address rising costs.

The findings point to the need for action in the following key areas:

- Universal coverage: This is critical for improving quality and delivering cost-effective care, as well as ensuring access. Federal action as well as state initiatives will be essential for progress nationwide.
- More information to assess performance and identify benchmarks: It takes information to guide and drive change. We need more sophisticated information systems and better information on practices and policies that contribute to high or varying performance.
- Analyses to determine the key factors that contribute to variations: States can use such information to develop evidence-based strategies for improvement.
- National leadership and collaboration across public and private sectors: This is essential for coherent, strategic, and ultimately effective improvement efforts.

Benchmarks set by leading states, as well as exemplary models within the United States and other countries, show that there are broad opportunities to improve and achieve better and more affordable health care. With health costs rising faster than incomes and straining family, business, state, and federal budgets, with access deteriorating, and with startling evidence of variable quality and inefficient care, all states and the nation have much to gain from aiming higher. All states can do better; and all should continually ask, "Why not the best?"

## *About the Authors*

**Joel C. Cantor, Sc.D.,** is the director of the Center for State Health Policy and professor of Public Policy at Rutgers University. Dr. Cantor's research focuses on issues of health care regulation, financing, and delivery. His recent work includes studies of health insurance market regulation, state health system performance, and access to care for low-income and minority populations. Dr. Cantor has published widely on health policy topics, and serves on the editorial board of the policy journal *Inquiry*. He is a frequent advisor on health policy matters to New Jersey state government and was the 2006 recipient of Rutgers University President's Award for Research in Service to New Jersey. Dr. Cantor received his doctoral degree in health policy and management from the Johns Hopkins Bloomberg School of Public Health.

**Dina Belloff, M.A.,** is a senior research analyst at the Rutgers Center for State Health Policy. She conducts research and policy analysis on access to care, affordability of care, and health care financing. Prior to coming to the Center, she worked at the U.S. General Accounting Office determining the adequacy of Medicare Part B reimbursement for covered prescription drugs. She also worked at Mathematica Policy Research in Princeton, N.J., where she participated in evaluations of Medicaid expansion programs, prospective payment for home health care, and social health maintenance organizations. She received her bachelor's degree with highest honors from Rutgers College and a master's degree in health policy studies from the Johns Hopkins University.

**Cathy Schoen, M.S.,** is senior vice president at The Commonwealth Fund, a member of the Fund's executive management team, and research director of the Fund's Commission on a High Performance Health System. Her work includes strategic oversight of surveys, research, and policy initiatives to track health system performance. Previously Ms. Schoen was on the research faculty of the University of Massachusetts' School of Public Health and directed special projects at the UMASS Labor Relations and Research Center. During the 1980s, she directed the Service Employees International Union's research and policy department. Earlier, she served as staff to President Carter's national health insurance task force. Prior to federal service, she was a research fellow at the Brookings Institution. She has authored numerous publications on health policy and insurance issues, and national/international health system performance, including the Fund's 2006 *National Scorecard on U.S. Health System Performance* and co-authored the book *Health and the War on Poverty*. She holds an undergraduate degree in economics from Smith College and a graduate degree in economics from Boston College.

**Sabrina K. H. How, M.P.A.,** is research associate for the Fund's Commission on a High Performance Health System. She is co-author of the Commission's 2006 *National Scorecard on U.S. Health System Performance*. Ms. How also served as program associate for two programs, Health Care in New York City and Medicare's Future. Prior to joining the Fund, she was a research associate for a management consulting firm focused on the health care industry. Ms. How holds a B.S. in biology from Cornell University and an M.P.A. in health policy and management from New York University.

**Douglas McCarthy, M.B.A.,** president of Issues Research, Inc., in Durango, Colo., is senior research advisor to The Commonwealth Fund. He supports The Commonwealth Fund Commission on a High Performance Health System's Scorecard project and is a contributing editor to the bimonthly newsletter *Quality Matters*. Mr. McCarthy received his bachelor's degree with honors from Yale College and a master's degree in health care management from the University of Connecticut. During 1996–97, he was a public policy fellow at the Humphrey Institute of Public Affairs at the University of Minnesota. He has more than 20 years of experience in public and private sector research, policymaking, and management.

# EXECUTIVE SUMMARY

# *Why Not the Best?*

## RESULTS FROM THE NATIONAL SCORECARD ON U.S. HEALTH SYSTEM PERFORMANCE, 2008

THE COMMONWEALTH FUND COMMISSION ON
A HIGH PERFORMANCE HEALTH SYSTEM

JULY 2008

ABSTRACT: Prepared for the Commonwealth Fund Commission on a High Performance Health System, the *National Scorecard on U.S. Health System Performance, 2008*, updates the 2006 Scorecard, the first comprehensive means of measuring and monitoring health care outcomes, quality, access, efficiency, and equity in the United States. The 2008 Scorecard, which presents trends for each dimension of health system performance and for individual indicators, confirms that the U.S. health system continues to fall far short of what is attainable, especially given the resources invested. Across 37 core indicators of performance, the U.S. achieves an overall score of 65 out of a possible 100 when comparing national averages with U.S. and international performance benchmarks. Overall, performance did not improve from 2006 to 2008. Access to health care significantly declined, while health system efficiency remained low. Quality metrics that have been the focus of national campaigns or public reporting efforts did show gains.

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# Executive Summary

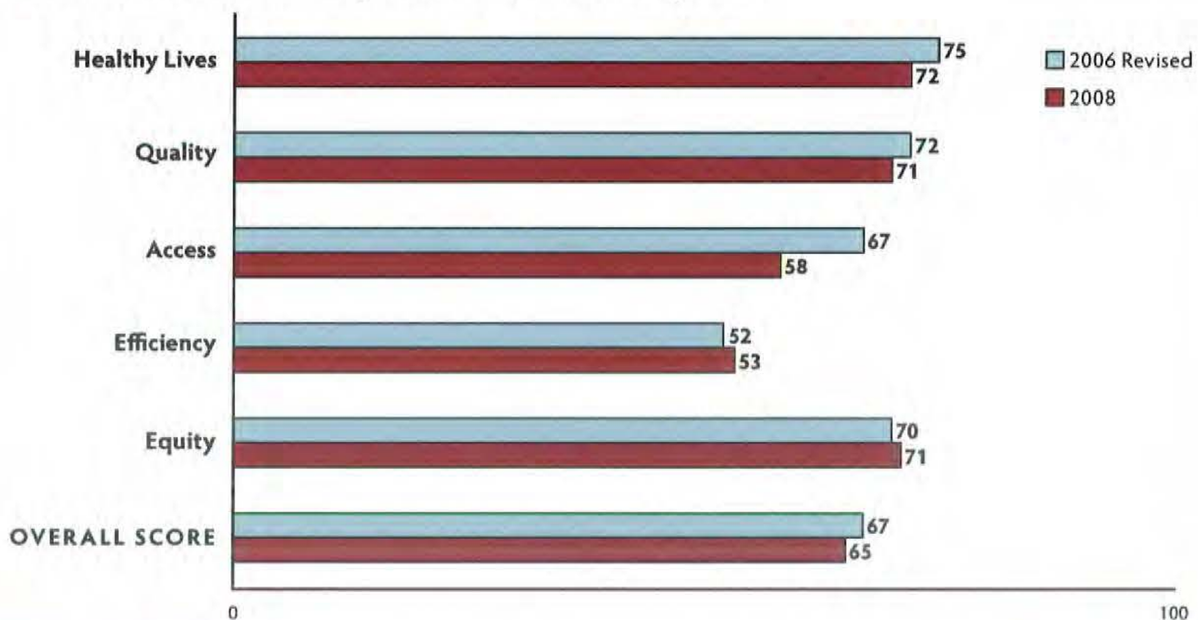
Every family wants the best care for an ill or injured family member. Most are grateful for the care and attention received. Yet, evidence in the *National Scorecard on U.S. Health System Performance, 2008*, shows that care typically falls far short of what is achievable. Quality of care is highly variable, and opportunities are routinely missed to prevent disease, disability, hospitalization, and mortality. Across 37 indicators of performance, the U.S. achieves an overall score of 65 out of a possible 100 when comparing national averages with benchmarks of best performance achieved internationally and within the United States.

Even more troubling, the U.S. health system is on the wrong track. Overall, performance has not improved since the first National Scorecard was issued in 2006. Of greatest concern, access to health care has significantly declined. As of 2007, more than 75 million adults—42 percent of all adults ages 19 to 64—were either uninsured during the year or underinsured, up from 35 percent in 2003. At the same time, the U.S. failed to keep pace with gains in health outcomes achieved by the leading countries. The U.S. now ranks last out of 19 countries on a measure of mortality amenable to medical care, falling from 15th as other countries raised the bar on performance. Up to 101,000 fewer people would die prematurely if the U.S. could achieve leading, benchmark country rates.

The exception to this overall trend occurred for quality metrics that have been the focus of national campaigns or public reporting. For example, a key patient safety measure—hospital standardized mortality ratios (HSMRs)—improved by 19 percent from 2000–2002 to 2004–2006. This sustained improvement followed widespread availability of risk-adjusted measures coupled with several high-profile local and national programs to improve hospital safety and reduce mortality. Hospitals are showing measurable improvement on basic treatment guidelines for which data are collected and reported nationally on federal Web sites. Rates of control of two common chronic conditions, diabetes and high blood

EXHIBIT 1

**Scores: Dimensions of a High Performance Health System**




Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

pressure, have also improved significantly. These measures are publicly reported by health plans, and physician groups are increasingly rewarded for results in improving treatment of these conditions.

The U.S. spends twice per capita what other major industrialized countries spend on health care, and costs continue to rise faster than income. We are headed toward $1 of every $5 of national income going toward health care. We should expect a better return on this investment.

Performance on measures of health system efficiency remains especially low, with the U.S. scoring 53 out of 100 on measures gauging inappropriate, wasteful, or fragmented care; avoidable hospitalizations; variation in quality and costs; administrative costs; and use of information technology. Lowering insurance administrative costs alone could save up to $100 billion a year at the lowest country rates.

National leadership is urgently needed to yield greater value for the resources devoted to health care.

## THE NATIONAL SCORECARD

The National Scorecard includes 37 indicators in five dimensions of health system performance: healthy lives, quality, access, efficiency, and equity. U.S. average performance is compared with benchmarks drawn from the top 10 percent of U.S. states, regions, health plans, hospitals, or other providers or top-performing countries, with a maximum possible score of 100. If average U.S. performance came close to the top rates achieved at home or internationally, then average scores would approach 100.

In 2008, the U.S. as a whole scored only 65, compared with a score of 67 in 2006—well below the achievable benchmarks (Exhibit 1).* Average scores on each of the five dimensions ranged from a low of 53 for efficiency to 72 for healthy lives.

On those indicators for which trend data exist, performance compared with benchmarks more often worsened than improved, primarily because of declines in national rates between the 2006 and 2008 Scorecards. Overall, national scores declined for 41 percent of indicators, while one-third (35%) improved, and the rest exhibited no change (or were not updated). Exhibit 2 lists indicators and summarizes scores and benchmark rates.

As observed in the first Scorecard, the bottom group of hospitals, health plans, or geographic regions is often well behind even average rates, with as much as a fivefold spread between top and bottom rates. On key indicators, a 50 percent improvement or more would be required to achieve benchmark levels.

## SCORECARD HIGHLIGHTS AND KEY FINDINGS

The U.S. continues to perform far below what is achievable, with wide gaps between average and benchmark performance across dimensions. Despite some encouraging pockets of improvement, the country as a whole has failed to keep pace with levels of performance attained by leading nations, delivery systems, states, and regions.

Following are major highlights from the Scorecard by performance dimension:

### HEALTHY LIVES: AVERAGE SCORE 72

- *Preventable mortality*: The U.S. fell to last place among 19 industrialized nations on mortality amenable to health care—deaths that might have been prevented with timely and effective care. Although the U.S. rate improved by 4 percent between 1997–1998 and 2002–2003 (from 115 to 110 deaths per 100,000), rates improved by 16 percent on average in other nations, leaving the U.S. further behind.
- *Activity limitations*: More than one of every six working-age adults (18%) reported being unable to work or carry out everyday activities because of health problems in 2006—up from 15 percent in 2004. This increase points to the need for better prevention and management of chronic diseases to enhance quality of life and capacity to work, especially among younger adults as they age.

### QUALITY: AVERAGE SCORE 71

- *Effective care*: Control of diabetes and high blood pressure improved markedly from 1999–2000 to 2003–2004 for adults, according to physical exams conducted on a nationally representative sample. Among adults with diabetes, rates of at least fair control of blood sugar increased from 79 percent to

*The overall score for 2006 changed from 66 to 67 due to revisions in baseline data and substitution of top U.S. states for countries as the benchmark for infant mortality. See methodology box on p. 17 for further details.

EXHIBIT 2

## National Scorecard on U.S. Health System Performance, 2008: Scores on 37 Key Performance Indicators

| | Indicator | U.S. National Rate | | Benchmark | Benchmark Rate | 2008 Score: Ratio of U.S. to Benchmark |
|---|---|---|---|---|---|---|
| | | 2006 Scorecard | 2008 Scorecard | | | |
| | **OVERALL SCORE** | | | | | **65** |
| | **HEALTHY LIVES** | | | | | |
| 1 | Mortality amenable to health care, deaths per 100,000 population | 115 | 110 | Top 3 of 19 countries | 69 | 63 |
| 2 | Infant mortality, deaths per 1,000 live births | 7.0 | 6.8 | Top 10% states | 4.7 | 69 |
| 3 | Healthy life expectancy at age 60, Years | Various | * | Various | Various | 87* |
| 4 | Adults under 65 limited in any activities because of physical, mental, or emotional problems, % | 14.9 | 17.5 | Top 10% states | 11.5 | 66 |
| 5 | Children missed 11 or more school days due to illness or injury, % | 5.2 | * | Top 10% states | 3.8 | 73* |
| | **QUALITY** | | | | | |
| 6 | Adults received recommended screening and preventive care, % | 49 | 50 | Target | 80 | 62 |
| 7 | Children received recommended immunizations and preventive care | Various | Various | Various | Various | 86 |
| 8 | Needed mental health care and received treatment | Various | Various | Various | Various | 76 |
| 9 | Chronic disease under control | Various | Various | Various | Various | 76 |
| 10 | Hospitalized patients received recommended care for heart attack, heart failure, and pneumonia (composite), % | 84 | 90 | Top hospitals | 100 | 90 |
| 11 | Adults under 65 with accessible primary care provider, % | 66 | 65 | 65+ yrs, High income | 85 | 76 |
| 12 | Children with a medical home, % | 46 | * | Top 10% states | 60 | 77* |
| 13 | Care coordination at hospital discharge | Various | Various | Various | Various | 74 |
| 14 | Nursing homes: hospital admissions and readmissions | Various | Various | Various | Various | 65 |
| 15 | Home health: hospital admissions, % | 28 | 28 | Top 25% agencies | 17 | 62 |
| 16 | Patient reported medical, medication, or lab test error, % | 34 | 32 | Best of 7 countries | 19 | 59 |
| 17 | Unsafe drug use | Various | Various | Various | Various | 55 |
| 18 | Nursing home residents with pressure sores | Various | Various | Various | Various | 66 |
| 19 | Hospital-standardized mortality ratios, actual to expected deaths | 101 | 82 | Top 10% hospitals | 74 | 90 |
| 20 | Ability to see doctor same/next day when sick or need medical care % | 47 | 46 | Best of 6 countries | 81 | 57 |
| 21 | Very/somewhat easy to get care after hours without going to the emergency room, % | 38 | 25 | Best of 6 countries | 72 | 35 |
| 22 | Doctor-patient communication: always listened, explained, showed respect, spent enough time, % | 54 | 57 | 90th %ile health plans | 75 | 75 |
| 23 | Adults with chronic conditions given self-management plan, % | 58 | * | Best of 6 countries | 65 | 89* |
| 24 | Patient-centered hospital care | Various | Various | Various | Various | 87 |
| | **ACCESS** | | | | | |
| 25 | Adults under 65 insured all year, not underinsured, % | 65 | 58 | Target | 100 | 58 |
| 26 | Adults with no access problem due to costs, % | 60 | 63 | Best of 7 countries | 95 | 66 |
| 27 | Families spending <10% of income or <5% of income, if low income, on out-of-pocket medical costs and premiums, % | 81 | 77 | Target | 100 | 77 |
| 28 | Population under 65 living in states where premiums for employer-sponsored coverage are <15% of median household income, % | 58 | 25 | Target | 100 | 25 |
| 29 | Adults under 65 with no medical bill problems or medical debt, % | 66 | 59 | Target | 100 | 59 |
| | **EFFICIENCY** | | | | | |
| 30 | Potential overuse or waste | Various | Various | Various | Various | 41 |
| 31 | Went to emergency room for condition that could have been treated by regular doctor, % | 26 | 21 | Best of 7 countries | 6 | 29 |
| 32 | Hospital admissions for ambulatory care–sensitive conditions | Various | Various | Various | Various | 56 |
| 33 | Medicare hospital 30-day readmission rates, % | 18 | 18 | 10th %ile regions | 14 | 76 |
| 34 | Medicare annual costs of care and mortality for heart attacks, hip fractures, or colon cancer (annual Medicare outlays; deaths per 100 beneficiaries) | $26,829 30 | $28,011 30 | 10th %ile regions | $24,906 27 | 89 |
| 35 | Medicare annual costs for chronic diseases: Diabetes, heart failure, COPD | Various | Various | Various | Various | 71 |
| 36 | Health insurance administration as percent of national health expenditures | 7.4 | 7.5 | Top 3 of 11 countries | 2.3 | 31 |
| 37 | Physicians using electronic medical records, % | 17 | 28 | Best of 7 countries | 98 | 29 |

Various = indicators that comprise two or more related measures; scores average the individual ratios for each component. COPD = chronic obstructive pulmonary disease.
* Indicator not updated; baseline score same as 2006.
See Exhibit 21 on page 35 for Equity scores; see Appendices A and B for more details on data and sources.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008

88 percent from 1999–2000 to 2003–2004. Among adults with hypertension, rates of control of high blood pressure increased from 31 percent to 41 percent over the same time period. Yet, a 30 to 60 percentage point difference remains between top- and bottom-performing health plans. Hospitals' adherence to treatment standards for heart attack, heart failure, and pneumonia also improved from 2004 to 2006, but with a persistent gap between leading and lagging hospital groups. Delivery rates for basic preventive care failed to improve: as of 2005, only half of adults received all recommended preventive care.

- *Coordinated care*: Heart failure patients were more likely to receive hospital discharge instructions in 2006 (68%) than in 2004 (50%), but rates varied widely between top and bottom hospital groups (from 94% to 36%). Hospitalizations increased among nursing home residents from 2000 to 2004, as did rehospitalizations for patients discharged to skilled nursing facilities—signaling a need to improve long-term care and transitions between health care providers.
- *Safe care*: One key indicator of patient safety—hospital standardized mortality ratios—improved significantly since the first Scorecard, with a 19 percent decline. Safety risks, however, remain high as one-third of adults with health problems reported mistakes in their care in 2007. Drug safety is of particular concern. Rates of visits to physicians or emergency departments for adverse drug effects increased by one-third between 2001 and 2004.
- *Patient-centered, timely care*: In 2007, as in 2005, less than half of U.S. adults with health problems were able to get a rapid appointment with a physician when they were sick. They also were the most likely among adults in seven countries surveyed to report difficulty obtaining health care after hours without going to the emergency department, and this rate increased from 61 percent to 73 percent since 2005. Within the U.S., there is wide variation among hospitals in terms of patient reports of how well staff responded to their needs.

#### ACCESS: AVERAGE SCORE 58

- *Insurance and access:* As of 2007, 75 million working-age adults (42%) were either uninsured or underinsured, a sharp increase from 61 million (35%) in 2003. More than one-third (37%) of all U.S. adults reported going without needed care because of costs in 2007, versus only 5 percent in the benchmark country.
- *Affordable care*: As insurance premiums rose faster than wages, the share of nonelderly adults living in a state where group health insurance premiums averaged less than 15 percent of household income dropped sharply, from 58 percent in 2003 to 25 percent in 2005. By 2007, two of five adults (41%) reported they had medical debt or problems with medical bills, up from 34 percent in 2005.

#### EFFICIENCY: AVERAGE SCORE 53

- *Inappropriate, wasteful, or fragmented care*: In 2007, as in 2005, U.S. patients were much more likely—three to four times the benchmark rate—than patients in other countries to report having had duplicate tests or that medical records or test results were not available at the time of their appointment.
- *Avoidable hospitalizations*: Average rates of hospital readmissions within 30 days remained high, at 18 percent in both 2003 and 2005. Rates in the highest regions were 50 percent higher than in the lowest regions. Rates of hospitalizations for preventable conditions decreased somewhat from 2002–2003 to 2004–2005, but continued to vary two- to fourfold across hospital regions and states.
- *Variation in quality and costs*: Among Medicare patients treated for heart attacks, hip fractures, or colon cancer, a high proportion of regions with the lowest mortality rates also had lower total costs, indicating that it is possible to save lives and lower costs through more effective, efficient systems. The total costs of caring for patients with chronic disease varied twofold across regions.
- *Administrative costs*: U.S. health insurance administrative costs as a share of total health spending are 30 percent to 70 percent higher than in countries with mixed private/public insurance systems and three times higher than in countries with the lowest rates.
- *Information systems*: U.S. primary care physicians' use of electronic medical records (EMRs) increased from 17 percent to 28 percent from 2001 to 2006. Still, the U.S. lags far behind leading countries, where EMRs are now used by nearly all physicians (98%) to improve care.

#### EQUITY: AVERAGE SCORE 71

- *Disparities*: Compared with their white, higher-income, or insured counterparts, minorities, low-income, or uninsured adults and children were generally *more likely* to wait when sick, to encounter delays and poorly coordinated care, and to have untreated dental caries, uncontrolled chronic disease, avoidable hospitalizations, and worse outcomes. They were also *less likely* to receive preventive care or have an accessible source of primary care.
- *Reducing gaps*: Among blacks and Hispanics, it would require a 19 percent to 25 percent decrease in the risk of poor health outcomes and inadequate or inefficient care to reach parity with whites. Gaps for uninsured and low-income populations are still wider: it would require a 34 percent to 39 percent improvement on indicators of health care access, quality, and efficiency to achieve equity with insured and higher-income populations.

#### SYSTEM CAPACITY TO INNOVATE AND IMPROVE: NOT SCORED

The capacity to innovate and improve is fundamental to a high-performing health care system. It includes:

- a care system that supports a skilled and motivated health care workforce, with an emphasis on primary care and population health;
- a culture of quality improvement and continuous learning that promotes and rewards recognition of opportunities to reduce errors and improve outcomes; and
- investment in public health initiatives, research, and information necessary to inform, guide, and drive health care decisions and improvement.

On all three aspects, the U.S. currently under-invests in the capacity of the health system to innovate and improve. U.S. payment systems undervalue primary care and fail to support providers' efforts to manage and coordinate care. Studies indicate that health care teams and well-organized work processes can achieve significant gains in quality and safety with more efficient use of resources. Yet, health professionals are rarely trained to work in teams, and larger organized delivery systems that employ multidisciplinary health professionals are not the norm. There is little investment in spreading best practices, and incentives are rarely designed to reward or support improved quality and greater efficiency. In an era of rapid medical advances, national investment in research regarding clinical and cost-effectiveness—what works well for which patients and when—has failed to keep pace to inform health care decision-making.

## SUMMARY AND IMPLICATIONS

#### POTENTIAL FOR IMPROVEMENT

Overall, the *National Scorecard on U.S. Health System Performance, 2008*, finds that the U.S. is losing ground in providing access to care and has uneven health care quality. The Scorecard also finds broad evidence of inefficient and inequitable care. Average U.S. performance would have to improve by more than 50 percent across multiple indicators to reach benchmark levels of performance.

Closing performance gaps would bring real benefits in terms of health, patient experiences, and savings. For example:

- Up to 101,000 fewer people would die prematurely each year from causes amenable to health care if the U.S. achieved the lower mortality rates of leading countries.
- Thirty-seven million more adults would have an accessible primary care provider, and 70 million more adults would receive all recommended preventive care.
- The Medicare program could potentially save at least $12 billion a year by reducing readmissions or by reducing hospitalizations for preventable conditions.
- Reducing health insurance administrative costs to the average level of countries with mixed private/public insurance systems (Germany, the Netherlands, and Switzerland) would free up $51 billion, or more than half the cost of providing comprehensive coverage to all the uninsured in the U.S. Reaching benchmarks of the best countries would save an estimated $102 billion per year.

Studies further document the cost in lives and lost productivity from the nation's failure to provide secure health insurance to all. Based on areas within the U.S. that achieve superior outcomes at lower costs, it should be possible to close gaps in health care quality and access, and to reduce costs significantly.

Several implications for policy emerge from the Scorecard findings:

### WHAT RECEIVES ATTENTION GETS IMPROVED

Notably, all of the quality indicators showing significant improvement have been targets of national and collaborative efforts to improve, informed by data with measurable benchmarks and indicators reached by consensus. Conversely, there was failure to improve in areas such as mental health care, primary care, hospital readmission rates, or adverse drug events for which focused efforts to assess and improve at the community or facility level are lacking. Further, the continued failure to adopt interoperable health information technology makes it difficult to generate the information necessary to document performance and monitor improvement efforts.

### BETTER PRIMARY CARE AND CARE COORDINATION HOLD POTENTIAL FOR IMPROVED OUTCOMES AT LOWER COSTS

Hospital readmission rates and rates of potentially preventable hospitalizations for ambulatory care–sensitive conditions remain high and variable across the country, as do total costs for the chronically ill. Studies indicate that it is possible to prevent hospitalization or rehospitalizations with better primary care, discharge planning, and follow-up care—an integrated, systems approach to care.

Multiple indicators highlight the fact that the U.S. has a weak primary care foundation. Investing in primary care with enhanced capacity to provide patients with round-the-clock access, manage chronic conditions, and coordinate care will be key steps in moving to more organized care systems.[1]

However, current payment incentives for hospitals, physicians, and nursing homes do not support coordination of care or efficient use of expensive, specialized care.[2] Information also fails to flow with patients across sites of care due to lack of health information technology and information exchange systems. These inefficiencies require innovative payment policies as well as care delivery approaches to improve outcomes for patients and use resources more efficiently.

### AIMING HIGHER

The 2008 National Scorecard documents the human and economic costs of failing to address the problems in our health system. Recent analysis suggests it could be possible to insure everyone and achieve significant savings with improved value over the next decade.[3] Health care expenditures are projected to double to $4 trillion, or 20 percent of national income, over the next decade, and millions more U.S. residents are on a path to becoming uninsured or underinsured, absent new policies. We need to change directions, starting with the recognition that access to care, health care quality, and efficiency are interrelated.

Aiming higher and moving on a more positive path will require strategies targeting the multiple sources of poor health system performance. These strategies include:

- universal and well-designed coverage that ensures affordable access and continuity of care, with low administrative costs;
- incentives aligned to promote higher quality and more efficient care;
- care that is designed and organized around the patient, not providers or insurers;
- widespread implementation of health information technology with information exchange;
- explicit national goals to meet and exceed benchmarks and monitor performance; and
- national policies that promote private–public collaboration and high performance.[4]

Rising costs put families, businesses, and public budgets under stress, pulling down living standards for middle- as well as low-income families. New national policies that take a coherent, whole-system, population view are essential for the nation's future health and economic security.

## The Scorecard: Measuring and Monitoring Health System Performance

The *National Scorecard on U.S. Health System Performance* provides a unique, comprehensive approach to measuring and monitoring the performance of the nation's health care system. The Commonwealth Fund Commission on a High Performance Health System developed the Scorecard to serve three central goals:

- to provide benchmarks for assessing health system performance;
- to have a mechanism for monitoring change over time; and
- to be able to estimate the effects of proposed policies to improve performance.

The Scorecard includes key indicators of national health system performance organized into five core dimensions:

- *healthy lives*, which includes life expectancy, mortality, and prevalence of disability and limitations due to health;
- *quality*, a broad measure covering the extent to which the care delivered is effective and well-coordinated, safe, timely, and patient-centered;
- *access*, which is concerned with participation in the health care system and the affordability of insurance coverage and medical services;
- *efficiency*, which assesses overuse or inappropriate use of services, preventable hospitalizations and readmissions, regional variation in quality and cost, administrative complexity, and use of information systems; and
- *equity*, which looks at disparities among population groups in terms of health status, care, and coverage.

The 2008 Scorecard uses the same framework, methods, and set of 37 performance indicators included in the first Scorecard published in 2006. The analysis assesses current performance as well as changes over time.

For each indicator, the Scorecard compares national performance against benchmark levels achieved by top-performing groups within the U.S. or other countries. In a few instances, benchmarks reflect targets or policy goals. The report updates the benchmarks whenever top performance improved from baseline values observed in the 2006 report. Each score is a simple ratio of the current U.S. average performance to the benchmark representing best levels of achievement, with a maximum possible score of 100.

To examine trends, we compare the baseline and current national averages as well as the change in the range of performance. Time trends typically capture two years and up to five years for some indicators. Where indicators could not be updated, we retained baseline values to score. The tables in Appendix A present details for all indicators. (See box for further information on methodology.) An extensive *Scorecard Chartpack* is available online at www.commonwealthfund.org.

Future editions of the Scorecard will continue to monitor trends and add or improve indicators as new data become available.

### SCORECARD METHODOLOGY

The *National Scorecard on U.S. Health System Performance, 2008*, includes a set of 37 core indicators that builds on metrics developed by public and private quality improvement efforts, as well as several unique indicators created for the Scorecard that are not currently tracked elsewhere.

The 2008 Scorecard uses the same set of indicators used in the 2006 Scorecard, with one exception reflecting a change in the data source: a general measure of mental health care was replaced by a more specific measure of treatment of a major depressive episode. Many of the indicators are composites that summarize performance across multiple measures. Of the underlying 61 data elements, 53 were updated. Almost all updates spanned at least two years; more than one-third assessed change over three to five years. For each indicator, we present national data for the baseline used in the 2006 Scorecard and most recent year.

Scoring consists of a simple ratio that compares national performance to the benchmark, with a maximum score of 100. For each indicator, we identified benchmarks based on rates achieved by the top 10 percent of U.S. states, regions, hospitals, health plans, or other providers or top countries. Where patient data were available only at the national level, we identified benchmarks based on the experiences of high-income, insured individuals. Four access benchmarks aim for logical policy goals, such as 100 percent of the population to be adequately insured. For one quality indicator—adults getting all recommended preventive care—we set a target rate of 80 percent, since rates even among high-income, insured populations were low.

We updated benchmarks whenever they improved. Thus, it is possible for scores to decline if benchmarks improve faster than the national average. For costs, we used the most recent data on the lowest-cost groups as benchmarks. For patient-reported experiences in hospitals, we used the newly available broad sample to benchmark, rather than the pilot set in the first Scorecard. For infant mortality, we switched the benchmark from countries to top U.S. states to ensure comparable indicator methods.

To score, we calculated ratios of average rates to the benchmark. Where higher rates would indicate a move in a positive direction, we divided the national average by the benchmark. Where lower rates would indicate a positive direction (e.g., mortality, medical errors), we divided the benchmark by the national average. Where updated data were not available, we retained baseline scores.

To summarize, we averaged ratios within dimension and averaged dimensions for an overall score. For equity, we compared the percentage of the group at risk (e.g., percent not receiving recommended care, percent uninsured) by insurance, income, and race/ethnicity on a subset of indicators. We also included a few specific indicators of health care equity to highlight areas of concern. The risk ratios compare rates for insured relative to uninsured; high income to low income; and whites to blacks and Hispanics.

We recalculated baseline scores when necessary due to data revisions. As a result, the overall baseline score changed from 66 to 67 for the 2006 Scorecard. See Appendices A and B for scoring tables and details regarding indicator data, years, and sources.

Children's Health

January 2009

# Issue Brief

## Children's Health: The Connections between the Economy, Coverage, and Healthy Kids

Maine, like the most of the other forty-nine states, is caught in a conundrum. For the past decade state policymakers have worked in a bipartisan manner to extend health insurance coverage to young Mainers, but the economic recession that commenced in late 2007 is creating new pressure on both private and public health insurance coverage. This policy brief brings into relief the basic connections between the national economy, private and public insurance coverage for children, and the benefits of covering children and the issues that emerge when children's health insurance coverage becomes sporadic as often happens during times of economic distress.

### Maine's Children and Health Policy

Maine has sustained and expanded its commitment to health care during the last decade, but this commitment does not come cheaply and it is under pressure as both private insurance and public resources contract. Despite a relatively modest median family income, Maine's child poverty rate is six percentage points lower than the national average of 23%. Despite this relatively good economic profile, a slightly larger proportion of children in Maine, 31%, are enrolled in Maine's Medicaid program, MaineCare, which is the federal-state program serving low income children and adults, compared to a national average of 28%.

Because of the coverage provided by MaineCare and through employer based coverage, only 6% of Maine children lack health insurance coverage. Nationally, 11% of children are without insurance coverage. This coverage helps families access preventive, dental, and screening health services in a timely manner that improves public health and saves public and private resources over time.

### The Last Ten Years: Bipartisan Commitment to Covering Kids

The 1997 Balanced Budget Agreement between President Clinton and Congressional Republicans created the State Children's Health Insurance Program (SCHIP), which represented the largest federal initiative to extend health insurance coverage since Medicaid's passage in 1965. SCHIP became the foundation for a prolonged and successful bipartisan effort to reduce the number of uninsured children, particularly children whose families had incomes below 200% of the federal poverty line (the 2008 federal poverty line is $21,200 for a family of four). Over the next ten years, the percentage of children from families with incomes below 200% of the federal poverty line who lacked health insurance declined from 23% in 1997 to 14% by 2005. Nearly one-third of children from low and moderate income families became covered (Dubay, Guyer, et al. 2007). Figure 1 shows the progress that states made for low and moderate income families in comparison to upper-middle and higher income families, for whom uninsurance rates have remained nearly constant at 5% (Vistnes and Schone, 2008).

A closer look at the data about health policy and insurance coverage reveals that much of the progress in providing health coverage to children derived nearly equally from the State Children's Health Insurance Program and increased enrollment in Medicaid. During its first four years of enrollment, SCHIP enrollment grew briskly to 4.6 million children out of approximately ten to eleven million eligible

**Fast Facts**

- Because of its support for MaineCare and other outreach efforts, only 6% of Maine children lack health insurance coverage compared to a national average of 11%.
- Seventeen percent of children without insurance coverage delay seeking treatment compared to only 3% of children on Medicaid or SCHIP.
- A 1% increase in the unemployment rate leads to a 1 million person increase in Medicaid enrollment, 1.1 million people losing their health insurance, and $3.4 billion in increased Medicaid and SCHIP spending.
- Studies in California and Kansas have demonstrated that children enrolled in SCHIP miss fewer days of school, are more attentive, and are significantly more likely to keep up with school assignments than children who lack coverage.

**Author:** Glenn Beamer, Ph.D.
Margaret Chase Smith Policy Center
University of Maine
glenn.beamer@umit.maine.edu

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children. Enrollment growth then tapered off, and enrollment reached six million by 2003.

Parallel to SCHIP growth, Medicaid has experienced substantial enrollment increases during the 2000s. Ten years ago, Medicaid enrolled 20.7 million children. That enrollment has grown steadily throughout the last decade. By 2008, 28.3 million children were enrolled in Medicaid. The most recent monthly data from 2007 indicate that 121,000 Maine children were enrolled in Medicaid, and children comprise approximately 40% of MaineCare enrollees. Approximately 13,000 Maine children are in MaineCare via SCHIP funding.

The largest challenge currently facing state legislators and governors stems from the increasing cost of public insurance coverage coupled with the increasing demand for enrollment as the economy contracts. Based upon a 2008 study by the non-partisan Kaiser Commission on Medicaid and the Uninsured, every one percent increase in the national unemployment rate increases enrollment in Medicaid and SCHIP by approximately one million children, the number of uninsured Americans rises by approximately 1.1 million people, and state costs for Medicaid and SCHIP spending rise by $1.4 billion. Figure 2 presents these figures.

## Children's Coverage and Children's Health Services

As enrollment grows in both Medicaid and SCHIP nationally, and in MaineCare locally, legislators are likely to focus on the efficacy and cost-effectiveness of sustaining or expanding enrollment. Recent studies have indicated that overall children enrolled in public health insurance programs are nearly as likely as privately insured children and much more likely than uninsured children to receive adequate medical care in a timely manner and they perform better in school (Sommers, Dubay, et al, 2007).

By 2005, the Centers for Disease Control estimated that only 3% of children enrolled in Medicaid did not have a usual and reliable source of health care such as a family physician or locally-based clinic. In contrast, 28% of uninsured children had no usual source of health care (Lu, Lin, and Broaddus, 2007). The relatively low proportion of Medicaid and SCHIP children with a regular health care provider represents significant progress toward involving physicians and community providers in these programs. Over the last fifteen years the proportion of children on Medicaid without a regular health care provider has fallen from nine to 3%.

In terms of using physician services, 92% of children on Medicaid and SCHIP had one or more visits with a doctor or health professional (such as a physical therapist or physician's assistant), compared to only 74% of uninsured children. With respect to preventive care, three-quarters of Medicaid and SCHIP children had one or more well-baby or well-child visits during 2005. Less than half of uninsured children have well-child visits with a physician. Overall, children who are enrolled in Medicaid and SCHIP on a year-round basis are twice as likely as children with sporadic or intermittent insurance coverage to have a preventive or well-child health visit, and continually enrolled children are five times as likely as uninsured children to have preventive care (2005 National Health Interview Survey). Whereas 17% of uninsured children's parents reported delaying their children's medical care due to cost, only 3% of Medicaid and SCHIP children's parents reported having to do so.

In terms of cost effectiveness, efforts by policymakers to engage regular health services have generated some success. Although publicly insured children remain more likely than privately insured children to use emergency room services, rates of emergency room use by publicly insured children have fallen over the last decade. Thirteen percent of Medicaid & SCHIP enrolled children experienced two or more emergency room visits in 1997, but only 10% of this same group had two or more emergency room visits in 2005 (2005 National Health Interview Survey).

During the early 2000s, policymakers began to attend to and many states offered expanded dental care for children. Studies had demonstrated that lack of appropriate dental care had both short and long term costs. Although use of dental services by publicly insured children is less than their use of medical services, public coverage facilitates appropriate dental care. The CDC estimates that 9% of publicly insured children, compared to 23% of uninsured children and 4% of privately insured children, had unmet dental needs during 2005, the latest year for which reliable data are available (CDC, 2006). Similar to physician well-child care, children who have been continuously enrolled in Medicaid or SCHIP are more than twice as likely as intermittently covered children and more than five times as likely as uninsured children to have visited a dentist within the past year.

## Creating Healthy Children

In evaluating children's health and its relationship to enrollment in Medicaid and SCHIP a note of caution is in order. Table 1 shows children's health status by type of insurance coverage. As the table indicates, five percent of children on Medicaid or SCHIP report fair or poor health compared to three percent of uninsured children and one percent of privately insured children. In contrast, 70% of publicly insured children report excellent or very good health compared to 77% of uninsured children and 88% of privately insured children. At first glance, these data may indicate that public coverage is not producing better health outcomes, but some of the differences in program enrollment are driven by health status itself. Parents whose children have chronic or threatening conditions are more likely to apply for and enroll in public programs that will provide them access to needed health services.

An over-time or longitudinal perspective better informs our understanding of the roles of Medicaid and SCHIP. Among children who have enrolled in these programs within the last twelve months, 24% report improved health status, and this proportion differs significantly from the 18% of uninsured and 18% of privately insured children who report improved health status over a twelve month period. With respect to cost

effectiveness, a survey of SCHIP children in New York state estimated that eleven percent of children were hospitalized for asthma in the year prior to their enrollment in SCHIP. After one year in SCHIP, only three percent of children were hospitalized for asthma (Szilyagi, et al., 2006) .

Perhaps the best news for policymakers can be found in evaluations of the effects of Medicaid and SCHIP enrollment on school performance. Studies in California and Kansas have demonstrated that children enrolled in SCHIP performed better and missed fewer days of school due to illness after having been enrolled in SCHIP for one year. In the California study, SCHIP students improved their ratings for paying attention in class by more than two-thirds, and the proportion of SCHIP student who could keep up with school activities improved from thirty-six percent to sixty-one percent over the course of one year.

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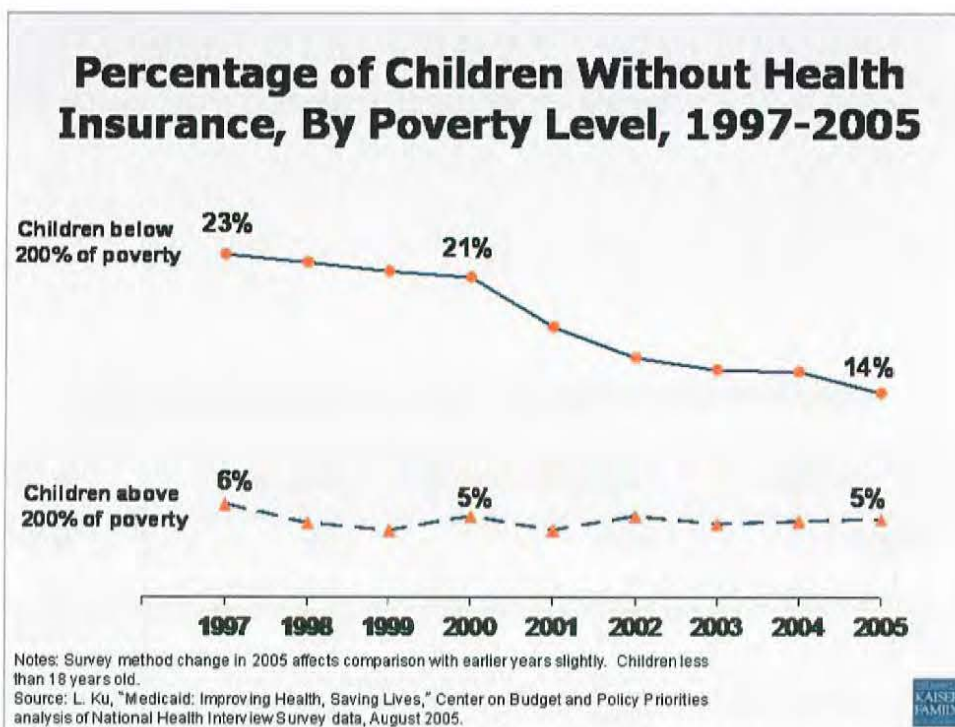
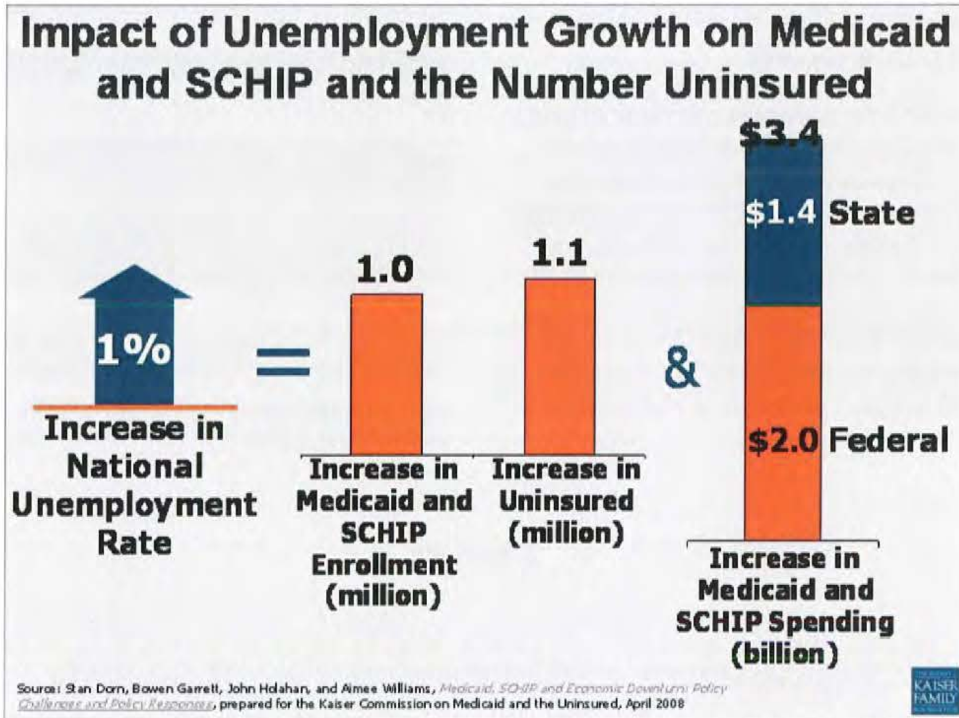
### Figure 1



## Figure 2




## Table 1: Health Status of Children, by Insurance Type

| Health Status | Medicaid/SCHIP | Uninsured | Privately Insured |
|---|---|---|---|
| Excellent | 41% | 47% | 61% |
| Very Good | 29% | 30% | 27% |
| Good | 25% | 21% | 11% |
| Fair/Poor | 5% | 3% | 1% |

Source: CDC, 2006, Analysis of 2005 National Health Interview Survey.

Dirigo Health

January 2009

# Issue Brief

## Dirigo Health Reform - An Overview and Progress Report

"It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments ...."
- Justice Louis Brandeis

### I. What is Dirigo Health Reform?

In 2003, Federal health care reform was well settled in a stalemate of inaction. Meanwhile, costs were spiraling out of control. Working people were losing their insurance. Businesses found themselves burdened in international competition.

Maine had a choice: either to sit still and wait for national reform, meanwhile allowing more of its citizens to suffer from high costs and lost health care, or to build on work already underway here, and take the next big step to achieve affordable, quality health care for all. Maine's action could never be a full substitute - national health care reform, needed then, is still needed now. No one state can solve this problem alone. But Maine could help its citizens out, and serve as a "laboratory of democracy."

Thanks to a bold Governor and Legislature, Maine's health care reform became law in September 2003. Named "Dirigo," after the state motto meaning "I Lead," the program was a first-of-a-kind effort in the nation. The country took notice. The New York Times editorialized, "it is encouraging that Maine, which led most states in efforts to control prescription drug costs, has now taken a new tack toward solving the nation's health care problems."

The reform proposed a comprehensive set of actions to: (1) reduce health care costs; (2) expand health insurance coverage; (3) improve public health; and (4) improve the delivery and quality of services.

Overall, Dirigo has three strategies to assure all Mainers have access to affordable, quality health care.

- Address health care system costs and quality reforms to assure those who now have private coverage can continue to afford it.
- Use MaineCare – the state's Medicaid program – to provide coverage to the lowest income Mainers by capturing just under $1.81 in federal funds for every $1 the state provides.
- Create DirigoChoice, an insurance program for small businesses, the self-employed and individuals who are not eligible for MaineCare. Sliding scaled subsidies are available to individuals and families with household incomes up to 300% of the federal poverty level ($61,950 for a family of four and $30,630 for a single adult).

### II. What Problems is Dirigo Designed to Address?

The US spends about twice as much per capita as other developed nations (see chart next page).[1]

**Fast Facts**

- The U.S. spends twice what other developed nations spend - and Maine spends more per capita than the U.S.- but we don't cover everyone and don't get better quality or health.
- Health care spending in Maine -- $8.3 M (2005) is about 18% of our economy.
- Dirigo Health Reform is comprehensive health reform – assuring costs are controlled; making Maine a healthier state; improving the efficiency and effectiveness of health care and offering subsidized insurance coverage for those least able to afford it.
- Dirigo Health Reform has, to date, covered over 29,000 Mainers statewide, most with incomes below 200% Federal Poverty Level (about $21,000) through DirigoChoice and MaineCare parent expansion including over 700 small businesses; and saved over $150 M in health care spending.

**Author:** Governor's Office of Health Policy and Finance
(207) 624-7442
GOHPF@maine.gov

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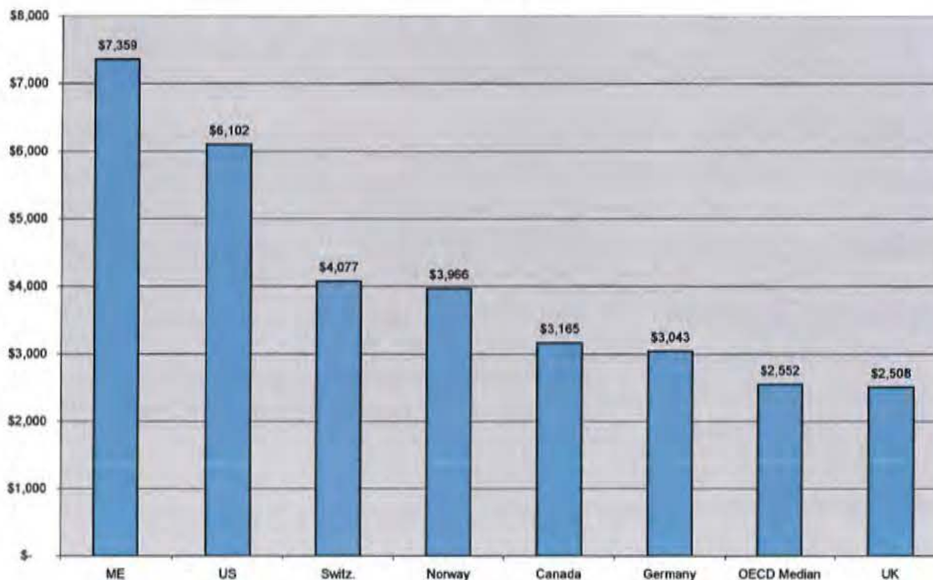
Those nations spend less but get more. They cover all their citizens and have better health outcomes. Health insurance premiums across the US and in Maine increase about 2-3 times faster than inflation, making insurance increasingly unaffordable for businesses and families, increasing the ranks of the uninsured and underinsured, and creating a drag on the economy. Health care spending in Maine was estimated at $8.3 billion in 2005, about 18-19% of the economy.

Much of our spending on health care is driven by our health and can thus be lowered by becoming healthier. Almost 40% of healthcare spending increases is caused by five largely preventable diseases: heart disease, cancer, lung disease, diabetes, and mental health issues.[2]




But a significant portion of our spending is driven simply by variation in how care is delivered across the state and lack of good public information to help patients understand their conditions and treatment options. In fact, one national study found that up to one third of Medicare spending goes to services that do not help people improve their health,[3] while another study found that only about half of the care we receive is care we should receive based on accepted best practices,[4] and that the system tends to over-use costly acute care and under-use inexpensive, preventative care that can improve health and save costs down the road.

Dirigo Health Reform's goal is to lower the growth in health care spending through strategies that address the health system's multiple cost drivers and inefficiencies, including reducing the cost shift to private payers from the uncompensated care costs of those without adequate health coverage. The focus of the Reform is improving cost, quality, and access simultaneously, because health reform is not sustainable unless we affect all three. Dirigo Health Reform also asks all the players in the health care system – hospitals, doctors, insurance companies, employers, state government, and consumers – to play a role in health reform.

The original proposal, which was rejected, was to finance Dirigo Health by a fee on insurers and third party administrators[5] that could not be passed on to consumers, and to give those payers tools, like global budgets to make hospital expenditures more predictable and contained, and to provide coverage for the un- and under-insured to reduce uncompensated care, with payers using those savings to pay for the cost of the assessment.

The Dirigo program was originally designed, then, to be self sustaining – that is, access expansions and the Maine Quality Forum would be financed and cost no more than payers would otherwise have paid in the absence of these reforms.

In enacting the bill, some of the original cost containment provisions were rejected and replaced by voluntary measures. The final Dirigo Health Reform Act included, as a compromise, the Savings Offset Payment (SOP), an assessment on paid claims which can only be assessed if there are measurable cost savings in the system that are validated by an independent review by the Superintendent of Insurance. The amount of the assessment cannot exceed those measurable savings or 4% of all health care paid claims, whichever is less. The compromise secured strong bipartisan support for the program but, coupled with other implementation compromises, resulted in lower revenues than originally projected and, therefore, are slowing enrollment to comply with the lower budget.

## III. Strategies to Address Health Care Costs

### *Making Maine the Healthiest State, with an Efficient and Effective, High-Performing Health System: The State Health Plan*

How we use health services and how healthy we are affects premiums. Becoming healthier and addressing the chronic illnesses that drive costs will lower the growth in our health care costs.

To improve our health and make Maine the healthiest state, the Dirigo Health Reform Act requires the Governor – advised by a

citizen and stakeholder council known as the Advisory Council on Health System Development (ACHSD) – to issue the State Health Plan every two years.

The first biennial Plan was released in April 2006 after extensive public input from hundreds of citizens at "Tough Choices in Health Care" in spring 2005; focus groups in summer 2005; meetings with multiple stakeholder groups in summer/fall 2005; a statewide "Listening Tour" in fall 2005; and public hearing and legislative review of a draft State Health Plan. Development of the plan was funded in part by the Maine Health Access Foundation (MeHAF) and others.

The goal of the State Health Plan is to make Maine the healthiest state and bring down growth in health care costs in large part by addressing chronic disease and other health conditions, and to create a better health system by: preventing illness, disability and improving health; helping people with chronic illness improve the care they get; strengthening the rural health system; expanding the use of telemedicine to ensure that all citizens in Maine have access to needed diagnostic and treatment options; and providing guidance for the state's Certificate of Need program (discussed later).

The State Health Plan is an action plan that sets specific goals for specific issues and brings the stakeholders together to work on each issue. For instance, working with employers to encourage them to offer wellness programs to improve their employees' health which will reduce the growth in their premiums; promoting transparency with provider data to raise awareness specific to variation and improve quality with use of "evidence-based" care; helping public and private payors to support best practices in their reimbursement models and prevention in their benefit designs; and creating ways to encourage individuals to practice good health.

A Public Health Work Group, created by the State Health Plan, has achieved a long sought after goal in Maine: building a public health system for the state. It has been done within existing resources. Eight public health districts now exist, served by Maine CDC staff out-stationed to the districts from the central office; Regional Coordinating Councils are developing measurable regional health improvement plans; Healthy Maine Partnerships have been strengthened and over 500 different grants have been streamlined to 125 grants to the new infrastructure; and, working with the Maine Municipal Association, local health officers roles will be clarified and better integrated with and supported by CDC. As envisioned, the system will coordinate with existing emergency management and bioterrorism efforts and build on the strengths of Maine's two city health departments. A statewide coordinating council will advise Maine CDC to assure a seamless local, district state public health system that assures the essential public health services are available statewide.

In 2007, the Legislature updated the ACHSD's responsibilities to include reporting to the Legislature on health care cost drivers, along with recommendations to slow the rate of growth of health care spending in Maine. The second biennial Plan was released in April 2008. Among other things, it laid out a plan for the cost driver report. The first cost driver report was included in the State Health Plan and Data Book.[6] Under the direction of the Dirigo Health Agency's Maine Quality Forum (see discussion of MQF later in this report), a more focused study on costs will be presented to the ACHSD. The Council will then issue a final report to the Legislature's Health and Human Services and Insurance and Financial Services Committees in the spring of 2009. It also created a stakeholder group that is looking at the causes of and solutions to Maine's emergency department use third highest in the nation, behind only Alaska and West Virginia.[7] The stakeholder group's report and recommendations are expected in spring 2009.

The ACHSD oversees implementation of the State Health Plan to ensure that the Plan's goals, tasks, and benchmarks are met, including reporting to the Legislature's Health and Human Services Committee.

### *Strengthening the Certificate of Need Program*

The purpose of the state's Certificate of Need (CON) program is to ensure that the health care infrastructure meets the needs of the population. Numerous studies have shown that, unlike in traditional economics where demand drives supply, the opposite has been shown to be true in health care. That is, if a service is there, people will use it and pay for it whether they really need it or not,[8] driving costs -- and ultimately premiums -- up. By making sure that investments only occur when there is a demonstrated need for a service, CON programs can help prevent unnecessary increases in health care spending.

The Dirigo Health Reform Act strengthened the CON program, which requires certain hospital and other capital investment projects to get state approval before investment can occur (for instance, before a hospital buys an MRI or a builds new wing). Maine is one of 36 states with a CON program. Roughly one-third of hospital capital expenditures in Maine are subject to CON review.

Dirigo made three important changes to CON:

- **Established limits on how much investment Maine can afford.** The Capital Investment Fund (CIF) is one of the

only cost containment tools available in state law. The CIF is one of the only cost containment tools available in state law. It places a cost limit on how much may be added to the health care system each year by capital investments approved under the CON program. The CIF establishes a measure of affordability against which CON decisions about need can be made. It balances need and affordability, recognizing that supply of health care services increases utilization and that increased utilization does not necessarily improve health outcomes.

- **Guided CON decisions through a State Health Plan.** To ensure that capital investments are made efficiently and effectively to meet Mainers' health needs.

- **Leveled the playing field: any major health investment – no matter who makes it – must meet the plan's goals.** CON now covers large capital expenditures made by providers other than hospitals (for instance, building a new ambulatory surgical center or a doctor's office acquiring a costly new technology).

In 2008, GOHPF and the ACHSD worked closely with stakeholders – hospitals, consumers, employers, insurers, and others – to revise the CIF rule to make it a more effective cost containment and health system planning tool than it was in its first several years. The Legislature will review this rule during the 2009 legislative session.

### *Facilitating Collaboration Between Providers*

The Legislature followed the recommendation of the Hospital Study Commission that was created by the Dirigo Health Reform Act by amending the Hospital Cooperation Act to make it easier for hospitals and other providers to voluntarily collaborate and to share services to achieve cost saving efficiencies and/or quality improvements, without violating anti-trust laws. The Act is currently being used for the first time by MaineHealth and the Southern Maine Medical Center. The process includes the active involvement of DHHS, the Attorney General's office, and GOHPF.

### *Reducing Cost Shifting from the Uninsured and Underinsured*

The debt that hospitals accumulate when the uninsured and underinsured are unable to pay for services received, is shifted to the privately insured through increases in the cost of services, that ultimately results in increased premiums. In 2006, hospitals provided $87 million in free care and incurred approximately $125 million in bad debt for a total of $212 million. These costs are shifted to the privately insured as bad debt and charity care expenses.

Bad debt and charity care (BDCC) is driven primarily by two things:

- The number of people who are uninsured and underinsured (a 2004 survey conducted jointly by GOHPF and the Maine Hospital Association found that approximately 30% of hospital bad debt is from insured people, likely those with high deductible policies), and

- Hospitals' charity care policies. State law requires hospitals to provide free care to people up to 100% of the federal poverty level. MaineCare provides coverage to this level. All but two hospitals have voluntarily extended their policies to more people, with 28 hospitals increasing their charity care eligibility policies between September 2003 and November 2005. As of September 2007, 24 hospitals provided free care up to 200% FPL and one up to 250%.

By bringing down growth in the number of uninsured and underinsured, Dirigo Health Reform reduces cost-shifting.

### *Reducing Paperwork for Providers and Insurers*

Medical claims have historically been submitted on paper, creating an administrative burden for both insurers and providers. The Dirigo Health Reform Act requires providers to submit their claims to insurers in a standardized electronic format to lower administrative costs throughout the system. The Superintendent of Insurance may grant an exemption for providers with 10 or fewer full-time-equivalent health care practitioners and other employees based upon hardship.

### *Regulating Premium Increases in the Small Group Market*

For the first time, Dirigo Health reform regulates premiums in the small group market (where employers with up to 50 employees get insurance, covering almost 115,000 people in 2005), requiring that insurers operating in the state spend at least 78 cents of every dollar of premiums over any given three-year period on medical expenses, limiting administration, marketing, tax payments, and profit to 22 cents of each premium dollar. As a result of this provision, in 2008 Aetna refunded $6.6 million to small employers for premiums paid from July 2004 through June 2007.

### *Increasing Transparency of Cost and Financial Data*

Dirigo made several changes to how providers and insurance companies report their cost and financial data to make it easier for the public to understand how premium dollars are spent.

- **Price posting.** To assist consumers in making apples-to-apples comparisons of what different providers charge

for services, Dirigo Health Reform required hospitals and doctors offices to maintain and make readily available to the public a list of what they charge for a standardized list of the most common procedures performed across the state. This will be improved in 2009 by a web-site where consumers can look up price estimates for specific services at hospitals and doctors offices across the state.

- **Standardized reporting for insurance companies.** To solve the problem of insurance companies reporting data in different ways – which made it difficult for the public to understand insurance company information, such as how premiums are set and how much insurance companies profit from different lines of business – Dirigo Health Reform requires insurance companies to file annual reports on a standardized template with the Bureau of Insurance (BOI), which then summarizes this information for the public at the BOI web-site.[9] The reports include information on how much insurance companies collect in premiums, pay in claims, spend on administration, and keep as profit for each of their lines of business.

- **Standardized reporting for hospitals.** To solve the problem of hospitals reporting financial data in different ways – which made it difficult for the public to understand hospital financial health and operations – the Legislature acted on a recommendation of Dirigo's Hospital Study Commission by requiring hospitals to give the Maine Health Data Organization (MHDO, an independent state agency) their financial information on a standardized template. The MHDO summarizes this information in a report posted at its website to help the public better understand the financial situation of Maine's 39 non-profit hospitals. The first posting – 2005 and 2006 data – was posted in 2008,[10] and 2007 data will be posted in early 2009.

### *Voluntary Targets for Hospitals and Insurance Companies*

- Hospitals. Dirigo asked hospitals to voluntarily limit their profits to 3% and their growth in spending per patient to 3.5%. The voluntary limits were later renewed for another three years by the Legislature at the recommendation of a Dirigo's Hospital Study Commission.[11]

- Insurance Companies. Dirigo asked insurance companies to voluntarily limit their profits to 3% for the first year after Dirigo was passed. Anthem (including MainePartners), Mega Life and Health, and United Healthcare abided by the limit. The targets were not renewed.

### *Reviewing Medical Malpractice in Maine*

Medical malpractice is frequently brought up when discussing health care costs, so the Dirigo Health Reform Act asked the Bureau of Insurance to review medical malpractice lawsuits and insurance rates in Maine. BOI found that medical malpractice rates in Maine have not been experiencing the kind of inflation seen in other states. In 2005, malpractice coverage in Maine was less than half the cost seen nationally and among the lowest in the country.

### *Enhanced Public Purchasing*

The Dirigo Health Reform Act also created the Public Purchasing Group, a group representing public purchasers, including state employees, the University system, Maine Education Association, Maine Municipal Association, Maine School Management Program, some large municipalities, MaineCare, and Dirigo Choice. The group's charge is to coordinate and collaborate where feasible in the purchase of cost effective, quality health care services. The group has issued three reports which detail the purchasing power of public entities, including a finding that public entities spent $2.8 billion in health care expenditures in 2005, a significant portion of total health care spending in the state.

## IV. Strategies to Address Health Care Quality

### *Getting the Right Care at the Right Time: Reducing Variation & Increasing Use of Best-Practices*

Patients in certain Maine communities are up to three times more likely to get some expensive procedures than an identical patient in another community, even when there is no evidence that the procedure is what's known as a "best practice" for a given medical condition.[12] This variation – which can be high or low – is unrelated to underlying differences in the population (such as differences in age, for example, or the prevalence of disease), but instead are driven by the capacity of health resources in an area (or lack thereof) and the preferences and training of the medical personnel serving the population. This variation can result in both wasted spending and in decreased quality and patient safety. To help raise awareness and reduce this variation to ensure we get the right care, the right way, at the right time, Dirigo Health Reform created the Dirigo Health Agency's Maine Quality Forum (MQF). MQF collects and analyzes data on medical practice around the state and serves as a clearinghouse of the latest information on best, and evidence-based practice, all of which helps providers improve their performance, reducing costs and improving quality.

### *Establishing the Maine Quality Forum*

The Maine Quality Forum (MQF) was created within the Dirigo Health Agency to be a forum where providers, employers,

consumers, and insurers can work together to produce information to improve health care quality. The duties of the Maine Quality Forum are:

- Research Dissemination
- Quality and Performance Measures
- Data Coordination
- Public Reporting
- Consumer Education
- Technology Assessment
- Health Information Technology
- State Health Plan
- Health Care Associated Infection Surveillance and Prevention

As discussed above, MQF's work will help to reduce unnecessary medical spending by reducing variation in medical service use and increasing use of best practices.

MQF's accomplishments include:

- Completed analysis and website posting of hospital quality metrics (Chapter 270 data)

- Began cost driver study based on paid claims database

- Received expanded grant under Robert Wood Johnson Foundation Aligning Forces for Quality Initiative, now $1.5 million over 3 years for extension of AF4Q activities into hospital quality improvement (with emphasis on disparities in care and consumer engagement)

- Selected as a demonstration site for CMS electronic health record initiative which has the potential to bring to the state up to $29 million in reimbursement for providers selected for the project

- Increased number of primary care practices and physicians assessed in the Voluntary Practice Assessment Initiative (109 of desired 150 physicians)

- Developed comprehensive statewide primary care provider database

- Facilitated development of the Maine Critical Access Hospital Safety Collaborative

- Facilitated the development of the Maine Patient-Centered Medical Home Pilot, including exploration of reimbursement models, practice selection, and evaluation components

- Continued to support In a Heartbeat activities including community awareness, development of Emergency Medical System (EMS) capabilities, and hospital performance analysis

- Supplied quality analysis of five CON project applications for CON Unit of DHHS

- Developed collaborative partnership (with Quality Counts, Maine Health Management Coalition, and HealthInfoNet) to apply for Chartered Value Exchange status from U.S. Department of Health and Human Services, awarded February 2008

- Recommended that 2008-2010 State Health Plan emphasize healthcare-associated infection, health information technology, patient-centered medical home, and health care services variation analysis

- Led formation of the Maine Infection Control Consortium

- Led multi-organization reassessment of performance of the Northeast Healthcare Quality Foundation as Medicare Quality Improvement Organization for Maine (and as a result supported NEHQF proposal to accomplish Medicare QIO 9th Scope of Work)

- Supported and helped organize:
    - MMA/MHA joint quality conference on subject of unwarranted variation
    - Quality Counts 2008 annual conference on population-based care management
    - 2008 Governor's Summit of the Maine Cardiovascular Health Council on patient-centered medical home
    - 2008 Hanley Forum on patient-centered medical home and public policy
    - Team STEPPS conference on patient safety (with Maine DHHS and Maine Medical Center)
    - 2008 Maine Center for Public Health Focus conference on patient-centered medical home

### *Building a Statewide, Interconnected Electronic Medical Record System*

The majority of medical records in the US are kept in paper files, making it difficult for doctors and hospitals to share records to guarantee the best patient care. If you are in a car accident and taken unconscious to an emergency room at a hospital far from home, the doctor won't know important information about you, such as what medications you are on, what medical conditions you may have, and so on, putting you at risk and

subjecting you to duplicative, time consuming, costly tests and procedures.

There is an emerging consensus around the US that an interconnected electronic medical record (EMR) system will improve patient safety and quality of care, as well as saving millions of dollars each year.

With the help of the Maine Quality Forum, Maine is leading the way among the states in developing a statewide interconnected health information system. In early 2006, following a year of feasibility studies and organizational development, HealthInfoNet (HIN) – an independent not-for-profit organization governed by a board of directors comprised of 19 representatives from the medical community, private business, state government, and related advocacy organizations – was created to build an electronic health care superhighway for sharing patient information, with care to assure confidentiality.[13] HIN has received backing from philanthropic and private business organizations (e.g. the Maine Health Access Foundation and KeyBank). HIN's 24-month pilot will go live later this year. It includes participation by Maine's four largest health care delivery systems (MaineHealth, MaineGeneral, Eastern Maine Healthcare Systems, and Central Maine Medical Family), Franklin Memorial Hospital, Martin's Point Healthcare and the Maine Center for Disease Control and Prevention. These organizations account for 52% of annual inpatient discharges and more than 40% of annual outpatient visits across Maine.

### *Creating Incentives to Use Higher Quality Providers*

The Dirigo Act amended Maine law to allow insurers to offer financial incentives to encourage patients to use providers that have been identified as providing higher quality.

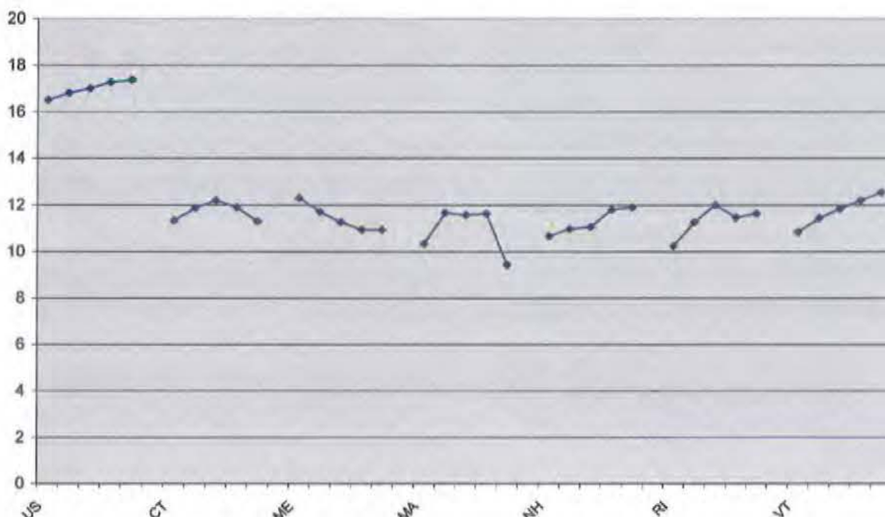
## V. Strategies to Increase Health Care Access

### *MaineCare – Maine's Medicaid Program*

Medicaid is a state-federal partnership for low income individuals through which states get roughly $1.72 for every $1 the state spends. States participating in the program – all 50 states do – have to meet certain federal standards defining who to cover and what benefits to offer, but states then can implement optional expansions.

The Dirigo Health Reform Act included two modest MaineCare expansions. It expanded coverage of parents of MaineCare eligible children from 150% to 200% of the federal poverty level (FPL) (from $25,755 to $34,340 for a family of three in 2006). Enrollment began in May 2005 and as of November 2008 covered 5,526 parents. The Dirigo Health Reform Act also authorized expanded MaineCare coverage for childless adults from 100% to 125% FPL (from $10,210 to $12,763 for an individual); however, this expansion was never implemented due to a federal cap on funding and was eliminated by the legislature.

As seen below,[14] before Dirigo Reforms, Maine had the highest rate of uninsurance in New England, but from then on Maine consistently bucked national trends. Due in large part to MaineCare, Maine's uninsured has fallen while the nation's has risen, and as a result, by 2006 Maine had the lowest rate in New England. Maine was replaced by Massachusetts in 2007 as a result of that state's reforms that included mandates for individuals to buy coverage; for employers to participate in coverage costs; and for the state to finance through a unique Federal waiver that allowed them to use about $400M of existing federal funds other states do not receive to pay for the expansions.



The table below compares how Mainers and Americans age 0-64 got coverage in 2007 (the most recent years for which data are available).[15]

| | US | ME |
|---|---|---|
| **Employer** | 60.9% | 61.5% |
| **Individual** | 5.5% | 5.6% |
| **Medicaid** | 13.9% | 19.6% |
| **Other Public** | 2.5% | 2.7% |
| **Uninsured** | 17.2% | 10.6% |

*DirigoChoice*

Most of Maine's uninsured and underinsured work in small businesses or are self-employed. DirigoChoice is an insurance program for small businesses, the self-employed, and individuals. DirigoChoice was designed as a public/private partnership administered through the Dirigo Health Agency and, originally, through Anthem Blue Cross and Blue Shield of Maine. In 2007, when the renewal bid from Anthem proved unaffordable, the Dirigo Health Agency contracted with the non-profit Harvard Pilgrim Health Care (HPHC) effective January 1, 2008. HPHC has been consistently ranked the number one health plan by US News and World report and the National Committee on Quality Assurance. DirigoChoice offers comprehensive coverage, with a strong preventive focus, and a subsidy program that reduces premiums and deductibles. Sliding scale subsidies are available to individuals and families with household incomes up to 300% of the federal poverty level ($61,950 for a family of four and $30,630 for a single adult). DirigoChoice pays providers commercial reimbursement – not Medicaid reimbursement – rates.

The connection between MaineCare and DirigoChoice is important. Currently, if you are on MaineCare and are given a raise, or you work more hours; that additional income could disqualify you from the MaineCare program. You fall off the cliff of eligibility, unable to afford private health insurance, but earning too much to qualify for MaineCare. DirigoChoice discounts are based on a sliding scale to eliminate that cliff.

DirigoChoice enrollment began January 1, 2005. By November 2008, over 29,000 people had been covered by DirigoChoice and Dirigo financed MaineCare expansions. However, on-going challenges to the funding of the program reduced revenues and required the program to close to new DirigoChoice enrollment over a year ago. As of November 2008, 10,663 DirigoChoice members and over 600 small businesses were enrolled and nearly 2,000 people are on a waiting list, should funding be available again. Twenty-six percent of DirigoChoice enrollees came in through small business, 29% were sole proprietors, and 45% were individuals. The map in the appendix shows that Dirigo enrollment is statewide and has been since its inception.

A more complete discussion of DirigoChoice, including definitions of the discount groups, costs for each discount group, how enrollment breaks out by income level, and more, is available at the Dirigo Health web-site.[16]

## VI. Financing Dirigo Health Reform- The Savings Offset Payment (SOP) & Beyond

Dirigo Health reform was designed as a comprehensive solution to Maine's growing health care crisis. It set forth a number of strategies to reduce the rapid growth of health care costs and stated that savings should offset the cost of any coverage expansions. In a compromise that helped win unanimous bipartisan Committee support and a 2/3 majority vote in each chamber of the Legislature, a savings offset payment (SOP) was created. The SOP can be assessed only if there are measurable savings in the system, as validated by an independent review by the Superintendent of Insurance. The amount of the assessment cannot exceed the measurable savings or 4% of all claims, whichever is less. An initial state appropriation of $53 million started the program and was used to support in the first three years.

Controversy has followed the financing of the program. The state argues that SOP includes savings from the full range of Dirigo's reforms, including bad debt and charity care (BDCC) reductions from covering the uninsured and under-insured, the voluntary hospital targets, Certificate of Need changes, increases in MaineCare payment to reduce MaineCare cost shifting, and other Dirigo reform strategies.

For the most part, insurance companies and employers argue that savings should be limited to bad debt and charity care reductions from covering the uninsured and that other savings were not tangible, so they would have to raise premiums to pay for the SOP. The intent of Dirigo was to create adequate reductions in the growth of health care costs to assure that the program would be self supporting – would cost no more than would otherwise have been spent.

Modifications made to the SOP in PL 2005, Ch 400, Part A effectively allowed those who paid the SOP 27 months to pay an annual assessment. The Dirigo Health Agency recognized that this amendment would create cash flow problems for the program and sought revisions to the financing structure over the years.

In July 2006, Governor Baldacci appointed a Blue Ribbon Commission to develop alternatives to the SOP. The Commission's final report was presented to the Governor in January 2007. That year the Governor presented a bill to the Legislature with an alternative financing strategy that was rejected. Efforts continued with Legislative leadership, the Governor's office

and stakeholders, and in 2008 the Legislature enacted a bill that (1) addressed high costs in the individual market, and (2) enacted recommendations of the Blue Ribbon Commission to stabilize program funding and eliminate the cash flow problem caused by delayed SOP payments. Specifically, the bill: reformed the individual market to significantly reduce premium growth for many and hold premiums steady for the older and sicker; developed pilot programs to test lower cost products for younger people; reduced the SOP from 4% of claims allowed in law to a fixed 1.8%; and added Commission-supported taxes on soda, beer, and wine. The bill was enacted, achieving important reforms in the individual market for those who must buy coverage on their own without an employer contributing to the costs, and ending the contentious SOP, replacing it with new funding, recommended by the Blue Ribbon Commission. Importantly, these reforms solved the cash flow problems with the current SOP.

A People's Veto, largely financed by the beverage industry, secured enough signatures to put the new law before the voters in November 2008. A well financed campaign, " Fed Up With Taxes", succeeded in repealing the new law and financing.

As a result the Dirigo Health Agency will continue to rely on the SOP and if necessary defend itself in court against challenges to the SOP. Legislative action will again be required to assure the Agency receives annual funding over a one-year period, not the current 27-month payment cycle now required by law.

Adjudicatory hearings were held by the Superintendent of Insurance in 2005, 2006, 2007 and 2008 to determine the amount of savings. Three different superintendents have concluded that the savings form Dirigo's first four years totaled over $150 million.

Insurers and several employer groups filed suit against the state over the SOP. The Superior Court ruled that the SOP was constitutional and reasonable and was not a tax. The case was appealed to the Law Court which upheld the decision of the Superior Court. However, the most recent year's savings determination is again being appealed in the courts.

## VII. Conclusion

When enacted in 2003, Governor Baldacci's Dirigo Health Reform Initiative was widely heralded as the first to seek universal coverage. It was the first major health reform to be enacted in any state in over a decade. Dirigo Health Reform was named a top government innovation for 2006 by Harvard University's Ash Institute and the Council for Excellence in Governance.

In the years since passage of Dirigo Health Reform, other states have followed suit. Many include provisions of Dirigo, and, while none initially took on the comprehensive approach of Dirigo to address cost, quality, and access, Massachusetts and Vermont have revitalized strategies enacted in the 1980's – though ultimately repealed – to require employers to offer coverage or pay a fee, and Massachusetts has mandated individual coverage.

States remain the laboratories of democracy, testing new ideas to solve problems like health care. Dirigo Health Reform is a work in progress requiring providers, business, insurers, labor, consumers and government to work together. With legislative direction and support, and the collaboration of stakeholders, Dirigo Health Reform will continue to evolve to better meet its goals of assuring all Maine citizens have access to affordable, quality health care and is a platform ready to launch reforms that may be enacted at the national level, as promised by President Obama.

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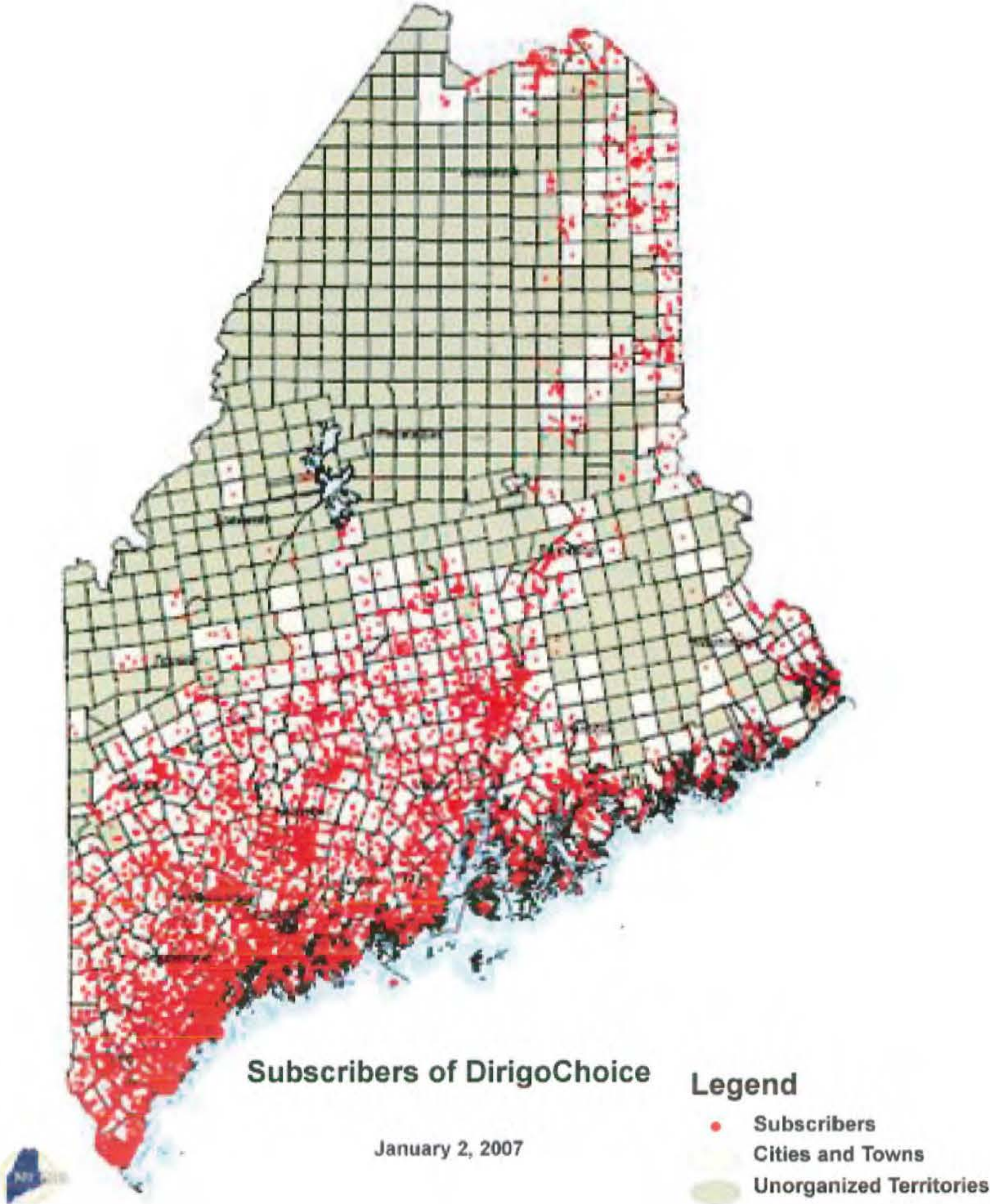
## Appendix 1 DirigoChoice Enrollees



Health & Aging

January 2009

# Issue Brief

## Health Promotion for Maine's Aging Population: A Legislative Roadmap

Maine has the distinction of being the oldest state in the nation based on the median age of its residents. The rapid aging of our citizenry has been accompanied by increases in rates of chronic disease, health care spending, and, in particular, the purchase of pharmaceuticals. This policy brief considers various strategies for promoting the health of aging Mainers with an emphasis on promising approaches that can be implemented with limited use of new resources through increased coordination and communication among providers and their consumers, enhanced integration of the health and human service networks, and reductions in health care service inefficiencies and duplication.

### Inside the Numbers

For many Maine citizens the benefits of living in a rural state far outweigh the challenges. Yet, for those who decide to reside in Maine in their later years, those challenges can make it difficult to access services vital to their daily living; and as a state we are not alone in the challenge of providing rural services effectively and efficiently to older adults. As of 2005, 50 million people lived in rural America and approximately 7.5 million of those people were over the age of 65 (Jones, Kandel, & Parker, 2007). In Maine, approximately 14% of our population is age 65 or older, and that percentage will continue to increase due to the large number of young adults leaving the state and because our state continues to attract retirees, making our median age climb to 41.6, the highest in the country (The Henry J. Kaiser Foundation, 2007).

A recent report by the National Advisory Committee on Rural Health and Human Services (NACRHHS, 2008) outlined many of the challenges that rural elders face, including those in Maine. The report found that older adults in rural regions are more likely to be less educated, have worse health outcomes, and have incomes that fall below the poverty level compared to their urban counterparts (Cromartie & Gibbs, 2007). In Maine, we have the added demand created by a large proportion of our population that falls under the category "dual eligible." As defined by the Center for Medicare and Medicaid Services, dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are also eligible for some form of Medicaid benefit (Center for Medicare, 2008). As

**Population Distribution by Age, Maine and U.S. (2007)**

| | ME # | ME % | US # | US % |
|---|---|---|---|---|
| Children 18 and under | 300,961 | 23% | 78,645,221 | 26% |
| Adults 19-64 | 816,714 | 62% | 182,781,246 | 61% |
| 65+ | 192,289 | 15% | 36,788,888 | 12% |
| 65-74 | 95,523 | 7% | 19,587,238 | 7% |
| 75+ | 96,766 | 7% | 17,201,650 | 6% |
| Total | 1,309,964 | 100% | 298,215,355 | 100% |

**Sources:** The Henry J. Kaiser Foundation's Commission on Medicaid and the Uninsured (estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey).

### Fast Facts

- In 2008, approximately 15% of Maine's population was over the age of 65. By 2025, one in five Mainers will be 65 years of age and older.
- Nearly 37% or $1.2 billion of Maine's increase in health spending from 1998 to 2005 is attributable to the leading chronic illnesses including cardiovascular disease, cancer, chronic lung disease and diabetes.
- Twenty-two percent of the total population and 63% of Medicare beneficiaries suffer from multiple chronic conditions.
- Older Americans with five or more chronic conditions have, on average, 14 doctors, see physicians 40 times a year, and fill almost 50 prescriptions.

**Author:** Lenard W. Kaye, D.S.W./Ph.D.
Director & Professor, Center on Aging
University of Maine
len.kaye@umit.maine.edu

Rachel Hutchins, M.S.W.
rmwhutchins@yahoo.com

Dyan M. Walsh, M.S.W.
dwalsh@eaaa.org

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of 2003, there were approximately 82,000 dual eligibles in the state of Maine (The Henry J. Kaiser Foundation, 2007). Dual eligible beneficiaries influence greatly the state's annual fiscal budget expenditure. This budgetary obligation will only climb over the next few decades and states like Maine will have to make tough choices about how to offer services to this population. A recent article in the Bangor Daily News notes that incoming state legislators are charged with the task of deciding between eliminating services, reducing payment to physicians and hospitals, and/or increasing the out-of-pocket costs for beneficiaries to include higher co-pays and deductibles; there is no easy answer (Haskell, December 13, 2008).

## Challenges of Rural Living

"Aging in place" for rural Mainers can be a difficult task, especially when access to health providers and services is limited. The 2008 NACRHHS report found that in non-metropolitan areas, the number of general practitioners has actually decreased by over 4% since 1985. The challenges of obtaining healthcare do not stop with the scarcity of Primary Care Physicians (and other health care professionals) in rural states like Maine. Emergency medical services (EMS) also play an unusual role in the lives of older Mainers. Due to the long distance to a hospital for many Maine residents, EMS is often times used as a primary means of medical support for older adults. The NACRHHS report found that due to limited access to preventive and primary care, EMS is often times utilized as a primary source of medical care. Maine also has a much higher than average rate of hospital emergency room (ER) visits. From 1996-2006, the rate of ER visits for the state of Maine was 576 visits per 1,000 population compared to the national average of 396 visits per 1,000 (The Henry J. Kaiser Foundation, 2007). One bright spot in healthcare access is that between 2002 and 2007 the President's Health Center Initiative funded over 1200 new health center sites. This enabled health centers to increase the number of patients that could be seen by 38% to 6.7 million individuals nationwide (HRSA Press Office, 2008). Federally Qualified Health Centers (FQHCs) have grown significantly in number and size in Maine during this time.

It is important to appreciate that the need for human (social) services is frequently just as great in rural areas as is the need for health services and it is difficult, if not impossible, to consider policies for one without simultaneously considering the other. Three out of the four factors that most influence demand for human services are present in rural America and in Maine: poverty, disability and advanced age (NACRHHS, 2008). Approximately, 24% of Maine citizens age 65 and older live at or below 150% of the federal poverty level (Purvis & Flowers, 2008). The need for human services is positively associated with the need for health and medical care.

Ask a Maine citizen over age 65 what his or her greatest challenge is in daily living and the majority will tell you lack of access to transportation. The lack of transportation options can and does make getting to the doctors office or picking up a prescription at the pharmacy difficult. The Older Americans Act (OAA) funds human services for the elderly through the Administration on Aging (AoA); included in these services is assistance with transportation (O'Shaughnessy, 2008). In 2006, President Bush reauthorized the OAA for an additional five years. An underlying theme of the legislation is more flexibility given to the State Units on Aging (SUAs) and the Area Agencies on Aging (AAAs) in developing human services programs for older adults. However, the calculations used to distribute the funds are flawed because they put rural states at an extreme disadvantage because there are fewer providers that offer services and a larger geographic area to cover (NACRHHS, 2008).

## Finding What Works

Finding answers to the challenges of access to health or human services by Maine's older citizens remains illusive. One reality appears clear in today's recessionary climate - an increase in funding from either the state or federal government is not an option that Maine citizens can count on. Policy makers, service providers and citizens must become more creative in finding ways to meet their needs without depending on additional dollars to make it happen.

Innovation and ingenuity is the key, and while there is no quick fix to this issue, it is up to Maine's aging network, including politicians, educators, practitioners and Maine's general populace, to come up with the answers. Several suggested strategies include:

- Utilize the additional and expanded Federally Qualified Health Centers that were created as part of the President's Health Center Initiative by encouraging those providers to reach out to greater numbers of older adults in Maine and provide those patients with efficient access to preventive and primary care health services.
- Encourage greater collaboration and cooperation across health and human service agencies, including AAAs, to strategically develop integrated or blended service delivery options for older adults that utilize existing services and do not reinvent programs that are already available.
- Reassess eligibility requirements for MaineCare to try and bring spending in line with other rural states and decrease health care costs to all Maine citizens.
- Find creative ways to educate Maine citizens about available health and human service programs by utilizing resources already in place including 2-1-1 Maine and the outreach programs offered by the AAAs, community action agencies, FQHCs, and others.

## Chronic Disease and the Use of Prescription Medications

As chronic disease is common among older adults, this population is more likely to require the use of prescription medication, and often multiple medications, to manage these conditions. While use of medications has become essential to the health of many older adults, there are a number of risks associated

with the use of drugs, with those risks increasing as the number of medications used increases (Shepler et al, 2006; Fulton & Allen, 2005; Brager 2004; and Rollason & Vogt, 2003). The burden of medication management shouldered by older adults and their relatives is a major factor leading to heightened likelihood of premature and costly institutional placement.

The "concomitant ingestion of four or more medications" (Rollason & Vogt, 2003) or polypharmacy, has a number of consequences including nonadherence to the drug schedule resulting in under or over dosage, adverse drug reactions, drug-drug interactions, increased risk of hospitalization particularly as a result of adverse drug reactions and drug-drug interactions, medication errors often occurring due to inconsistencies between the patient's medical report and the pharmacy prescription files, and increased costs due in part to the cost of the medications themselves but also due to the costs associated with the treatment of adverse effects (Rollason & Vogt, 2003).

Complicating the problem of polypharmacy is the fact that in addition to the use of prescription medications, many older adults self medicate with a combination of over-the-counter medications, and a variety of herbal remedies and supplements (Francis, Barnett, & Denham, 2005). While it is common for patients to discuss their prescription medication routine with their physician, it is less common for patients to disclose use of over-the-counter medications or herbal preparations to treat issues such as arthritis, constipation and allergies (Shepler et al, 2006; Francis et al, 2005). Just as multiple prescriptions can cause adverse reactions, over-the-counter drugs and herbal remedies can also result in negative drug interactions. Also important to this conversation is the misconception that natural ingredients make an herbal or alternative treatment safe. However, as these products are not regulated by the Food and Drug Administration, the safety and efficacy of these medications should be considered prior to use and especially prior to combination with other medications (Brager, 2004).

Another aspect of medication management and routine are the complications encountered by the addition of alcohol use while taking any medication. Alcohol can change how the body metabolizes medications which can lead to an adverse drug reaction. Consumers and physicians should be concerned especially with the interaction of alcohol with psychoactive medications such as barbiturates, benzodiazepines and antidepressants. While consumption of alcohol by older adults may follow different patterns than those of younger age groups, it is certainly an important part of the medication management discussion (Blow et al, n.d.). In addition, the accumulation of expired, unused, and unwanted prescription drugs in the households of older adults only serves to increase the possibility of drug misuse and abuse.

A promising method to combat discrepancies between multiple providers and pharmacy records is the use of e-prescribing, a type of electronic health record. Providers who utilize e-prescribing, have access to a patient's prescription history and can eliminate medication error that is often caused due to medications being prescribed by more than one provider. Because this type of system can be in real-time, a physician can bring up a patient's complete medication record at the time of the interaction with the patient thus allowing for conversations about medication practices, change in dosage, use of over-the-counter or alternative therapies, and other medication concerns (Lapane, Dube, Schneider, & Quilliam, 2007). While use of e-prescribing could benefit the management of medication use by older adults, the integration of electronic health records in rural locations can prove challenging due to the lack of broadband access, and qualified IT assistance and maintenance needed to implement and sustain these programs (eHealth & CIMM, 2008). The Center for Improving Medication Management: (http://www.thecimm.org/index.htm) has a number of resources for providers and consumers to get the latest information on the use of e-prescribing.

Although the use of multiple medications to manage chronic conditions has become a necessity for many older adults, polypharmacy brings with it potentially severe consequences. While there is not one avenue to address this problem, there are a number of ways to help prevent the occurrence of negative consequences. Policies such as the following should be considered:

- Providers should review complete medication histories with their patients, including prescription, over-the-counter and herbal medications. Patients or caregivers need to be asked to bring in all medications on a regular schedule.
- Patients need to be educated about the administration, purpose and risks of their medications and the implications of multiple medication combinations.
- Providers should ask patients about their consumption of alcohol to screen for potential negative alcohol and drug interactions.
- Encourage the use of one pharmacy because it helps to eliminate discrepancies between patient medical records and pharmacy prescription files thus helping reduce potential adverse drug reactions and interactions.
- Improved consumer access is needed to product information through increased font size and design of medication packaging.
- Provider use of electronic health record tools like e-prescribing can help minimize medication error and provide continuity between physicians, specialists, and pharmacists.
- Honest and open communication between health providers and consumers is essential to safe use of prescription medication and appropriate integration of over-the-counter and herbal preparations into patient drug routine.
- Older adults should be encouraged to take advantage of available expired and unwanted prescription drug take-back programs such as the state-wide Safe Medicine Disposal for ME program.

## Conclusions

The aging revolution remains an undeniable and highly influential demographic force influencing Maine's population profile and health care landscape in significant ways. There is little disagreement as to the harsh health care realities and challenges which serve to reduce quality of life for older Mainers. A commitment to enacting common sense policies and program practices which integrate existing services, use all available technology, make access to care less difficult, reduce service duplication, and encourage more cooperation and open communication between community providers and older adult consumers and their families is crucial and needed now.

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Health IT

# Issue Brief

## Information Technology: A Key Strategy for Transforming Health Care

There is an increasing sense of urgency around efforts to transform our health care delivery system---to find ways to make health care more affordable without jeopardizing quality and patient safety. Nearly all health care and public policy leaders now believe that health information technology will be one of the most important tools we have available to moderate the growth of health spending---and simultaneously improve patient safety and quality of care. This transformation will require substantial improvements to Maine's – and the nation's - electronic information infrastructure:

- More doctors and other providers must acquire electronic medical records (EMRs);
- Better access to broadband connections is needed to effectively support improved communications among providers, especially in rural areas, and
- Clinical data (lab results, diagnostic test reports and medication profiles) must be uniformly organized and shared across hospitals, laboratories and providers so doctors, nurses and other health care providers can make effective and responsive decisions about treatment and care.

Over time, interconnected electronic systems will help reduce duplicate, and potentially dangerous, prescriptions, medical procedures and tests. These systems will also help Maine collect, measure and report clinical outcomes information, an increasingly important step in improving care.

### Health Information Technology (HIT): A National Priority

The federal government has been promoting the adoption of electronic health information systems and "interoperability" - which is the capacity to share secure electronic information across systems - for a number of years. Natural disasters such as Hurricane Katrina forcefully reminded elected leaders and many Americans about the risks of relying on paper medical records that can be destroyed and lost forever. Yet relatively little federal funding has been made available thus far to help states build an interconnected health information infrastructure.

"We must ensure that our hospitals are connected to each other through the internet. This won't just save jobs, it will save lives. We will make sure that every doctor's office and hospital in this country is using cutting edge technology and electronic medical records so that we can cut red tape, prevent medical mistakes, and help save billions of dollars each year."
- President Barack Obama.

The federal government now appears poised to make major new investments in the nation's health information infrastructure. The Obama Administration clearly supports advancing this infrastructure, and indicated HIT investments will be a part of its economic stimulus package. HIT investments are supported by leading Republicans and Democrats, making early passage of spending measures more likely. Preliminary plans call for $10 billion per year to be invested in HIT over the next five years, however, federal funding for state HIT initiatives have typically required that states contribute local matching funds.

**Fast Facts**

- Nearly 60% of Maine residents believe coordination of health care information among providers is a significant problem.
- In 2006, MaineCare paid over $12 million for hospital care associated with "adverse drug events," many of which could have been prevented by providing more complete information to doctors, nurses, and other providers.
- *HealthInfoNet*, could initially save $40 million to $50 million per year in health care costs as caregivers order fewer unnecessary and duplicative tests, procedures, and prescriptions.
- Maine was recently awarded a federal grant to transition small physician practices from paper to electronic medical records (EMRs).

**Author:** Devore S. Culver
Executive Director
*HealthInfoNet*
(207) 430-0676
dculver@hinfonet.org

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Maine is well positioned to compete for its share of federal funding, particularly if public and private state resources are identified to meet local match or funding requirements. These resources would further advance Maine's work as a national leader in a major transformation of our own HIT infrastructure, and capitalize on recent federal support of more than $25 million to extend broadband access to rural and remote parts of Maine.

### Health Information Technology Terminology

- Health Information Technology (HIT): The broad term describing many levels of use of technology in storing, organizing, retrieving, and sharing information about health.
- Electronic Medical Records (EMRs) or Electronic Health Records (EHRs): Electronic systems that store information about an individual patient's medical care. Notes from office visits or specialists, diagnoses, prescriptions, immunization records, test results such as x-rays or ultrasounds, and laboratory tests are stored electronically. These systems are based in individual doctors' offices or hospitals.
- Health Information Exchange (HIE) or Health Information Networks (HIN): Highly secure electronic systems that quickly and efficiently gather existing clinical information from EMRs, hospital-based systems and laboratories so medical care teams have complete and up to date information to guide clinical decisions.
- Personal Health Record (PHR): These records store information about an individual's medical care, but they are held by individuals rather than health care providers.

## Maine's Progress in HIT: Challenges and Leadership

Despite substantial progress in building Maine's health information systems, much work remains to be done to achieve an integrated, interconnected electronic health care system. In Maine, less than 25% of practicing physicians have transitioned from paper to electronic medical records (EMRs), and our HIT infrastructure is still a patchwork of mostly local and regional systems that are not connected. However, we know what our HIT infrastructure should look like, and groups from all sectors of the state are working together to achieve important changes.

- Maine has drawn national attention for developing one of the nation's first pilot statewide health information exchanges (HIEs), which is a key element of a state's electronic health information infrastructure. Maine's new statewide medical information-sharing network is an independent, nonprofit network called *HealthInfoNet* (www.hinfonet.org).
- Maine hospitals have invested well over $100 million in new and updated HIT systems in the past five years, and physician practices and other providers in every corner of the state are transitioning from paper to electronic systems. Currently two of every ten primary care practices in the state have installed EMRs. If additional financial support can be secured, HIT leaders believe eight of every ten practices in the next seven years will move to electronic records.
- The Finance Authority of Maine and the Maine Health Access Foundation have partnered to establish a $750,000 low-interest loan fund that is dedicated to helping small primary care practices participating in a new federal Center for Medicare and Medicaid Services (CMS) demonstration project purchase EMRs for their offices so they can be eligible for future federal CMS bonus payments for better quality care.
- A goal has been set to provide every Maine resident with an electronic medical record by the year 2020---just over a decade away.

## Connecting Caregivers Across Maine through *HealthInfoNet*

While health information exchanges (HIE) such as *HealthInfoNet* are a fairly new concept in this country, HIEs are already in use in a number of countries, such as New Zealand, Australia and in some Canadian provinces. Nearly every state in this country is in the process of building its own exchange. Long term plans call for connecting states through a national network of HIEs.

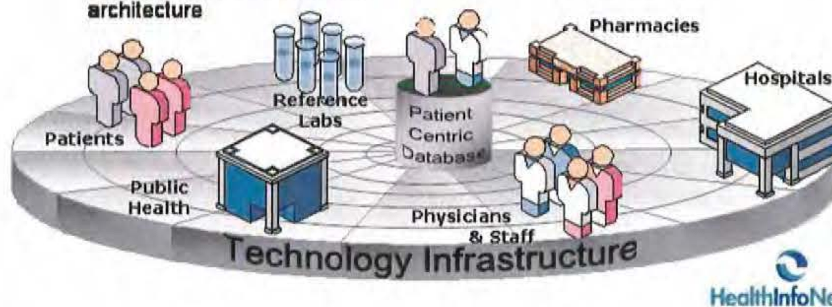
Organized as a public-private partnership, Maine's *HealthInfoNet* was established as a nonprofit corporation in 2006. As an independent nonprofit organization, *HealthInfoNet* is not owned by hospitals, insurance companies, employers, industry or the government. *HealthInfoNet*'s board of directors includes doctors, hospital officials, consumers, insurers, public health, business leaders, and representatives of state government.

Under development for the past five years, *HealthInfoNet*'s goal is to bring the most current and comprehensive electronic clinical information to all caregivers in Maine at the point of service so doctors, nurses and other providers can provide the best, most timely and efficient care for their patients. Electronic networks of this kind are expected to help reduce medical errors and lead to better, more informed treatment decisions. This advance will save lives and money. Over time, the *HealthInfoNet* network will also enable individual Maine residents to have greater access to their own medical records.

Early in 2008, *HealthInfoNet* kicked off a 24-month statewide Demonstration Phase. More than 2,000 healthcare providers, including 15 rural and urban hospitals across Maine and one-

## HealthInfoNet Places The Patient At The Center Of A Coordinated Statewide Information-Sharing System

- **Key clinical information from many sources stored in secure database**
- **Disparate IT systems are unified through a shared information architecture**
- **Collaborative Care Model**
- **All providers have access to up-to-date patient information**




third of practicing physicians are currently part of this Demonstration Phase. Hospitals and physician practices taking part in this Phase oversee more than half of the state's annual inpatient hospital admissions, half the annual emergency department visits, and nearly 40% of Maine's outpatient visits each year As this Phase enters its second year in 2009, many hospitals, physicians and other caregivers across Maine will---for the first time ever---have access to a more complete and up-to-date clinical profile of their patients. Armed with more complete and timely information, caregivers say they can provide better quality care and improve the coordination of care, particularly for those patients who see several providers and receive care in more than one community or care setting.

"As a rural healthcare resource, access to patient information from the major medical centers can make all the difference in caring for our patients. Immediate access to critical patient data is paramount to safe patient care and in this day and age of advanced technology we need to participate in this program for our patients' sake." - Rick Batt, Former President and CEO, Franklin Community Health Network, Farmington

Many of Maine's other community hospitals and clinics have been involved in *HealthInfoNet*'s planning process. They are expected to become part of the statewide network following the Demonstration Phase if additional funding and support can be identified. With the successful completion of the Demonstration Phase, plans call for *HealthInfoNet* to be expanded to include other providers who care for Maine's entire 1.3 million residents.

Since its inception, *HealthInfoNet* has been planned as a unifying system for all health and health care information. *HealthInfoNet* has worked closely with the Maine Center for Disease Control (CDC) and Prevention (which is part of the Department of Health and Human Services) to insure this state-wide electronic information exchange gathers vital public health information in addition to the clinical information needed for patient care. This linkage will support automating the laboratory reporting requirements mandated by Maine law for disease outbreak management purposes. *HealthInfoNet* will help laboratories more quickly report certain conditions, such as food poisoning, Lyme disease, and tuberculosis to public health experts at Maine CDC. This capacity will be highly valuable in the event of a natural disaster or bioterrorism incident. Over time, the health data collected through *HealthInfoNet* will enhance and guide more targeted efforts by the Maine CDC to improve the health of all Maine people.

## Protections Address Patient Privacy Concerns

Many people are concerned that electronic systems are not secure enough to protect their private medical information from inappropriate disclosure. *HealthInfoNet* is being built as a secure private network. This means that only a patient's medical care team can see their electronic record. The organization's board of directors is charged with ensuring that the system operates in full compliance with rigorous state and federal laws and regulations that are designed to protect the privacy of personal medical information. Patients can choose not to take part in *HealthInfoNet* at any time.

*HealthInfoNet* has studied existing state and federal confidentiality laws and has carefully structured its operations to comply with existing law and mirror well-established health information exchanges such as the Indiana Health Information Exchange. Maine also has participated in a national project organized by the federal government to identify and address differences in privacy and confidentiality laws, regulations and practices.

## Funding Reflects Public-Private Partnership

Over the last four years, *HealthInfoNet* has received start-up funding from a wide range of private foundations, provider organizations and state and federal government agencies. In 2006, the Maine legislature appropriated $265,000 so *HealthInfoNet* could secure a $1 million matching grant opportunity. Funding for the two-year Demonstration Phase that is now under way has come primarily from private foundations, state and federal government, as well as providers. As part of the vital start up funding, Maine's four largest health care delivery systems (MaineHealth, Eastern Maine Healthcare Systems, MaineGeneral and Central Maine Healthcare, and Martin's Point Health Care) have provided more than $1 million to *HealthInfoNet* to streamline and connect their electronic health information. This work has contributed to the rapid development of an integrated statewide system.

## HIT's Potential to Control Maine's Soaring Health Care Costs

It is now widely accepted that electronic information-sharing is the most powerful tool currently available in Maine and across the nation to moderate the soaring cost of health care. The potential of HIT to capture savings in Maine has been demonstrated in a recent analysis conducted by the University of Massachusetts Medical School that examined how a statewide HIE could impact health care costs. This analysis projected that:

- *HealthInfoNet* Demonstration Phase annual savings are estimated to range from $10.6 - $12.5 million in calendar years 2009-2010 and, if *HealthInfoNet* becomes fully operational, this figure could increase to about $20 million annually by 2011;
- If *HealthInfoNet* can extend to other providers beyond those in the Demonstration Phase, between $40 million and $52 million in annual health care savings could be realized;
- Through *HealthInfoNet*, MaineCare is projected to realize annual savings of between $900,000 and $1.3 million in 2009 and 2010. This figure is projected to nearly double in 2011.
- Maine's four largest public employers are projected to experience annual cost reductions of $740,000 in 2009-2010 as a result of the *HealthInfoNet* Demonstration Phase.

The data from the UMASS study was based exclusively on calculating cost savings based on the narrow range of clinical content that is included in *HealthInfoNet*'s Demonstration Phase, with just six participating provider organizations. If providers continue to adopt EMRs and *HealthInfoNet* can continue its expansion, the clinical content and the number of participating providers will grow substantially over the next five years. This means that the UMASS study understates the potential savings during *HealthInfoNet*'s Demonstration Phase and beyond.

## Recent Maine Legislative Activity and Future Opportunities

In 2007, the 123rd Legislature passed a *Resolve to Advance Maine's HealthInfoNet* Program. The resolve stipulated that a stakeholder process be convened and report be submitted to the Health and Human Services Committee by December 1, 2008.

The stakeholders, comprised of leaders from business, health care providers, hospitals, consumer representatives, insurers, policy experts and others agreed that the first priority is for *HealthInfoNet* to achieve success during the Demonstration Phase, and then expand its services and participation. Recommendations from this stakeholder group will be presented to the legislature early this session. In addition to calling for a General Fund appropriation to enable *HealthInfoNet* to complete its Demonstration Phase and offset a portion of its ongoing annual operating costs, the stakeholder group supports a General Obligation Bond to create a new statewide Health IT Fund. If approved by the Legislature and then by voters later in the year, this Fund would provide a way for Maine to raise dollars needed to match federal health information technology investments now taking shape as part of the Obama administration's stimulus package.

In addition, the proposed Health IT Fund would accelerate the development of key elements of Maine's health care infrastructure, including the acquisition of EMRs, promoting electronic prescribing, and supporting the development of a statewide health information exchange that will advance improved quality, better care coordination and efficiencies that can help moderate costs. Approximately $20 million of the fund would be used over a seven-year period starting in 2009 to improve information technology infrastructure at the provider level. This will transform patient care management at the point of care and allow providers to effectively participate in the *HealthInfoNet* electronic information exchange. Providers eligible for initial assistance from the Health IT Fund will include primary care practices, which is consistent with the prioritization of primary care services in the State Health Plan. Over time, other providers would be eligible for funding.

An estimated $4 million of the fund would be used to further develop the *HealthInfoNet* technical infrastructure. These funds would be used to pay for a portion of the capital investment projected for building out the exchange as a statewide resource over a five year period.

## Issues and Action Steps To Strengthen Maine's Progress in Health IT

Through substantial investments in recent years, Maine has positioned itself as a national leader in the development of its health IT infrastructure. Hospitals across the state have invested well over $100 million in information systems. Physicians and other providers are demonstrating a growing willingness to transition to electronic systems. Employers and payers have joined with the federal government in promoting greater adoption of these systems by providing financial incentives to

providers who acquire EMRs. However, despite this strong and growing support, funding remains a serious challenge at both the state-wide level and in local communities where many providers are struggling to afford these systems.

The business plan for *HealthInfoNet* assumes revenue from user fees/subscriptions, as well as technical services provided to other organizations. This is expected to provide approximately two-thirds of *HealthInfoNet*'s operating capital requirements. The stakeholder group created by the legislature concluded that because all Maine residents will benefit from a state-wide system, public funding for the remaining portion of operating and capital requirements is appropriate and needed. Given the uncertainty of federal funding, it's especially important for the state to identify funding strategies that insure that investments already made are not lost.

During this legislative session, elected officials will need to seriously consider actions that will:

- Identify HIT investment as a high priority strategy for improving quality and moderating costs;
- Establish specific state-wide goals for adopting HIT and assuring every Maine resident will have an electronic health record by 2020;
- Assure that the transition to electronic health records is supported by the continuing refinement of privacy laws, regulations, policies and practices;
- Create targeted funds and other approaches that will enable providers with limited resources to acquire electronic systems;
- Invest in integrating Medicaid systems with developing state-wide health information exchanges;
- Support matching funds that may be needed for federal funding that would help build-out health IT infrastructures;

## References and Resources for More Information:


Agency for Healthcare Research and Quality (AHRQ) National Resource Center for Health Information Technology. Available at: http://healthit.ahrq.gov/portal/server.pt?open=512&objID=650&parentname=CommunityPage&parentid=1&mode=2&in_hi_userid=3882&cached=true

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Hospitals

January 2009

# Issue Brief

## Policy Issues Affecting Maine's Hospitals

### Overview

Maine's 42 general and specialty hospitals provide a wide range of inpatient, outpatient, emergency, psychiatric, rehabilitation, and long term care services. Thirty seven are acute care medical-surgical hospitals, four are specialty psychiatric hospitals, and the remaining facility is a rehabilitation hospital. The figure shows the distribution of hospitals across Maine. In terms of organizational structure, the majority (33) operate as not-for-profit entities. Of the remaining hospitals, three are church operated, five are government operated (e.g., Federal Department of Veterans Affairs, state, municipal, or hospital district), and one operates as a partnership.

### Distribution of Maine Hospitals

All 37 acute care hospitals provide 24 hour emergency services, with 10 hospitals additionally designated as trauma centers and two operating as part of trauma systems. In addition to the four psychiatric hospitals in the state, eight of 37 provide inpatient psychiatric and four provide inpatient alcohol and drug abuse services.

Fifteen hospitals are designated as Critical Access Hospital (CAHs) by the Centers for Medicare and Medicaid Services (CMS).[1] CAHs are small (25 beds or less), low volume hospitals that must be located in rural areas; meet federal program requirements related to distance between hospitals and limitations on average length of stay; and maintain an affiliation with a larger support hospital. In exchange, CAHs receive cost-based reimbursement from Medicare and MaineCare. Cost-based reimbursement, a payment methodology better suited to the volume fluctuations experienced by these facilities, provides CAHs with a degree of financial stability.[2,3] An additional four hospitals are designated as Sole Community Providers (SCPs), defined as being 35 miles or more from the nearest similar provider. SCPs qualify for special formulas which result in higher payments.

Most Maine hospitals are located in small towns or rural areas and have less than 100 beds. Only three have 200 or more beds. Twenty-three hospitals are associated, under different arrangements, with one of three large hospital systems. MaineHealth has five member (i.e. owned) hospitals, five affiliate hospitals, and one joint venture with HealthSouth. Eastern Maine Health Systems has seven members and two affiliates. The Central Maine Medical Family has three member hospitals. Mercy Hospital in Portland is part of a regional health system, Catholic Health East. Six independent hospitals in Maine contract with QRH of Brentwood, Tennessee for management services.

### Underpayment of Maine Hospitals by Medicare and MaineCare

While Medicare and MaineCare enrollees use 58% of hospital services in Maine, the two programs account for 43% (33% by Medicare and 10% by MaineCare) of hospital payments.[4] Reports commissioned by the Maine Hospital Association estimate that Medicare pays 88% of costs for hospital services while MaineCare pays 75%. To recoup these shortfalls, Maine hospitals increase their charges to commercial insurers, who in turn pass these costs on to their subscribers.[5] Known as cost-shifting, the practice is a difficult policy issue. The extent to which cost-shifting contributes to increases in prices for commercial insurers and private pay patients in Maine has not been quantified. A

**Fast Facts**

- Maine's hospitals provide a range of inpatient, outpatient, and emergency services as well as free and reduced price care, community health education, and workforce initiatives.
- Hospitals struggle with low payment from Medicare and MaineCare, while these sources represent an increasing share of patients.
- Current and future challenges for hospitals stem from federal and state regulations, trends in physician practice, and emerging payment models.

**Author:** John A. Gale, M.S.
Jennifer D. Lenardson, M.H.S.
Muskie School of Public Service
jgale@usm.maine.edu
(207) 228-8246

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2006 study of the impact of cost shifting in California estimated that cost shifting accounted for 12.3% of the total increase in private payer prices from 1997 to 2001.[6] The New Hampshire Center for Public Policy Studies estimated that the impact of cost shifting due to Medicare and New Hampshire Medicaid rates ranged from 8% in 2001 to 10% in 2006.[7] Based on these studies, cost shifting from Medicare and MaineCare likely accounts for a relatively small portion of premium increases in Maine with the remainder accounted for by underlying service utilization, changes in enrollment, changes in health plan and hospital margins, and cost-shifting due to the provision of uncompensated care to uninsured and low income patients.

A major factor in the underpayment of hospitals by Medicare is the hospital wage index. Medicare reimburses relevant acute care hospitals using the acute inpatient prospective payment system (IPPS) which pays a per-discharge rate for illness episodes based on national base payment rates for operating and capital expenses. The base rates are adjusted to account for the patient's condition, treatment needs, and market conditions in the facility's location. Medicare assigns discharges to discharge related groups (DRGs) which are groups of clinical problems that require similar levels of hospital resources. Each DRG is weighted to reflect the relative costliness of treatment for that group. To adjust for market conditions, the base rates are adjusted to reflect variations in input-prices using the local market's hospital wage index and other factors, such as resident training programs, disproportionate number of low-income patients, certain transfers and extraordinarily costly cases.

Each area's hospital wage index is intended to reflect expected differences in local market prices for labor and is revised each year based on wage data reported by IPPS hospitals. According to the MHA, low Medicare payment rates in Maine are due to Medicare's failure to adjust its payments to accurately reflect wages paid in Maine. MHA estimates that the Medicare Payment Advisory Committee's (MedPAC) recommendations for revising the wage index, if implemented, would net an additional $10 million in Medicare payments for Maine Hospitals. Maine's 2008-2009 State Health Plan calls for the development of an Ad Hoc Medicare Equity Work Group to analyze this issue and work with MedPAC and CMS to increase the wage index for Maine hospitals.

## Uncompensated Costs of Treating the Uninsured

Closely related to the above issue are the uncompensated costs borne by hospitals for providing care to Maine's 124,000 uninsured residents. Maine law requires hospitals to provide free care to patients with income below 100% of the Federal Poverty Level (FPL). All but one of the 39 hospitals (the Togus VA facility and the two state psychiatric hospitals were excluded) responding to the MHA's 2007 survey of free care policies has extended their eligibility standards for free care to 150-200% of FPL with 62% setting their eligibility standards at 200% of FPL. Additionally, 85% offer a sliding fee scale, which allows patients to pay a portion of hospital fees based on their income.[8] In 2005, Maine hospitals provided $78.7 million in uncompensated care for uninsured people.[9] The costs of providing free and discounted care are passed on to commercial and self-pay patients through increased hospital rates (i.e., cost-shifting).

## Understanding the Community Benefits Provided by Maine's hospitals

Nationally, there is a growing interest in documenting the community benefits provided by not-for-profit hospitals within the context of the tax benefits they receive due to their exempt status. Seventeen states have implemented mandatory community benefit reporting. Voluntary reporting programs have been implemented in eight states. More are expected to follow.

Community benefits are programs or activities that provide services and/or promote health in response to an identified community need. Community benefits must:

- Generate low or negative margins;
- Respond to needs of special populations (e.g., persons living in poverty);
- Supply a service/program that would likely be discontinued if based on financial criteria;
- Respond to public health needs; or
- Involve education or research that improves overall community health.

Examples include charity care provided to low income, uninsured individuals; participation in medical student or residency training programs; provision of subsidized services that are typically not self supporting such as burn or neonatal care units; health education programs; shortfalls in revenues from government payers such as Medicaid; and free care clinics.

The Internal Revenue Service (IRS) has revised its Form 990, *Return of Organization Exempt from Income Tax* to collect data on the community benefits provided by not-for-profit hospitals, based substantially on the Catholic Health Association's community benefit reporting guidelines. Beginning in tax year 2009 (with returns filed in 2010), not-for-profit hospitals will be required to provide a full accounting of cost of their community benefits. Thirty-three of Maine's 42 hospitals are not-for-profit entities and will be required to report this information (government owned and certain other hospitals are exempt from reporting).

A large portion of most hospitals' community benefits is charity care provided to individuals who meet the hospitals charity care guidelines. At the national level, Senator Charles Grassley of Iowa, ranking Republican on the Senate Finance Committee is weighing the possibility of proposing legislation in early 2009 that would require not-for-profit hospitals to spend a minimum amount on charity care, impose penalties on hospitals that fail to meet the new requirements, and set curbs on executive

compensation and conflicts of interests.[10] In the past, Senator Grassley's staff has suggested that not-for-profits spend at least 5% of their patient care revenues on charity care although it is not clear that the legislation under consideration would adopt that threshold. Based on data reported to the Maine Health Data Organization, Maine's hospitals provided 1.2% of total gross revenues as charity care 2.5% of gross revenues as bad debt in 2005.[11] Hospitals will legitimately argue that some portion of their bad debt is attributable to individuals that would qualify for charity care if they were to provide the required financial data. The exact percentage, however, is difficult to quantify and Maine hospitals may need to improve how they qualify patients if Senator Grassley is successful. Unfortunately, no comparative data exists to determine if Maine's hospitals provide more or less charity care and bad debt than other hospitals nationally. This is an issue that bears watching.

## Challenges Related to the Provision of 24 Hour Emergency Services

Under the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals must provide 24-hour emergency services regardless of patients' ability to pay and to maintain physicians to cover those services. The New York Times reports that an increase in unemployment could significantly increase the number of uninsured people presenting for care in emergency rooms, resulting in overcrowding and an increase in hospitals' unpaid medical bills.[12] With Maine's large rural population which has higher rates of uninsurance and underinsurance, Maine hospitals may see an increase in uncompensated care costs.

A related national issue with implications for Maine is the declining ability of hospitals to secure physician coverage of emergency departments due to lack of reimbursement for these services and impingement on physicians' limited non-work hours. Historically, physicians have provided emergency room coverage voluntarily in exchange for hospital admitting privileges; however, many hospitals across the country now must pay physicians for coverage.[13]

The emergency departments of Maine hospitals are the safety net for critical services not available in the community, such as mental health and substance abuse services. This is particular challenge for Maine's rural hospitals. A national study of Critical Access Hospital (CAH) emergency room usage indicated that almost 10% of visits were mental health related.[14] Nationally, 42% of hospitals reported an increase in "boarding" behavioral health patients in emergency rooms.[15] Boarding refers to patients in need of inpatient psychiatric or substance abuse services remain in the emergency department until a suitable placement can be found. Maine hospitals report ongoing problems with this issue given the relative shortage of available inpatient beds, particularly for children and adolescents. Boarding of behavioral health patients in emergency rooms places a difficult burden on staff as these patients often require very intensive coverage while awaiting transfer.

## Maine's Certificate of Need program

Maine's Certificate of Need (CON) program is designed to contain costs among health care providers through the formal review and approval of proposals to add new services and construction.[16] Reviews are required for proposals to transfer of ownership or licensure, acquire major medical equipment and make capital expenditures over a certain dollar threshold, and add new health services and facility beds.[17] The program had been praised for covering an appropriate range of services and for its well-defined procedures and recorded decision-making process. It has also been criticized for operating outside of state health planning activities, its lack of monitoring and enforcement of decisions, and the size of its staffing resources given the magnitude of health spending to review.[18,19] Addressing at least one criticism, the CON process is now required to use the State Health Plan as a basis for assessing projects.[20]

The Capital Investment Fund (CIF), enacted in 2003 as part of the Dirigo Health legislation, is another aspect of the CON program that has come under criticism. The CIF, one of the only cost containment tools available in state law, was implemented to cap spending for projects approved under the CON statute. It places a cost limit on how much may be added to the health care system each year by capital investments approved under CON. The CIF establishes a measure of affordability against which CON decisions about need can be made; it balances need and affordability, recognizing that supply of health care services increases utilization and that increased utilization does not necessarily improve health outcomes.

The CIF's formulas have been set out by regulation which requires any amount over $2 million for a project's third year operating costs to be debited against subsequent years' CIF cap. This results in surplus amounts from prior years being carried over under the current CIF cap, limiting the amount available for current projects with CON approval. For 2008, the CIF cap for large hospital projects is $8.7 million; however, due to debits from previous years, this amount has been reduced to $3.4 million. As a result, the amount available varies year to year and the potential result is that only small projects move forward and other large projects must be re-reviewed under the CON process.[21] Hospitals are concerned that the current CIF process makes it difficult to conduct strategic planning because the available CIF amount can vary significantly from year to year.

An advisory committee of hospitals representatives, consumers, and employers was assembled to review the CIF and make recommendations.[22] Over the summer of 2008, the committee worked with the Governor's Office of Health Policy and Development to develop recommendations and language to revise the CIF. These groups have proposed rules that will:

- Set the CIF according to straightforward formula (0.31% of statewide operating expenses);
- Facilitate effective health system planning by setting the CIF once every three years for a three year period; and

- Enhance the ability of DHHS to ensure economic and orderly development of the state's health care systems by giving DHHS a better sense of all projects that providers wish to undertake.

## Financial Incentives Linked to Clinical Performance

To re-align reimbursement with clinical performance, public and private payers are implementing pay-for-performance initiatives, where payment is tied to providers' quality improvements. These incentives may be positive when enhanced payments are made to hospitals achieving established quality targets. They may also be negative when payment is withheld from hospitals that fail to meet acceptable quality standards. These changing reimbursement incentives, while clearly designed to improve the performance of the health care system, have implications for many of Maine's small hospitals as successful implementation requires resources and information technology that may not be available to these facilities. Many incentive programs are based on volume assumptions that may not apply to small rural facilities as one or two poor outcomes can significantly impact their public rating.

## Pay-For-Performance Initiatives

As part of a larger effort to improve health care quality and the information available to consumers about that quality, CMS has implemented Hospital Compare, a program in which hospitals publicly report their performance for four conditions. Their participation is tied to each hospital's annual payment update. Hospitals, with limited exceptions, are required to submit quality data on ten core measures or face a 0.4 percentage point reduction in their annual payment updates. (While CAHs are not required to participate, many do so.) The ultimate goal for these measures is that they will be reported by all hospitals and accepted by all payers. CMS is also sponsoring a three-year demonstration that pays hospitals bonuses based on their performance on quality measures selected for inpatients with specific clinical conditions. In response to employer demands, a growing number of commercial health plans have established pay-for-performance initiatives, covering 23% of the insured population in 2007. Reporting on pay-for-performance measures can be burdensome for hospitals, particularly since measures vary widely by payers, and can impact public image.[23]

## Hospitals "Not Paid for Preventable Complications"

In a further effort to improve quality, CMS is no longer paying hospitals for Medicare patients who develop any of eight preventable complications that hospitals may be expected to prevent through quality improvement and tracking systems. These "preventable complications" include objects left in patients after surgery, hospital-acquired urinary tract infections, central line associated bloodstream infections, administration of incompatible blood products, air embolism, patient falls, mediastinitis after cardiac surgery, and pressure ulcers. CMS may expand that list in 2009. Hospital advocates have pointed out that it is not necessarily possible for hospitals to eliminate all preventable complications. For some issues, accurate diagnosis is complicated and may result in false-positives. At the same time, the evidence conflicts on how well these conditions respond to prevention. As a result, full implementation may be premature.[24]

## Conclusion

Legislators and other policymakers will be continually challenged to balance the needs of hospitals for appropriate reimbursement and oversight with supporting their provision of important services to local communities.

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Insurance Reform

January 2009

# Issue Brief

## How Health Insurance Works in Maine and Looking to the Future

This issue brief reviews current health insurance coverage in Maine, how insurance is supposed to work (and why it oftentimes does not) and how can/should Maine position itself in light of expected health care reform at the national level.

Health care in Maine (and elsewhere) is very expensive. Insurance costs reflect the underlying costs of medical care (plus administration and profit or surplus, which are usually modest compared to the cost of care). Advanced technology; provider and consumer driven demand for services, i.e., utilization; malpractice expenses; the aging of the population; unhealthy lifestyles and other factors are major contributing factors that would still drive the high cost of health care even if Maine established a perfectly efficient and effective insurance program.

### Who has Health Insurance Coverage?[1]

When it comes to paying medical bills, nearly all Mainers fall into one of five categories:

- Employee-sponsored. For more than half of us (704,000), health insurance is provided through a place of work[2]. This coverage varies widely from employer to employer and often depends on the size of the company, whether it is unionized, pressures on the company's bottom line and competitive pressures to retain a workforce.
- Individual. About 5% of Maine's population (63,000) purchases a private health insurance plan directly. These individuals often pay the entire premium cost directly. In order to reduce these premium costs, individual policies are often characterized by a very significant front end deductible. Such plans are increasingly purchased through a Health Savings Account ("HSA") which permits individuals to deposit, invest and withdraw funds to pay cost sharing expenses under favorable, federal tax treatment.[3,4]
- Medicare. A federal insurance system for people over age 65 or disabled, coverage is provided to about 18% of Maine's population (243,000). Medicare premiums are collected through payroll taxes and payments by individuals covered by the program.
- Medicaid. More than one out of five Mainers (305,000) is covered by Medicaid, known as "MaineCare" in Maine. This program is generally available to low and lower income individuals and families. Medicaid is jointly funded by both the state and the federal governments; for every dollar that Maine pays for health care services, the federal government "matches" approximately two dollars.
- A subset of the Medicaid population (about 66,000) is also covered by Medicare. An example of a "dual eligible" would be someone with very low income who is over age 65 (Medicare eligible for hospital and physician services) and resides in a nursing home (covered by Medicaid). Dual eligible individuals are typically the most expensive population covered by the Medicaid program
- No coverage. Less than 9% of the population (119,000) is estimated to be uninsured and pays directly for health services. This population is the greatest source of

**Fast Facts**

- For more than half of us (704,000), health insurance is provided through a place of work.
- About 5% of Maine's population (63,000) purchase insurance directly.
- Over 18% of Maine's population (243,000) has Medicare coverage.
- About 23% of Maine's population (305,000) is covered by Medicaid.
- Less than 9% of the population (119,000) does not have any insurance and pay directly for health services.

Author: Gino Nalli, M.P.H.
Muskie School of Public Service
(207) 780-4237
gnalli@usm.maine.edu

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bad debt and charity care for health care providers. As a consequence of Medicaid expansion activities and the Dirigo Health Plan, this population has diminished by about 13,000 people since our 2007 Issues Brief.

## How Insurance is Supposed to Work, and Doesn't

The underlying principle behind insurance is simple: everyone pays a little in order to have funds on hand to pay the medical bills incurred by a few. This principle is dramatically illustrated by the fact that 80% of the costs of care for a large population of people will be incurred by about 20% of the individuals in that population. This principle is described as "pooling" risk for health care expenses and it works best when the risk is distributed across a large population.

This basic concept starts to break down when there is "fragmentation" in the risk pool. Fragmentation means that a population of individuals is divided in one or more subgroups and separate premium costs are calculated for these groups. To the extent that the underlying health risk (and likely costs) for these subgroups is different, the sharing of insurance risk across a large group has been undermined. And, premium costs will vary among subgroups.

There are many examples in Maine (and elsewhere) where fragmentation of the risk pool occurs. Employers that choose to self-insure their employees and dependents effectively fragment the commercial insurance pool.[5] The medical expenses associated with a self-insured group are not blended with other groups. Employers choose to self-insure for a number reasons. First, they believe (usually correctly) that the medical expenses of their employees and dependents will be less, on average, than the general population. Secondly, self-insurance provides greater flexibility for companies to design their medical benefit plans (see The Role of Regulation, below). To the extent that an employer adopts wellness, case management and other cost management programs, a self insured arrangement assures that any realized savings will accrue to the company and its workers. Finally and particularly for a company that has multi-state locations, a self insured plan simplifies administration.

Insurance companies also establish separate risk pools for different segments of the market, usually in response to regulatory requirements and competitive pressures. For example, small businesses may be grouped together with a premium rate that reflects the expected medical expenses of this market segment; a "community rate" is established. If the cost of insurance becomes disproportionately more expensive for certain small businesses, these businesses may leave the pool. A small employer with a relatively young and healthy workforce may discontinue coverage, providing additional cash compensation instead. The groups remaining are increasingly less healthy and their costs will increase even faster. This phenomenon is known as adverse selection and more likely to occur among insured individuals and small groups, two market segments which insurance companies are required to community rate. Among market segments that include mid and large employers, there is more stability in the group and virtually no migration due to health insurance costs.

Taken to its logical conclusion, adverse selection will result in a risk pool that contains only very sick people who pay exorbitant premiums. Many argue that adverse selection is happening in Maine today for individuals who purchase Anthem's individual policies and that this will lead to the eventual demise of this product.

One final word on fragmentation: Medicare and Medicaid represent subsets of the general population that have been segregated for purposes of providing health insurance. On one level, this fragmentation of the risk pool has had a positive impact on the cost of private health insurance. Medicare and Medicaid provide coverage to populations who are sicker and consequently more costly. These public programs effectively remove these populations from the general risk pool. However both programs reimburse providers at levels below what providers believe are adequate. In order to recover this shortfall, providers charge commercial insurance programs more than would otherwise be the case. This is referred to as "cost shifting" and is a separate consequence of fragmentation of the State's insurance pools.

## The Role of Regulation

Maine, like all states, regulates health insurance sold within its borders. This regulation does not extend to self-insured companies that are regulated by the Department of Labor and the federal Employee Retirement Income Security Act or ERISA. In Maine, the Bureau of Insurance, within the Department of Professional and Financial Regulation, regulates health insurance companies selling policies within the state. The chief regulatory authority is the Superintendent of Insurance.

There are two major components of Maine's regulatory activity. The first is to assure that a company will be able to pay claims to individuals for whom premiums have been collected, either directly or through an employer. Insurance is a form of promise. A premium is paid today in exchange for the promise that medical expenses, if incurred, will be paid at some future date. The regulators' job is to assure that the insurance company will be in business to fulfill this promise.

Secondly, the Bureau of Insurance is required to implement various legislative requirements. Many states, including Maine, have identified certain benefits and services that are required to be included in any medical insurance plan that is operating in the state. Examples of "mandated benefits" include a minimum number of chiropractic exams, certain annual preventive services and the like. In Maine, there are over 40 such mandated benefits. If a company is self-insured, it is not required to provide mandated benefits because federal ERISA laws preempt the state.

Another example of the Bureau's regulatory authority is around rules governing how insurance companies can provide coverage to individuals and small groups. For example, Maine

has a "guarantee issuance" law which requires an insurance company, if it provides individual coverage, to enroll anyone who applies, regardless of prior medical condition. Similarly, there are regulations around the price that can be charged to an individual. Someone who is at higher risk to be sick cannot be charged an excessively higher premium than someone who is at lower risk. These provisions represent attempts to assure available and affordable health insurance for individuals. According to the insurance industry, however, these provisions make it very difficult to insure individuals profitably and, consequently, only a few companies offer individual coverage in Maine.

A final example is the Bureau's authority around provider contracting by an insurance company. Rule 850 requires an insurance company to reimburse for services provided by a hospital or doctor in a patient's geographic location, regardless of whether the insurance company has established a mutually acceptable contract with the provider. The purpose of this rule was to assure consumers that they would not be required to travel unreasonable distances for health care, simply because an insurance company could, or would, not contract with a local provider. Self insured companies are not subject to Rule 850. Some self insured companies are increasingly exercising their exemption to negotiate preferred contracts with a select network of hospitals and physicians that are determined, by the company, to provide greater value, as measured by quality indicators and/or cost effectiveness.

## Strategies and Limitations on Fixing the Insurance System

There are two broad policy perspectives that underscore efforts to reduce these costs through Maine's insurance system.

The first advocates for a single, broad-based insurance program. This approach would eliminate the inefficiencies and disparities that exist in a fragmented insurance market. This approach advocates for a single risk pool that insures all persons at the same premium cost (i.e., "community rating"). It is important to note that a "single" payer system is not the same as nationalized health insurance. Doctors and hospitals would continue to be private enterprises and consumers would continue to access the doctor and hospital of their choice. A single payer system currently exists in the United States: Medicare provides coverage to all eligible elderly and disabled consumers through a single insurance pool. Medicare is administered through different insurance companies and consumers can almost always access the doctor or hospital of their choice.

While a single insurance pool may be appealing, it would be nearly impossible for a state to adopt this reform. The federal government's authority extends over Medicare, a large part of Medicaid, and self-insured groups through ERISA. While a state could require the pooling of all insured populations within its regulatory authority, a decline in one population's premium means an increase for another. For example, it has been suggested that Maine require small groups and individuals to be pooled together. This would likely result in a lower cost to individuals but a higher cost to small groups which might cause more small groups to discontinue their health insurance program or attempt to self-insure.

The second often touted approach is one of deregulating Maine's insurance markets. For example, it is estimated that Maine's mandated benefits contribute from 4 to 6 percent to the annual premium for groups of 20 or fewer employees and approximately 8 percent for groups of more than 20 employees[6]. Many of these mandates, such as mammography, have become standardized benefits among both insured and self-insured plans. These benefits are not likely to be removed from benefit plans and therefore savings opportunities may be less than expected.

While many states, including Maine, have initiated health reform, Massachusetts' recent effort has been particularly noteworthy in attempting to address underlying structural issues around insurance.

In early 2006, Massachusetts enacted legislation that explicitly required all citizens to have health insurance by July 1, 2007. A number of collateral steps were taken to implement this "individual mandate". Employers were required to offer health insurance or pay a modest penalty. A new infrastructure was established, the Health Insurance Connector, to arrange for the provision of "quality, affordable insurance products". In order to assure affordability, Massachusetts also provides state funded premium subsidies up to 300 percent of the federal poverty and expanded its Medicaid program to include children up to 300 percent of the federal poverty level. In an effort to provide greater underwriting stability and lower costs to the individual market, Massachusetts also required the merger of individual and small-group markets.

Not surprisingly, the individual mandate has led to significant, new enrollment. By August, 2008, in excess of 400,000 individuals had obtained health insurance coverage.

The policy shift that is embedded in the individual mandate cannot be understated. First, there is a clear affirmation of a market based approach to health reform. While government assures a minimum benefit levels and underwriting requirements, consumers select among alternative, private insurance plans. Secondly, while employers are encouraged to provide insurance, the responsibility clearly falls on the individual to secure coverage. Government's role is one of assuring that affordable options exist, through subsidies and/or required benefit levels.

The Massachusetts approach and its evolving results have been noticed by other states. California enacted a similar approach based on the individual mandate; implementation of which has succumbed to broader state budget limitations. Vermont's Catamount reform initiative references the imposition of an individual mandate in 2010 if coverage levels are less than 96 percent of the State's population.

The Massachusetts effort is clearly aimed at rebuilding and "de-fragmenting" the insurance pool. As noted above, there are however limits to what an individual state can accomplish.

Health reform has emerged as a principal policy initiative for the new federal administration. While few details exist, it is unlikely that a national health care system (similar to Britain) or even a single payer system will be adopted. Instead, early indications are that the many of the principles contained in the Massachusetts approach may be adopted by the Obama administration. These include:

- Maintaining the current employer based system, as well as Medicare and Medicaid.
- Identifying one or more options that will be available to individuals (outside of an employer based system) to access at an "affordable plan".
- Providing premium subsidies for lower income individuals.
- Mandating enrollment for at least some populations. Children have been initially defined but this mandate may be expanded to ultimately include all Americans.

## Implications for Maine

Presuming the evolution of a national health care initiative in the next few years, what can and should Maine do to best position its citizens?

Ironically, the Dirigo Health Plan may ideally position Maine to serve as a pilot for the Obama administration's reform initiative. If, as initially indicated, the federal program is grounded in the establishment of a "standard" plan that is available to individuals who do not or cannot qualify for an existing, current option, Dirigo could be re-engineered to serve as this option. In many ways, this evolution would be entirely consistent with Dirigo's original goal to serve as an affordable program for the uninsured and underinsured. As a pilot for the federal program, additional funding and support are likely to be available and help resolve Dirigo's perennial funding challenges which are largely due to premium and cost-sharing subsidies that were provided to low income Mainers.

In addition to maintaining the Dirigo program as a potential pilot to the federal program, policymakers can continue to identify and advance policies which:

- Promote the efficient and effective delivery of health care services. As noted in this brief, insurance costs are largely a function of the underlying cost of health care services. These costs can be positively impacted by:
  - Eliminating duplication and redundancy in service capacity. Maine's certificate of need (CON) and state health plan are two important instruments for meeting this objective.
  - Advancing patient centered medical homes. There is an evolving crisis in the availability of primary care services. Patient centered medical homes, which are grounded in primary care practices, offer to transform the financing and delivery of primary services in order to attract and retain these providers.
- Advance informational transparency that empowers consumers and providers. The Maine Quality Forum, an important agency created by the Dirigo legislation, is working with private organizations such as the Maine Health Management Coalition, Maine Health Information Center and others to identify and communicate quality and efficiency indicators that better inform value based purchasing of health care services.
- Educate Maine citizens as to their roles and responsibilities in advancing and maintaining good health practices that include but are not limited to tobacco and alcohol consumption, obesity and accident prevention. Rhode Island and New Hampshire have recently required health insurance companies to dramatically reduce premium costs for a small group product that explicitly requires consumers to comply with a set of good health practices.
- Advance a sustainable private insurance market in Maine. As already noted, federal reform is likely to be grounded in the current array of health insurance programs that meet established qualifying criteria. For Maine citizens, the opportunity to select a health plan from an array of current as well as hopefully new options will be welcomed.

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2. Includes individuals covered through the military or Veteran's Administration (approximately 17,000 persons in Maine). See Kaiser reference above.
3. Maine, unlike most states, does not parallel federal policy and provides no favorable tax treatment with regard to HSAs.
4. The Dirigo Health Plan provides coverage to individuals as well as employees in small groups (often times one person firms). Total enrollment is currently about 16,000. Premiums are established by an insurance company (with approval by state government) and collected from employers and individuals. For lower income individuals (who earn too much to be eligible for Medicaid), a subsidy is provided to help pay their share of the monthly premium. Dirigo provides a similar, income based subsidy to help eligible individuals pay the annual deductible expenses.
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Long-Term Care

January 2009

# Issue Brief

## Long-Term Care Policy

### Overview

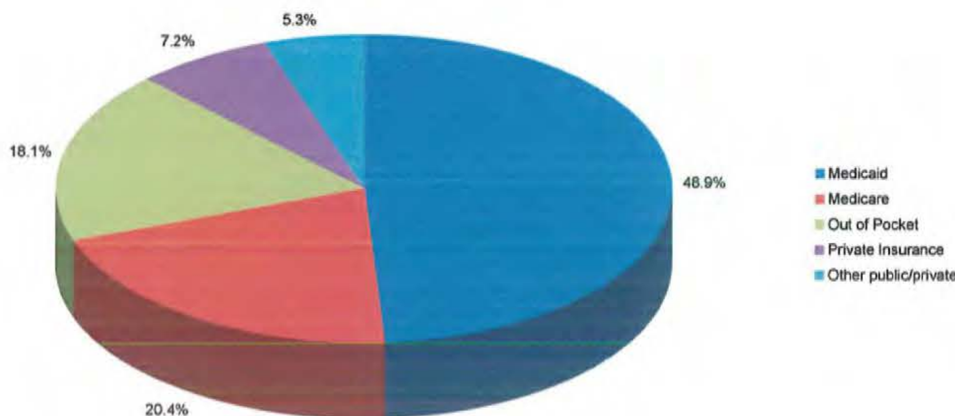
*What is long-term care?*

Long-term care begins at home and in the community and is about more than nursing home care. Long-term care services and supports include everything from round the clock nursing care or end-of-life care, to hands-on personal assistance with activities of daily living, to daily or intermittent assistance with routine household tasks such as meal preparation, transportation or medication management. Few Mainers have long-term care insurance and these supports are rarely paid for through other private insurance or Medicare and yet are critical to helping vulnerable individuals and their family members manage at home and live as independently as possible in the community.

*What are the major sources of funding for long-term care?*

Total long-term care expenditures are difficult to capture due to the multiple sources of payment and varying definitions. National data presented in Figure 1 offers a sense of the sources of funding for long-term care services. In 2005, approximately $206.6 billion was spent on long-term care, with nearly half (48.9%) of care paid for by Medicaid (referred to in Maine as MaineCare), roughly one-fifth paid each by Medicare (20.4) and privately (out-of-pocket = 18.1%) and the remaining 12.5% paid by private insurance and other public & private sources.[1]

**Figure 1: National Spending on Long-Term Care[2]**




**Fast Facts**

- Long-term care is more than nursing home care.
- Medicare does not pay for long-term care.
- Mainers of all income groups need long-term care.
- Reductions in home and community-based services lead to increased nursing home use and higher costs.
- Evidence-based practice gets the most from every dollar spent.
- The state and local communities must engage public and private interests in dialog as both create the leadership and practical solutions we need.

**Author:** Elise J. Bolda
Louise Olsen
Phyllis Bailey
Laura Lowenthal Bly
Muskie School of Public Service
eliseb@maine.edu
(207) 780-4847

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### *Who needs long-term care?*

Mainers in all income groups and of all ages may need long-term care due to limitations of the mind or body. People needing long-term care services and supports include adults with mental illness or physical disability, and older adults who are no longer able to manage independently, children with complex medical needs, and those born with a developmental disability such as mental retardation or cerebral palsy. The Maine Department of Health and Human Services is currently preparing a profile of children and adults with need for long-term services and supports.[3]

### *Why is the cost of long-term care growing?*

The number of Mainers using long-term care is growing rapidly as a consequence of increased longevity, and medical, pharmaceutical and technological advances. The majority of needs are met by unpaid family members and caregivers. The cost of care varies by setting and intensity of need and services. For example, privately paid care at a nursing facility costs well over $50,000 per year, care in private assisted-living facilities costs $30,000 or more a year, and privately hired in-home caregivers cost $10.00 to $25.00 per hour, or more for personal care, nursing and therapies. As a result of population changes and costs of care, demand for publicly subsidized long-term care is also growing rapidly, a trend that is nationally recognized.[4]

### *What is the issue?*

In light of the current economic downturn and a mounting state budget deficit the most immediate long-term care policy issue will be the challenge of assuring that the needs of Mainers are met. In the short run difficult funding choices must be made within and across programs to assure equitable distribution of public funds relative to other demands on state resources. And, as state and federal funding continues to shrink, a longer view is necessary to clarify Mainers' expectations, the state's role and statewide capacity to meet long-term care needs now and over the next 15-20 years.

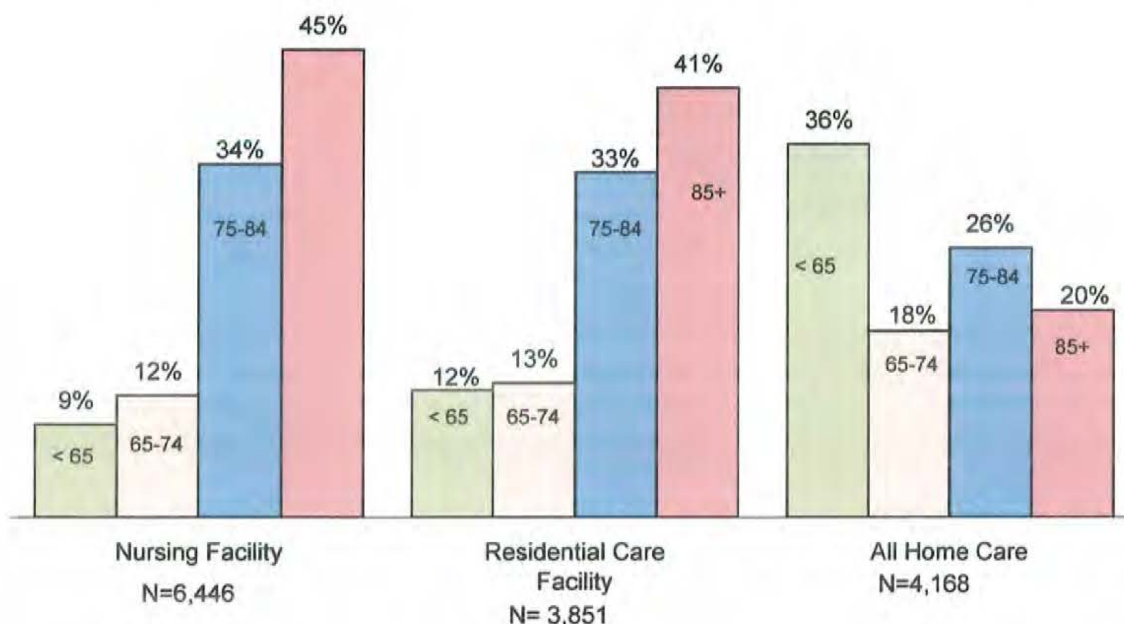
It is important to note that program budget cuts that may help balance the state's budget today can seriously undermine the ability of Mainers to remain in their current living arrangements. Further, reductions in long-term care services can quickly lead to higher costs. When needs are not met, health deteriorates and those with unmet needs seek assistance through higher cost care options like nursing facilities and hospitals, or in dire circumstances, shelters for the homeless. Like childhood immunizations, maintaining good care and evidence-based preventive services can reduce future demand for avoidable, expensive health services. The following sections provide a brief overview of Maine's current long-term care policy, needed improvements and options for the future.

## Long-Term Care in Maine

### *Where is long-term care provided?*

In Maine, funding for long-term care is primarily through MaineCare (Medicaid) and state-funded programs for those who are not MaineCare eligible. Table 1: Age Distribution of Maine Long-Term Care Users by Setting in SFY 2006, provides a summary view of older adults and adults with a physical disability using MaineCare and State-funded Home Based Care Services, by setting. An estimated 37% of those receiving publicly funded long-term care in Maine reside in nursing facilities, 37% live in licensed residential care facilities and 35% live at home and receive assistance through home and community-based services.[5] In addition to these recipients of services, publicly funded services are used by persons with mental illness, mental retardation, and other developmental disabilities who are not included in these data.

**Table 1: Age Distribution of Maine Long-term Care Users by Setting in SFY 2006**



### *Who is eligible for publicly funded long-term care in Maine?*

Eligibility for MaineCare and state funded long-term care varies by program. Aged, blind and disabled Mainers receiving a guaranteed minimum income through Social Security Supplemental Security Income (SSI) are automatically "categorically" eligible for MaineCare. And, those with very low incomes and few assets likely are "income eligible." Frequently, long-term care recipients' eligibility for MaineCare is under the "medically needy" eligibility category. Eligibility under this classification is determined using a complex formula including both financial and medical need. For example, a person eligible for MaineCare under "medically needy" criteria may become impoverished due to out-of-pocket payment for long-term care and other medical needs. Once savings are exhausted, an individual may be eligible for MaineCare subsidized services where the individual contributes most of their income to service costs and MaineCare pays the remainder. State-funded Home Based Care eligibility also considers financial and medical need. For many assisted through this program services are paid for on a cost-sharing basis where the individual's contribution varies according to the individual's income.

### *What is Maine's long-term care policy?*

Changes introduced in Maine 15 years ago positioned Maine as a leader in state long-term care policy reform. A series of policy reforms served to reduce Maine's dependence on nursing homes as the primary source for publicly funded long-term care. Among these reforms were: disincentives for private payers' use of nursing homes when needs could be met through home and community-based services; incentives for nursing facilities to convert excess supply to residential care; and introduction of more stringent medical need eligibility criteria for nursing home care. These changes also provided incentives for individuals who were paying privately for their care to seek other care arrangements. Specifically, these reforms encouraged people to avoid unnecessarily moving to more expensive nursing home settings when their needs could be met at home through community-based services or a less expensive non-medical care setting such as a licensed residential care or assisted living facility. These reforms were implemented through introduction of a pre-admission screening process that offered information on long-term care options to all Mainers and led to Maine's nationally recognized pioneering work in the development of a uniform assessment instrument used with older adults and adults with physical disabilities.

Maine's uniform assessment, referred to as the Medical Eligibility Determination (MED) assessment, determines eligibility for 14 long-term care programs using objective criteria that are assessed by an independent assessing agency. The MED also creates a rich data resource that permits Maine policymakers to make difficult choices in the allocation of public funds through a deliberate review of the impact of contemplated changes on actual clients' needs.[6]

### *What long-term care reforms are being discussed or recommended?*

Nationally, long-term care policy reform focuses on Medicaid reform. Since Medicaid is the 2nd largest item in most states' budgets, and roughly 40% of the Medicaid budget goes to long-term care, the challenges identified as national foci are also reflected in recommendations for Maine policy reform.[7] In 2007, the Kaiser Family Foundation issued their report on Long-Term Services and Supports: *The Future Role and Challenges for Medicaid*. Challenges facing Medicaid long-term care reform identified by Kaiser's national experts include:

1. Integrating services for people with long-term care needs – including integration with acute hospital care providers and housing, social services and other services beyond the traditional health care arena
2. Impact of varying disability criteria – criteria are not uniform and create potential for inequities across beneficiary groups
3. Means-testing the benefit – reconsidering financial eligibility criteria that require impoverishment
4. Balancing institutional and community-based care – waiting lists are a sign that access to home and community-based care is limited...rebalancing long-term care in favor of community settings...
5. Flexible benefit design – flexibility provides opportunity to individualize services..., but poses challenges in maintaining equity and assuring that needs are being met...
6. Maintaining and monitoring quality of care – identifying and remedying poor quality of care...standardized assessment of quality of care in Medicaid home and community-based settings...
7. Financing long-term care services and supports – ...greater coverage by private long-term care insurance and use of home equity programs such as reverse mortgages

Maine's Blue Ribbon Commission to Study the Future of Home-based and Community-based Care final report issued in November 2008 makes recommendations for long-term care services and support policies for 2 populations of long-term care users, older adults and adults with a physical disability. Highlights excerpted from Maine's Blue Ribbon Commission[8] 10 recommendations include:

1. ...new vision statement for a system of long-term care ... that optimizes the physical health, mental health, functional well-being and independence ... through high quality services and supports ... in settings that reflect the needs and choices of consumers and ...delivered in a manner that is flexible, innovative and cost-effective.
2. ...directs DHHS to provide ...a proposal for a unified budget (excluding the Office of MaineCare Services, MH and MR/DD services)...
3. ...state priority to reduce waiting lists for home and community-based care and homemaker services...

4. ...supports increase funding for the Priority Social Services program (services including Meals on Wheels, transportation and medical ride transportation)...to address the rising costs for these volunteers across the state...

5. ...supports funding ...Area Agencies on Aging...that wish to operate Aging and Disability Resource Centers (ADRCs) ...to work with hospitals, nursing facilities and residential care facilities to improve discharge planning... improving the provision of information to consumers ...

6. ...supports funding the family caregiver project...

7. ... recommends Department of Health and Human Services (DHHS) explore uses of and develop funding for assistive technology...

8. ...supports tax credit assisted living projects funded by MaineCare and directs DHHS to explore alternative non-Medicaid sources of funding...to ensure these programs survive.

9. ...directs DHHS ... to develop a comprehensive and systematic approach to reimbursement, health benefits and training for direct care workers in home and community-based services...

10. ...directs DHHS to report annually on its progress in reversing the spending trend to the joint standing committees with jurisdiction...

In addition to these recommendations, state policy makers anticipate federal policy changes that will require Maine to reconsider programs funded under MaineCare. Discussion of these potential changes in MaineCare "optional" Medicaid benefits and their impact on long-term care is beyond the scope of this brief.

Pursuing the recommendations listed above and other proposed legislation likely will perpetuate the already growing expectations on communities. Projections of population growth overlaid on current public programs and policies make it clear that more of the same is not a viable solution to meeting the growing demand for long-term care in Maine or elsewhere. During the past 15 years, Maine has developed a responsive home- and community-based services network, supported development of residential care options and Maine nursing facilities have continued to provide some of the highest quality of care in the country.[9] Through Maine Health's Partnership for Healthy Aging, Maine has also provided national leadership in the development and dissemination of evidence-based practice in falls prevention. Maine's Office of Elder Services has received grant support to develop and disseminate new ways of meeting needs through evidence-based practice initiatives in chronic disease self-management and the identification and treatment of older adults and caregivers with depression. These notable achievements offer evidence of Maine's resourcefulness in finding solutions and opportunities during difficult times.

*What are long-term care policy options for the future?*

Just as policy changes in 1995 began shifting Maine's policy from an over-reliance on nursing facilities to a more balanced system with home and community-based service and support options, policymakers are faced with a new series of critical choices to define state long-term care policy today and for the next 20 years. In the short run Maine must continue to refine existing state policy to assure the equitable allocation of public funds across various populations. At the same time, policymakers must begin to consider state long-term care policy in a broader context and in relation to other public and private stakeholders and other levels of government. In so doing, Maine can more clearly define the role of state government in long-term care policy.

In constructing future policy, it is critical to understand that changes in MaineCare/Medicaid and public funding alone will not meet future needs. The current systems that are delivering long-term care services and supports are built on a hodgepodge of federal funding streams that have developed over the past 45 years. With more than 75% of all long-term supports for older adults provided by family caregivers and neighbors it is time to take a step back and rethink long-term care with a view toward both public and private resources. We will have to find ways to address the needs of low income Mainers and to help middle-income Mainers meet their needs without impoverishing themselves and becoming dependent on MaineCare.

To continue shifting long-term care policy in Maine away from an overreliance on fragmented federal and state funded systems of supports, an essential next step is recognizing the key role played by families, neighbors and communities. As Mainers and their families find themselves in need of long-term care; their search for solutions begins in their communities. Policy in the future must engage public and private interests, build community capacity and open the dialogue for shared state and community responsibility for meeting needs in the long-term.

## Building Capacity to Meet Current and Future Long-Term Care Needs

One successful approach to developing this new perspective and potential for solutions which addresses current and future need is through the creation of community partnerships spanning both public and private arenas.[10] Such collaboration can identify priorities for improvement, devise strategies for change and align, leverage and maximize public and private resources at the local level. Community partnerships among older adults and other long-term care consumers, community residents, public, private and not-for profit providers, elected officials and other non-traditional partners provide a forum for community-level priority setting that can mobilize resources and develop new approaches to meeting needs.

*What are other states doing?*

Developing partnerships takes time and requires resources. New levels of trust and communication are necessary to mobilize community resources, leverage new resources and design and implement supports that really address the needs articu-

lated by the community. Such efforts also require political support and incentives for development.

In 2008, capacity building through community partnerships was identified as a promising practice in two states. The Virginia legislature voted support to the rural, 5-county Aging Together Partnership as a pilot program for their state. In New Hampshire, the Manchester-based SeniorsCount! Partnership model began replication through 2-year incentive matching grants offered through New Hampshire's federally funded long-term care transformation initiative. In both states, policy makers see the potential for community partnerships to convene diverse stakeholders, to leverage public and private resources and to inform state policy.

### *What steps can Maine take?*

Legislators face the challenge and opportunity to weigh state long-term care policy issues along side myriad other pressing issues competing for precious state resources. To foster the development of community partnerships where none exist, legislators can call upon local constituencies to meet and discuss the issues facing the legislature, develop shared leadership and identify and develop strategies to address local priorities for long-term care improvements. Currently, few communities are taking proactive steps to build or strengthen local partnerships. Beginning the dialogue is a first step that can encourage local leaders to work together to build community capacity.

Finally, to encourage new partnerships state policymakers can identify public and private matching funds to create incentives for community partnership development and state policymakers can support local partnerships' efforts to attract external funding.

## Conclusion

Long-term care policy is complex and can be viewed from many perspectives, that of the consumer, the provider or the tax-payer to name just a few. In the short run, managing Medicaid expenditures and assuring the equitable distribution of public funds for long-term care across all populations must be a priority. At the same time, efforts to advance evidence-based practices can help assure we get the most for each dollar spent. To prepare for the future, now is the time to create incentives for community leaders to share the responsibility and begin working as partners to leverage and align local resources to meet the need for long-term supports in their communities. Mainers hold their tradition of neighbor-helping-neighbor in high regard. And that tradition, along with thoughtful state policymaking and greater partnership between state and local leaders across the public and private sectors, will ensure that our safety net will be strong and the needs of vulnerable Mainers will be met. The one thing shared by all perspectives is a common understanding that we are all at risk for needing long-term care.

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Medicaid

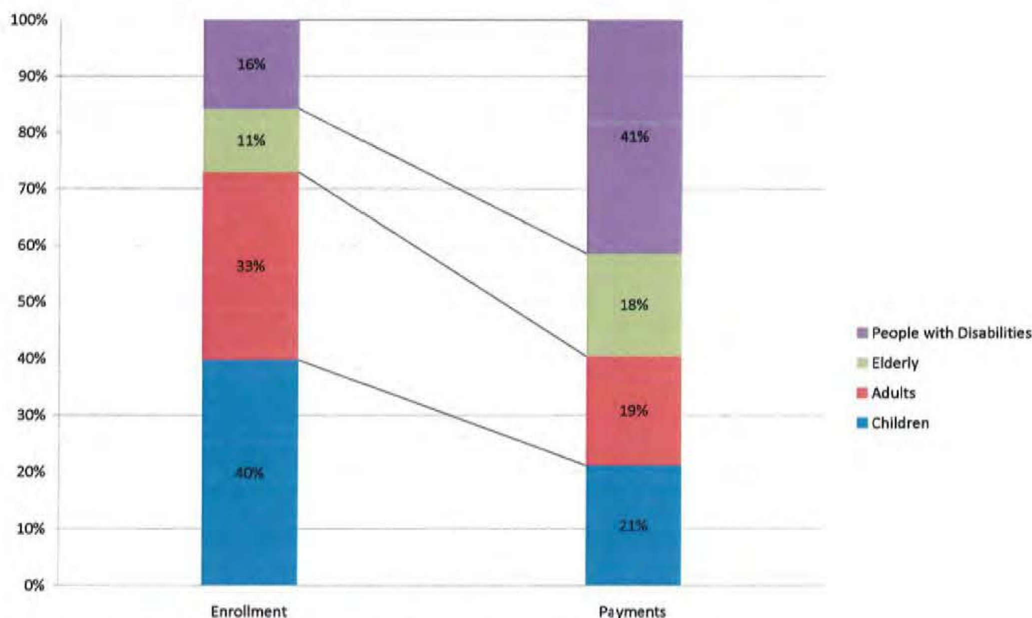
January 2009

# Issue Brief

## National and State Medicaid Issues in 2009

Maine's Medicaid program, called MaineCare, is an important part of the state's health care system. It provides coverage to 1 out of 5 Maine citizens. The largest group covered is poor children and their parents, though nearly two–thirds of the program's costs are attributed to a smaller number of people receiving long-term care and disability support services. In fact, Medicaid is the largest public payer of long term care and disability services, making it distinct from Medicare or other health care insurers.

**Figure 1: MaineCare Enrollment and Payments by Enrollment Group, FY 2004**




Source: Kaiser State Health Facts based on data from the Centers for Medicare and Medicaid Services.

Nationally and in Maine, the Medicaid program is a perennial issue for policy makers because it consumes such a large portion of the budget. In Maine, the state's share of MaineCare costs represents the state's second largest General Fund expenditure, after General Purpose Aid to Local Schools.

The current economic outlook has increased pressure on Medicaid programs and states across the country. The unemployment rate nationally is at its highest level in 15 years.[1] As unemployment rises and access to employer-sponsored health insurance and incomes decline, Medicaid enrollment increases. Medicaid officials across the country projected an average 3.6 percent increase in enrollment for FY 2009 due to the worsening economy.[2] At the same time, increases in unemployment and loss of income reduce state tax revenues, making it more difficult for states to pay for Medicaid

### Fast Facts

- MaineCare is the name of Maine's Medicaid program, which provides health care coverage to 1 out of every 5 Maine citizens.
- The State's share of MaineCare funding is the second largest General Fund expense, after support for local education.
- In 2008, the federal government paid just over 63% of MaineCare's $2.4 billion cost, or about $1.7 billion.
- Medicaid is the largest public payor of long term care and disability support services in the state and nationally.
- Nearly two–thirds of MaineCare's costs are attributed to long-term care and disability support services.


**Author:** Kimberley Fox, M.P.A.
Katie Rosingana
Paul Saucier, M.A.
Muskie School of Public Service
(207) 780-4950
kfox@usm.maine.edu



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spending increases. As of November 2008, at least 43 states have faced or are facing budget deficits for fiscal years 2009 and/or 2010. Maine's estimated shortfall for FY 2009 is $140 million.[3] The Governor's proposed supplemental budget closes Maine's budget gap with minimal changes to the MaineCare program,[4] but it is still likely to be a large part of upcoming legislative debates.

## Medicaid Overview

Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a means-tested federal entitlement program. MaineCare, like all Medicaid programs across the country, operates as a partnership between the state and federal governments. State participation is voluntary, but since 1982 every state has chosen to participate. States must adhere to federal regulations, but have some flexibility regarding eligibility, benefits and payments to providers. State flexibility in administering programs means no two Medicaid programs are exactly alike.

### *Financing mostly federal*

The federal government provides matching funds as an incentive for states to provide Medicaid coverage. The federal medical assistance percentage (FMAP) is the share of total Medicaid expenditures that the federal government pays and varies by state based on relative income. Because Maine's median income is below the national average, the federal government provides a relatively high matching rate for MaineCare services -- 64.4% for federal fiscal year 2009 (Oct 2008- Sept 2009).[5] This means that for every $100 of services purchased by MaineCare, the federal government pays about $64 and the state pays about $36. The federal government pays a flat 50% matching rate to all states for administrative costs. In SFY 2008, total MaineCare costs were around $2.4 billion. Of this, the state paid $607 million, and the federal government paid over $1.7 billion.[6]

### *Many eligibility categories*

In order to qualify for Medicaid, a person must have low income, expressed as a percentage of the Federal Poverty Level (FPL), and must fall into one of the groups that are "categorically eligible" as defined by the federal government. Federal law requires states to cover certain "mandatory" groups in order to receive any federal matching funds. These groups include low-income pregnant women and children, parents below state welfare eligibility levels, and most elderly and persons with disabilities with low incomes who receive Supplemental Security Income (SSI). States have some flexibility in extending eligibility for each categorical group beyond the required minimum income level as an "optional" group. As a result, Medicaid eligibility limits differ from state to state.

Because of the strong federal financial incentive, Maine and most other states have added services and population groups to the Medicaid program over time, especially those that were previously funded with 100% state dollars. Similarly, many state efforts to expand insurance coverage, including the large efforts currently underway in Massachusetts and Vermont, maximize Medicaid eligibility to bring as much federal funding to the effort as possible.

Adults without dependent children, no matter how poor they are, are categorically excluded from Medicaid unless they are disabled or pregnant. However, some states, including Maine, Massachusetts and Vermont, have received special federal permission to extend coverage to these individuals who are referred to variously as "non-categoricals" or "childless adults."[7] States are able to cap enrollment for these groups and due to pressures on the Maine state budget, enrollment in this program is currently closed.

### *Mandatory and optional benefits*

The benefits provided by Medicaid are also guided by federal minimum requirements and options. States must provide services in certain categories (called "mandatory"), and have the option to provide several additional benefits (called "optional") by including them in their State Medicaid Plans. Maine and every other state cover many optional services to maximize federal matching funds and to stay current with evolving health care delivery trends including prescription drugs and home health services, which are critical services for many MaineCare recipients today.[8] Generally, if a state offers a benefit, it has to offer the same set of services to all individuals covered in the state.

### *Service delivery options*

For traditional medical services, Medicaid generally relies on the same network of doctors, hospitals, home health agencies, rural health centers and other providers used by commercial insurers. Despite paying less than commercial rates for many services, the MaineCare program enjoys high participation among most types of providers. Medicaid also funds a large array of long term care and disability support service providers that are generally not covered by commercial health plans or Medicare, including long term nursing home stays, home care services, and personal assistance services.

Medicaid was originally modeled on the fee-for-service delivery system. Paralleling the trend in employer-based coverage, many state Medicaid programs have moved to various forms of managed care, particularly those with urban centers.

## How Much Flexibility Do States Have, and How Are They Using It?

For greater flexibility from minimum Medicaid requirements, states can seek an §1115 waiver. This mechanism can be used to waive most provisions of federal Medicaid law, but the overall proposal must be cost neutral to the federal government costing no more than it would have cost under the regular program. In other words, the state assumes the risk if actual expenses are higher than estimated. If the waiver program covers a small sub-population of beneficiaries, the state takes on a relatively small risk. But if all or most beneficiaries are included, as in some of the comprehensive reform proposals, a state needs to be confident it can really deliver the innovative approach within the available budget. §1115 waivers are

notoriously difficult to obtain from the federal government. There are no set time frames on the approval process, and they can take years to negotiate. However, if a state presents a well-prepared proposal that introduces innovation of interest to the federal government, approval can be relatively quick.

Several waivers approved by the Bush administration – including those in Vermont, Florida and most recently Rhode Island - significantly expand state flexibility under Medicaid and have drawn national attention. Florida's program relies on a market-based approach paying private managed care plans risk-adjusted premiums to serve Medicaid beneficiaries and allowing them some discretion in setting benefit packages. Beneficiaries are responsible for choosing plans that meet their needs. The program has been implemented in five counties and serves around 9 percent of Florida Medicaid enrollees. While too early to determine the program's impact on access and program costs, early findings suggest that it has not resulted in a large influx of commercial insurers to Medicaid or significant differences in benefit packages. Beneficiary enrollment has also been concentrated in a small number of plans and awareness of an enhanced plan designed to encourage healthy behaviors has been limited. Pending further study, the state has delayed expanding the program statewide.[9]

Vermont -- which like Maine has low population density and few health plans in their market -- established its Medicaid agency as a managed care organization, directly taking on the risks and potential rewards of managing beneficiary care within a capped global budget. Vermont's waiver has not yet been evaluated, but the state expects to stay within its negotiated cap even while expanding insurance coverage up to 200% FPL[10] through reduced administrative costs resulting from combining multiple waivers into one, a statewide health information exchange, improved purchasing, and chronic care management. Thus far, it has not proposed to modify benefits or eligibility even though the waiver gives them that option.

A highly controversial waiver recently approved in Rhode Island modifies the federal Medicaid matching structure to a fixed annual amount, while limiting the state's Medicaid contribution to a constant share of the state budget. Unlike typical 1115 waivers that operate under a per capita or per person cap that allows federal funding to grow with enrollment increases, Rhode Island's unprecedented program would move its Medicaid program under a block grant. The state also has the authority to establish waiting lists, eliminate optional services, or increase cost-sharing for certain eligibility groups.[11]

The future of these waivers under the new Obama administration is unknown. Both the General Accounting Office and Democratic members of Congress have raised concerns about these waivers regarding the extent of public input and whether the scope exceeds statutory authority.[12]

In 2005, new rules under the Deficit Reduction Act (DRA) also allowed states to vary benefits, premiums and cost-sharing requirements across beneficiary groups or geographical areas and to replace the traditional Medicaid benefit with new "benchmark" plans offered in the state.[13] DRA flexibility can be gained by amending the State Medicaid Plan, a process that requires formal review by the federal government but is considered much less cumbersome than seeking waivers of existing law. However, few states have taken advantage of the new rules. In 2009, only 8 states were using the DRA authority related to benefit changes.[14]

## Current Issues in Maine

As in all the other states, the immediate challenge for Maine in 2009 will be how to maintain or retool MaineCare in the current fiscal environment. The options for cost containment in the traditional Medicaid program are limited, and each option creates other problems for the system. Basically, in order to contain costs, policy makers can reduce the number of eligible people, reduce benefits, reduce rates or manage utilization of services. The first two options contribute to the number of uninsured and under-insured people in the state, and the third results in cost shifting to commercial payers. The last option, managing use of services, has potential to control costs and improve quality and coordination of services. The following are some MaineCare issues likely to be discussed:

### *Federal fiscal and administrative rule relief under new administration*

As states confront large budget deficits, many state policymakers are looking to the new Obama administration for federal relief. Several Congressional proposals would temporarily increase the Medicaid FMAP to help states avoid having to cut critical health services as was done during the last economic downturn.[15] President-elect Obama has indicated some federal Medicaid assistance would be made available and his stimulus package may include as much as $100 billion to subsidize the state Medicaid programs.[16] With an FMAP temporary increase, Maine could see as much as additional $228 million in federal support for Medicaid over the next two years.[17]

In addition to fiscal relief, states are seeking relief from regulatory rules and directives promulgated by the Bush administration. In 2007, unable to get Congressional support for Medicaid budget cuts, DHHS issued a series of regulations designed to limit federal Medicaid spending through administrative action. The rules limit the amount of Medicaid reimbursements for rehabilitative services, intergovernmental transfers, graduate medical education, targeted case management services, school based administrative and transportation services, as well as payment to public safety-net institutions and coverage of hospital clinical services. Together these rule changes could shift $15 to $50 billion in federal Medicaid spending over to the states in the next five years.[18] While Congress passed a moratorium on most of these regulations until April 1, 2009, it is unclear which of these rules will remain in place under the new administration.

A related issue that could impact Medicaid (and discussed in more detail in a separate brief on Children's Health) is federal action on the reauthorization of the State Children's Health Insurance Program (SCHIP). SCHIP is a block grant program designed to provide health insurance to low-income children and their families who are above the income limits in state

Medicaid programs. Medicaid and SCHIP are closely linked. In implementing SCHIP, states were allowed to either expand Medicaid and/or create a new state SCHIP program.[19] Maine did both, creating what is known as a "combined" SCHIP program – with some children covered under a Medicaid expansion and others covered under a separate SCHIP program called CubCare. The federal match rate for services funded through SCHIP is higher than in Medicaid. In FY 2009 Maine received an enhanced SCHIP match of 75% for every dollar spent on services, compared to the regular Medicaid federal match of 64.4%.[20] Children in both CubCare and Maine's Medicaid expansion are eligible for this enhanced rate.

In 2007, SCHIP was up for renewal, but attempts to reauthorize the program by Congress were vetoed by the President. A compromise measure temporarily funded the program through February 2009. Without legislative action before March 2009, Maine along with all states would lose the states' FY 2008 and FY 2009 federal allotments and funds for eliminating FY 2009 shortfalls of approximately $1.8 billion in 28 states- including Maine. The impact could be mitigated by the ability to access Medicaid funding, but it would be at a reduced matching rate compared with SCHIP.[21]

Other federal actions that could assist states include increasing rebates that pharmaceutical companies are required to offer state Medicaid programs and greater support to build and enhance Health Information Technology (HIT) infrastructure.

### *Could more savings be achieved through greater managed care?*

Depending on the type of managed care and the market in which it is implemented, managed care can produce modest savings, with many states reporting 5 to 10% savings over fee-for-service. However, many Medicaid directors argue that the real benefit is in better coordination of care and the potential to place a greater focus on quality improvement, and that cost savings should not be the primary goal. Following an unsuccessful effort with risk-based managed care in the 1990s, MaineCare focused on primary care case management models, which are generally thought to be more viable than risk-based models in rural areas, because they do not depend on having a large commercial managed care infrastructure in the market.

MaineCare has also contracted with APS Healthcare to pilot a risk-based model for managing behavioral health care services for MaineCare members with mental health or substance abuse diagnoses. This intervention is still being evaluated to assess cost savings.

### *Should MaineCare providers be paid more and how can provider payment be tied to quality?*

Whether MaineCare pays providers sufficiently is a perennial debate, and the answer depends in part on what one considers the appropriate base of comparison. MaineCare rates are generally lower than those paid by commercial insurers and Medicare. However, MaineCare rates are similar to those paid by Medicaid programs in the other New England States, with the exception of physician fees which are lower.[23] Maine has attempted to address this issue by raising provider reimbursement in the last two years.[24] In addition, as part of the state's PCCM program, MaineCare does offer a payment enhancement to providers that offer care management ($3.50 per member per month they are managed) and Maine's Physician Incentive Program ties 30 percent of a performance bonus to emergency department utilization measures. Following Medicare's lead, other states are also using negative payment incentives (i.e. not paying for medical errors or 'never events') to address quality. The degree to which MaineCare should pay rates even closer to those paid by commercial payors is likely to continue to be debated. Doing so would result in very large aggregate cost increases in a program already under fiscal stress, but would theoretically reduce the amount of cost shifting in the system.

### *How can MaineCare improve the quality of care for persons with chronic health conditions?*

To better manage the chronic care needs of the program's highest cost beneficiaries, which includes 10% of adults and 5% of children, MaineCare has contracted with Schaller Anderson, a national care management company. An initial pilot of 300 members demonstrated some positive results in reducing inpatient and emergency room use. The program is currently serving approximately 3,000 of the estimated 17,000 highest cost users.[25] Continued evaluation of this intervention is needed to determine its efficacy.

Another approach for managing chronic care through enhancing primary care delivery that may hold promise is the patient-centered medical home model (PCMH). The PCMH is a model for delivering comprehensive primary care through coordinated, care which is supported by an alternative payment model that recognizes the additional investment required by practices. Studies have shown that practices modeled on the principles of a medical home in other states are associated with better patient outcomes, reduced costs and reduced disparities. The MaineCare program in collaboration with the Maine Quality Forum, Quality Counts, the Maine Health Management Coalition, and Anthem Blue Cross Blue Shield have begun designing a PCMH pilot in 10-20 primary care practices in Maine over a 3 year period. In addition to including key components of a medical home defined by national provider associations,[26] the pilot adds Maine-specific principles of using a team-based approach and promoting physical-behavioral health integration.[27]

### *What can Maine do to address long term care and disability costs?*

Maine has also recognized the need to reform its long term care system. The final report of the Blue Ribbon Commission to Study the Future of Home-based and Community-based Care recommends that the State adopt a vision of long-term care services and supports in settings that optimize health and independence, and reverses the spending trend from residential and nursing facility care toward home and community-based care. It also recommends a uniform budget for institutional and home and community-based services to facilitate coordinated planning. If implemented, these changes, combined with new opportunities available to expand home and community-based services and to offer evidence-based programs in the community, may help to improve quality of care and reduce costs in the future.

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13. For a more extensive summary of Medicaid flexibility authorized in the DRA, see Wilson, 2006, *Deficit Reduction Act of 2005: Summary of Medicaid/Medicare/ Health Provisions*.

14. Smith et al, 2008. In addition, 5 states were using or planning to use DRA authority to make at least some copays enforceable, 2 states were using DRA authority to extend nominal copayment requirements and 2 states used DRA authority to eliminate copayment requirements.

15. For the last two quarters of 2003 and the first three quarters of 2004, Congress passed a 2.95% increase in FMAP rates.

16. NY Times, Obama Team Is Seeking Stimulus Bill by New Year, December 19, 2008,

17. Rebecca Brown et al, *ibid*. Dollar estimates in the Families USA report are from a Center on Budget and Policy Priorities analysis of S.3689, introduced by Senators Reid and Byrd.

18. CMS estimated the regulations would cost states $15 billion over the next five years, while a state-by-state analysis conducted for the U.S. House of Representatives estimated it would cost states $49.7 billion. US House of Representatives, Committee on Oversight and Government Reform,The Administration's Medicaid Regulations: State-by-State Impacts, March 2008.

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Medical Transportation

January 2009

# Issue Brief

## Maine's Twin Challenges: Transportation for Health Care

The challenge of providing high quality, accessible health care to Maine's aging and rural population has been evident and slowly mounting for twenty or more years. More recent energy and transportation cost volatility has compounded this challenge and complicated policy making and health service delivery. Despite these challenges, Maine has maintained its commitment to providing high quality, effective transportation for health care services and has improved its infrastructure for doing so via private, public, and cooperative initiatives.

As Maine's population grows older, communities across the state will confront issues not only of how to provide medical transportation services, but also of how to preserve Maine's quality of life in rural communities, towns, and cities. The recent spike in gas prices signals that planning and coordination are essential if Maine is going to effectively meet the transportation and health care challenges throughout the United States.

### Medical Services and Transportation: How Maine Stacks Up

Medical service provision and transportation services are necessarily intertwined and thus policymakers should understand that efforts to address one issue are likely to directly or indirectly affect a second issue. Progress in one area of health care or health service delivery could create new demands on a second related area . For example, Maine has made substantial progress on lowering its annual rate of hospital inpatient days. In 1999, Maine recorded 696 hospital inpatient days per 1000 Maine residents, and by 2006 this rate had dropped by 7% to 648 inpatient days per year. However, this lower rate of hospitalization, while cost-effective and likely preferred by many Mainers, also implies that more Mainers will need more frequent use of medical transportation services as health care providers shift services from in-patient to out-patient settings. This latter challenge is in one sense welcome, it's generally good not to have to be in the hospital, but it also increases the needs for coordinated support services at a time when many Maine community agencies have experienced service decreases because of funding reductions, cost increases, or loss of volunteer services.

Relative to the rest of the United States, Maine citizens are older and have correspondingly higher rates of chronic or limiting conditions that imply greater need for health transportation services. As table 1 indicates, Mainers have relatively high rates of death from Alzheimer's Disease and from cancer – both of which are conditions that often involved prolonged health services preceding death. These relative high rates of cancer and Al-

Table 1:Maine Disease and Death Rates

| | Maine | USA |
|---|---|---|
| Number of Deaths Due to Alzheimers per 100,000 population, 2004 | 32 | 22 |
| Number of Cancer Deaths per 100,000 population, 2005 | 205 | 184 |
| Invasive Cancer Rate per 100,000 population, 2004 | 526 | 458 |

Sources: US Cancer Statistics Working Group, United States Cancer Statistics, 1999-2004. Atlanta, GA: Centers for Disease Control and Prevention. National Center for Health Statistics, Division of Vital Statistics, National Vital Statistics Report Volume 55, Number 19, August 21, 2007. Table 29.

**Fast Facts**

- Maine has 2 ½ times more seniors (as a percentage of all seniors) living in rural areas as other states. Distances travelled for medical appointments range from 15 to 40 miles.
- Maine has relatively high rates of some chronic conditions such as Alzheimer's Disease and cancer. Patients with these conditions often need transportation assistance for health services.
- In a recent survey, a majority of Maine seniors responded that they could not pay more than $5 to $10 for transportation assistance for medical appointments.
- Volatile energy prices have decreased volunteer services upon which community agencies rely to provide transportation assistance.

**Author:** Glenn Beamer, Ph.D.
Margaret Chase Smith Policy Center
University of Maine
glenn.beamer@umit.maine.edu

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zheimer's disease are indicators of the demands for home health and medical transportation services that many Mainers, especially older Mainers, are likely to need and may need with increasing frequency. In terms of health services utilization, Maine citizens rely on outpatient services disproportionately. In 2006, Maine's rate of hospital outpatient visits per 1,000 persons was 3,198 compared to a national rate of 2,007 per 1,000 persons (American Hospital Association, 2008). Maine's rate is 50% higher than the national average, and thus Maine faces a larger challenge in providing medical transportation than other states. Maine's forty-one rural health clinics are facilitating health delivery to hundreds of thousands of Maine residents, but can only continue to do so if adequate support services are in place.

A 2005 survey of senior Mainers from 19 health services offices and clinics in Maine reflected the types of services people sought. Among sixty-seven survey respondents: 8 received diabetes care, 13 received cancer care, 12 received dialysis, 14 received physical therapy, and 17 received cardiac rehabilitation services. Only a small number of respondents, three, were visiting the clinic or office for a routine office visit. All of these services are very likely to involve repeated and routine visits to health care providers. These survey respondents reported relatively long travel distances to attain services. Persons from Washington County reported traveling an average of 27 miles for health services, Penobscot County residents reported traveling an average of 18 miles, and Hancock County residents reported an average travel distance of 10 miles (Kaye, 2005).

In terms of transportation modes that senior Mainers relied on for their health care visits, respondents remained most likely to drive themselves. Among Washington County residents, 52% drove themselves to their appointments. This figure was 33% for Hancock County residents, and 18% for Penobscot County residents. 22% of Hancock County residents and 25% of Penobscot resident relied on a spouse to bring them to their appointment, while approximately 16% of residents from all three counties relied on family members other than a spouse for transportation. 9% of respondents relied on volunteer drivers and an equal number took a bus. Less than 5% of respondents used a taxi and none relied upon a religious organization for transportation. 50-60% of respondents from all three counties indicated that they needed transportation assistance on a weekly or monthly basis for routine medical visits, for chronic care appointments, and for filling prescriptions. Only 21% of respondents reported that they were willing or able to pay more than five dollars for a one-way ride to a medical appointment (Kaye, 2005).

Maine's relatively senior population and its rural character recommend that policymakers plan now for changes that are in the offing. Among all American's over age 65, 21% do not drive. Half of the seven million seniors who do not drive report that they are likely to stay home because of a lack of transportation options. Among non-drivers in rural areas, 61% report staying at home because of a lack of options (Bailey, 2004). Among the fifty states, Maine ranks second in the proportion of resident age 65 and over who live in rural areas. Just less than 56% of senior Mainers reside in rural areas compared to 21.7% nationally. Among these rural Maine residents, nearly one-third live alone and thus are more likely to need transportation assistance from a relative, friend, or community agency when ill.

For a variety of reasons, it makes sense for policymakers to consider options other than encouraging the elderly to drive. Drivers over age 85 have a traffic fatality rate that is nine times as high as other adult drivers when the number of miles driven is controlled for. Driver fatality rates decline with age until drivers reach age 65. A 2002 National Institute on Aging study found that the average American will stop driving some time after age 70 and then spend approximately six to ten years being dependent upon others for transportation. This dependence coincides with increased needs for medical services. The need to provide transportation services goes beyond Mainers' needs for direct medical services. Public health research has demonstrated that geographic and physical isolation contributes to a number of health problems including obesity and depression, and Mainers living in rural areas are 40% more likely to smoke than those living in towns and cities.

## Building a Medical Transportation Infrastructure

Volatility in gasoline prices during the last four years has led to sporadic and in some cases permanent decreases in medical and health services transportation assistance. An in-depth study of community action services following the gasoline price increases in 2005, after Hurricane Katrina, revealed substantial losses from volunteer service. Penquis CAP's Lynx program experienced a 30% reduction in volunteer hours, the Washington-Hancock Community Agency (WHCA) estimated that it lost approximately 60% of its volunteer effort for transportation services, and Waldo Community Action Partners lost 15 of its 25 volunteer drivers. Although private sector efforts remain critical to helping Maine residents access medical services, increased gasoline and home heating fuel prices directly affect the ability of Mainers to volunteer these services.

One area in which Maine has substantially expanded its medical transportation infrastructure has been through the Lifeflight program, which provides emergency helicopter transportation to critically injured and ill individuals. 85% of individuals served are taken to Maine hospitals. Lifeflight has been recognized as among the leading providers of emergency medical transportation and emergency medical services. In 2007, Lifeflight received the National Excellence in Community Service Award. In 2008, the national Association of Air Medical Services presented its Program of the Year Award to LifeFlight of Maine recognizing it as the medical transport program that had demonstrated superior patient care, management prowess, customer service, safety, and community service. Lifeflight provided service to 1400 patients in 2008 and has provided its services to over 8500 Mainers since its inception (LifeFlight, 2008). Its coordinated design of heliports, weather observation, and emergency health delivery may provide a basis for better coordinating other parts of Maine's medical transportation efforts.

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Mental/Behavioral

January 2009

# Issue Brief

## Mental Health and Substance Abuse in Maine: Building a Community-Based System

### Overview

One in five persons experiences a diagnosable mental illness in a given year.[1] Half of all persons will experience a diagnosable mental illness during their lifetime.[2] Mental illness strikes people of all ages, gender, race, and income affecting their well-being, health, and productivity. The World Health Organization has found that mental illness imposes the second highest burden (including direct care, family impact, and lost productivity) of any disease – behind only cardiovascular disease and ahead of cancer.[3]

Policy makers are confronted with a variety of issues as to how to help persons with mental illness. This may come before you in several very demanding ways, including:

- The state's responsibility to provide care for persons with severe mental illness who may be a danger to themselves or to others. This requires deciding how to deliver and how to fund appropriate services to these persons. Historically, treatment had been primarily provided in state psychiatric institutions, such as the Riverview Psychiatric Center. Thanks to improved treatment and knowledge, these persons can now be treated, and fare much better, in the community.
- The increasing share of Maine's MaineCare Program expenditures spent on mental health care. From 1996 through 2004, mental health expenditures increased more sharply than other health care areas within MaineCare. Many states have experienced similar dramatic increases in Medicaid mental health expenditures. How does Maine meet its commitment to provide mental health services, while at the same time providing other health care services, under MaineCare and also meet other non-health care obligations with state revenues?
- The demand that persons with mental health problems and illness place on non-specialty mental health systems, services, and venues. Persons with emerging, undiagnosed, or untreated mental illness are found needing or seeking care in many diverse settings including schools, emergency rooms, prisons and jails, and child welfare and social services. The gap between needed and available mental health resources and services results in on-going pressure on these non-specialty mental health systems. It is estimated that half the prisoners in county jails have a mental illness.[4]
- Requests from constituents about where to turn to, or what to do, when they, or a family member, need help for a mental health problem. Mental health systems in all states are fragmented and incomplete especially for children's mental health.[5] In Maine, as in the rest of the country, there is usually not an obvious place to go for parents concerned about their child's behavior and mental health.

The medical and scientific understanding of mental illness is steadily increasing, as are effective ways to address and treat it. Yet, there still remains much misunderstanding, fear, and stigma about mental illness. This issue brief tries to provide a way to understand the scope of the problem, Maine's responsibilities in addressing it, and to suggest ways to think about mental health and resources you may use in working to meet these responsibilities.

**Fast Facts**

- One in five persons experiences a diagnosable mental illness in a given year. Half of all persons will experience a diagnosable mental illness during their lifetime.
- The World Health Organization has found that mental illness imposes the second highest burden of any disease – behind only cardiovascular disease and ahead of cancer.
- By their senior year in high school, 20% of Maine students will have misused prescription drugs, 9% within the previous 30 days. Nearly three quarters of students will have tried alcohol, half within the past 30 days.
- In Maine, and nationally, there are not enough mental health specialists to provide the care that is needed. The Maine Health Access Foundation is sponsoring long-term initiative to promote integration of physical and behavioral health in Maine.

**Author:** David Lambert, Ph.D.
John Gale, M.S
Muskie School of Public Service
davidl@usm.maine.edu
(207) 780-5402

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## Prevalence of Mental Illness

The overall prevalence of mental illness is generally consistent across states and over time.

### *Children*

One in five children (20%) experiences a diagnosable mental illness in a given year. A smaller group of children, 4-7%, have conditions severe enough to qualify for public funded services through state block grants, family income supplements from the Social Security Administration, or other public support funds.[6] These children meet the Federal definition for having a serious emotional disturbance. Estimates of this group are important because they suggest the relative magnitude of responsibility that a state has to provide access to treatment to children.

### *Adults*

One in five adults experiences a diagnosable mental illness in a given year. It is estimated that 3% of adults have psychiatric conditions severe enough to be classified as a disability that qualifies a person for publicly funded mental health services. Such conditions include schizophrenia, bipolar disorder dementia, or a mood disorder so severe that it requires hospitalization or major psychotropic medications. These adults meet the Federal definition of having a serious and persistent mental illness and are entitled to access to treatment, usually covered by a state's Medicaid program.[7] This group roughly corresponds to those persons a state is responsible for protecting from themselves or others. Another 18% of the adult population, age 18-54, experiences mental illness in a year. Adult Medicaid beneficiaries tend to have higher rates of mental illness than non-Medicaid adults. (Research suggests that these higher rates are associated with poverty, low-income and low or unemployment.) This explains, in part, why growth in adult enrollment in MaineCare has been accompanied by increased spending on mental health.

### *Older Adults*

Mental illness is slightly less prevalent for older adults than it is for children and adults. Mental illness among older adults, however, is more likely to be undiagnosed and go untreated, even when diagnosed, than among younger persons. This is unfortunate in that mental health treatment, particularly for depression, is often more effective in older adults than in younger persons. It can also improve the effectiveness of treatment for chronic physical health conditions, such as cardiovascular disease and diabetes that are often co-morbid with depression and anxiety disorders among older persons. Cognitive disorders are relatively common among older persons and can mask, or complicate treatment of, other mental health and physical health problems. In Maine, as in other states, it is often difficult to access treatment for geriatric mental health problems either in community-based or long-term care settings.

### *Co-Morbidity*

Mental illness often co-occurs with other health problems and illnesses. Mental illness and substance abuse often co-occur (and are commonly referred to as "dual diagnosis" or "co-occurring disorders"). Half of all persons with a severe and persistent mental illness abuse substances.[8] Substance abuse is also relatively common among persons with less severe forms of mental illness, including adolescents and young adults. Among all types of mental illness and age groups, the presence of substance abuse compounds the problem and makes effective treatment more difficult. Over the past ten years, Maine has been among the leaders nationally in attempting to address the problem of co-occurring disorders. Depression and anxiety disorders are relatively more common among persons with chronic health problems, including cardiovascular disease, diabetes, and cancer. This is significant in that these chronic health problems increase with age and Maine has an aging population.

### *Substance Abuse*

Substance abuse is an addictive disorder involving chemical dependency that may either be independent of, or co-occur with, mental health disorders. Drug deaths in Maine have continued to rise over the decade, increasing over 400% from 34 in 1997 to 176 in 2005.[9] Most of this increase is related to misuse and diversion of pharmaceuticals, particularly narcotics and tranquilizers. Abuse of heroin, cocaine and methamphetamine have all risen during the same time period resulting in substantial use of public dollars to protect the safety and health of Maine citizens. Alcohol abuse, however, continues to claim the lion share of public dollars, accounting for about 75% of the direct and indirect costs of substance abuse in Maine.

By their senior year in high school, 20% of students will have misused prescription drugs, 9% within the previous 30 days. Nearly three quarters of students (74%) will have tried alcohol, 49% within the past 30 days. It is important to note that the use of prescription drugs and alcohol among youth has declined since 2000.[10]

## Maine's Mental Health System

Although the term "mental health system" is commonly used, it is a bit misleading. Mental health systems in all states are generally under-resourced and provide fragmented services.[11] It is useful to distinguish the different sectors in which persons may receive mental health care: Specialty Mental Health, General Medical Primary Care, Human Services, and Voluntary Support Networks.

Anchoring Maine's specialty mental health system is made up of six community mental health centers; two state psychiatric institutions, the Riverview Psychiatric Center in Augusta and the Dorothea Dix Psychiatric Center in Bangor; two non-profit psychiatric hospitals, Spring Harbor Hospital in South Portland) and Acadia Hospital in Bangor; eight inpatient units in community based hospitals, and a number of smaller community based specialty agencies and practitioners. Over the last forty years, there has been a major move away from caring for persons with severe and persistent mental illness in inpatient psychiatric facilities and caring for them in the community. This is consistent with what we know allows people to live fulfilling, healthier lives and the availability of treatments, medications, and peer-supports to make this a reality. However, coordinating and funding these services is an ongoing-challenge which Maine has wrestled with under the AMHI Consent Decree.[12]

In Maine, and nationally, there are not enough mental health specialists to provide all the care that is needed. As a consequence, more people receive mental health care from providers who are not mental health practioners than those who are. In 1978, a NIMH psychiatrist dubbed the general health care sector, the "De Facto Mental Health System". In the 30 years since, the role of the general health care system in providing mental health care has continued to grow. How to best "integrate" primary care and mental health has emerged as a very important policy and clinical consideration nationally and in Maine.

The Maine Health Access Foundation (MeHAF) is currently sponsoring a major, long-term initiative to promote the integration of physical and behavioral health services in Maine. MeHAF's Integration Initiative will fund 40 grantee programs over the next five years. The Muskie School has recently completed a study – *Barriers to Integration in Maine*, funded by MeHAF.[13] This study identified and discussed a number of barriers to integration prominent in the national literature, including:

- National and system-level barriers (limited supply of mental health specialists, misdistribution of specialists relative to need, separate funding streams);
- Regulatory barriers (licensure laws, scope of practice);
- Reimbursement barriers,
- Practice and culture barriers (different practice styles, culture, language and administration) and
- Patient-level barriers (poor access; limited insurance coverage and reimbursement; stigma).

The study found that within Maine, facility licensure issues are complex and impact the ability to integrate across settings. The study also found that reimbursement barriers were a much more significant problem to integration than scope of practice issues and that potential changes in reimbursement and facility licensing have political and budgetary implications that must be taken into account.

Substantial mental health and substance care is provided in child welfare and social service agencies, as well as the criminal justice system. In a perfect world, this care would be better coordinated with mental health and substance abuse systems. Maine has been among the leaders nationally in examining how to better assess and address substance abuse within child protective cases. Consumer-run and self-help groups (sector) have been very effective in Maine helping persons with severe mental illness remain and do well in the community.

### *How is Maine's mental health system doing?*

State public mental health systems are usually in the news when there is a problem and things are not going well. The National Alliance for the Mentally Ill (NAMI)'s 2006 Report, Grading the States": A Report on America's Health Care System for Serious Mental Illness" provides an outside perspective on how Maine is doing.[14] The NAMI study gave Maine an overall grade of B-. While this may not seem like a positive assessment, Maine was one of only five states to receive a B: all other states received a grade of C or lower (19 states received a D and eight states received an F). Maine received an A for its recovery supports; a B for its services; a C- for its information access. The Report praised Maine for its mental health parity law and its progress in improving conditions in county jails. The Report urged Maine to (1) reduce its long waitlists for community services; (2) relieve crowding in emergency rooms; and (3) improve access to crisis and inpatient beds. NAMI is in the process of updating its Report Card Study and "new grades" and analysis are due out shortly and can be reviewed by visiting: http://www.nami.org/.

### *Managed care initiative.*

In December 2007, Maine implemented an Administrative Service Organization (APS Maine) to better manage the state's mental health care and resources. Maine is one of over twenty states that have turned to such an arrangement to help improve the efficiency and effectiveness of the behavioral health services provided to persons enrolled in the state's Medicaid program. APS Maine manages services on a fixed fee basis, including prior authorization, utilization management, quality management, and provider and member services. APS Maine does not assume medical or financial risk for the members it manages, which distinguishes it from other forms of managed care such as managed behavioral health organizations (MBHOs). An MBHO includes administrative functions similar to an ASO, but also manages services on a capitated fee basis and assumes medical and financial risk. The literature has shown that capitation may lead to more efficient (less costly) use of services, but also may adversely affect access to and quality of services. Since ASOs offer states a less costly, easier to administer form of managed care, it appears to have been a reasonable approach for Maine to have adopted. Key issues for policymakers include whether there are sufficient standards and oversight to monitor the program, whether the program is sufficiently transparent, what the service use and cost are under the ASO compared to historical trends. Because other programs, initiatives, and events (such as significant changes and reductions in mental health reimbursement under the Medicaid Modernization Act) affect service use and cost, it is difficult to evaluate precisely what the impacts of APS Maine are.

## Stigma

Despite the substantial strides that have been made in the diagnosis and treatment of mental illness, the myths and stigma associated with mental illness persist and prevent many persons from getting the care and help they need. The stigma associated with mental illness is often reinforced by outdated or misinformed public policies at the state and community levels. Over half of the states restrict voting rights based on a variety of definitions of mental capacity. These types of policies make it more difficult for persons with mental illness to be equal participants in their communities. A very encouraging event is the passage in October of the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 as part of the Emergency Economic Stabilization Act (HR 1424). This

Act culminates a 20 year effort to require group health plans to cover treatment for mental illness on the same terms and conditions as all other illnesses. The law becomes effective in 2009.

## Things To Keep In Mind

During the next two years, the Legislature will face a number of issues related to mental health and substance abuse. Some of the more pressing issues may include:

- Implementation of a plan to address the AMHI Consent Decree.
- Determining how to respond to federal cuts to the Medicaid program in the area of behavioral mental health.
- Monitoring and deciding whether to revise the statewide administrative service organization (APS Maine) currently responsible for helping to manage mental health resources more effectively.
- Continued restructuring of the Department of Health and Human Services that supports a community based delivery system.
- Focusing more attention on services for children and adolescents.
- Improving crisis intervention programs and creating more beds in community based hospitals.
- Addressing fatalities due to drug overdoses.
- Reducing underage drinking and drug use.
- Supporting the effort to integrate behavioral health and primary care throughout the state.

When examining these issues, it might be useful to consider that:

- A good way to continue to invest in a community based service delivery system is by building upon successful programs.
- Treatment does work. Prevention and early intervention, particularly with children and adolescents, leads to better treatment outcomes.
- Integrated services can be more effective when addressing both substance abuse and mental health issues.
- The availability of affordable housing and employment opportunities are critical to assisting persons with persistent mental health problems.
- Individuals live in systems (family, community) and, consequently, systemic interventions are most effective.
- Behavioral health initiatives may be strengthened when coordinated or integrated with other initiatives, such as developing and implementing patient-centered medical homes.

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# Prescription Drugs

January 2009

# Issue Brief

## Prescription Drug Misuse and Abuse in Maine

Maine reflects national trends in the dramatic growth of prescription drug misuse and abuse. The consequences have included rapidly growing costs for the state in both health care and criminal justice sectors: drug-related overdose emergencies, deaths, arrests, drug-addicted newborns, infections associated with injection drug use, property crime, and gang involvement. In particular, there has been a dramatic increase in overdose deaths due to drug misuse and abuse, rising more than 500% within the past decade. Most of the increase in what public health officials term "unintentional poisoning" deaths is due to prescription drugs as well as combinations of prescription drugs with each other, with illicit drugs and/or with alcohol.

The major role prescription drugs are playing is a new issue, presenting policy challenges for both public health and safety. For example, the fact that health care providers, who legitimately prescribe drugs, may play an inadvertent role in the supply of misused drugs presents particular challenges in the investigation of diverted drugs. Comprehensive and broad-ranging policy solutions are needed to address these interrelated, complex problems.

### Behind the Statistics

Rural populations had been shielded from the distribution and effects of drug abuse generally until the late 1990s when there was an increase in the use, marketing and availability of prescription narcotics (painkillers). Rural states have seen the steepest rise in prescription drug abuse.

During the last decade, physicians began treating pain more aggressively using narcotics. Although this approach is clearly desirable for cancer pain, there is still debate about whether narcotics are effective in treating chronic, non-cancer pain. Nevertheless, this approach is widely used and officially regulated.

Associated in time with these changes in clinical practice, Maine began experiencing a rise in the number of persons who misused drugs and/or became addicted to them. Along with the increased addiction numbers came an increase in the number of people needing treatment and the number who needed emergency treatment or died of overdoses. Trafficking in pharmaceuticals became more and more prevalent, along with arrests and convictions. And related crimes of theft of drugs or money increased.

The reasons for the epidemic are not simple. Within medical care settings nationally there was increasing pressure to treat pain as one of the "vital signs," along with pulse, respirations, and blood pressure. As a result more prescriptions were written for narcotics. During the 1990s a new, long-acting (hence higher concentration) synthetic prescription narcotic was developed and it became more available and more widely used. Views on advertising of pharmaceuticals also changed, and drug companies were allowed to advertise certain categories of drugs, although not narcotics, directly to consumers via magazine and television ads. This promoted the idea of patients having more access to pharmaceuticals for their health problems. Insurance plans expanded to pay for prescription drugs, which improved patient access.

Patients and their families have appreciated the improvements in the pharmaceutical treatment of pain and other health problems, but it has come at a societal cost. A minority of persons are more vulnerable to addiction than others,

**Fast Facts**

- In Maine about 130 people die every year of accidental drug overdose, and another 30 from suicidal drug overdose. The total has in some years exceeded motor vehicle fatalities.
- About 85-90% of drug deaths in Maine are caused by misuse of prescription drugs.
- Methadone is the cause of about a third of Maine's accidental overdose deaths.
- Among young American adults aged 18-25, about 12% say they used prescription analgesics such as OxyContin non-medically in the past year. And 53% of those had obtained them for free from a friend or relative.
- The Maine law enforcement community ranks prescription drugs above illicit drugs in terms of the threat they are posing to public safety in violence and property crime, according the 2008 National Drug Assessment survey.

**Author:** Marcella H. Sorg, Ph.D., R.N., D-ABFA
Director, Rural Drug and Alcohol Research Program
Margaret Chase Smith Policy Center
University of Maine
Marcella.Sorg@umit.maine.edu
(207) 581-2596

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differences which may have a genetic as well as a behavioral or environmental base. We know that youth, whose brains are still growing and maturing, are also much more susceptible to addiction. Recent research has shown that drug use can permanently change the developing brain, altering the way narcotic receptors work for life. So, inevitably, as a result of the increased (legitimate) distribution and availability of narcotics to patients, there was more misuse, and more addiction. And with addiction come unfortunate consequences for health and safety. The obvious benefits from better pain treatment and improved access to prescription drugs for all of us carry a cost of drug addiction for some of us, and a resulting cost to society and to the state, which must be addressed.

In 2007 the Maine Office of Substance Abuse published a comprehensive report that estimated the cost the state bears for substance abuse: annually $898, over $600 per Maine resident. This includes the costs of health, welfare, and public safety. Included in their calculations is an estimated economic cost of a single death due to alcohol or drug abuse: about $300,000.

## How is Maine Responding?

One of the most focused policy responses to the problem of prescription drug abuse was to monitor certain "controlled" substances. In 2003 Maine enacted a law to create the Prescription Monitoring Program (PMP), which receives federal grant money for its operation. Over 30 states have similar programs. Maine's PMP began in 2004. It was developed to improve the quality of the prescriber-patient relationship, rather than as a law enforcement tool. The PMP, which is administered by the Office of Substance Abuse, focuses just on certain categories of substances that have a higher risk of abuse: narcotics, tranquilizers, and stimulants.

One goal of the PMP is to prevent misuse and abuse through "doctor shopping." Pharmacies must report all prescriptions they dispense in the high-risk categories. A prescribing health care provider, such as a physician, can have access to their own patient's record of prescriptions, including medicine prescribed by other providers, in order to be aware if they are being prescribed excess or interacting drugs. Prescribers and pharmacies have access to these records, only for their own patients. The system, which has an on-line feature for enrolled prescribers, requires all dispensers to participate, but participation by doctors and other prescribers to check their patients' records is voluntary. Only a minority of health care prescribers are using the system so far, but use is growing.

Maine has also provided partial support for the Northern New England Poison Center (NNEPC). Located within Maine, the NNEPC serves Maine, New Hampshire, and Vermont with 24/7 services to prevent drug and other kinds of poisoning, minimize the effects of poisonings, and reduce health care costs by providing critical information to patients and health care providers.

The NNEPC is a private organization rather than a state program, but it depends on partial state funding for its operation. It also works with many drug abuse related programs to provide statistics on the numbers and kinds of calls it receives concerning prescription drugs and illicit drugs. It responds to many kinds of urgent calls from persons who are experiencing an emergency poisoning (including prescription drugs), or health care workers in emergency rooms who need information about particular substances. It also handles information requests about substances from the public, as well as from law enforcement officers, who may be dealing with an emergency or trying to identify an unknown pill or other substance.

The 123rd Maine State Legislature passed a resolve to create a workgroup to study how best to sustain the NNEPC financially. The workgroup will make recommendations about funding. The NNEPC estimates the cost of the work that they do to prevent injury saves many more health care dollars avoiding emergency services or making them more effective.

The Maine Drug Enforcement Agency, the Maine State Police, and local law enforcement units have been dealing with a large increase in prescription drug trafficking. This includes the illegal use and sale of legally prescribed substances in Maine, as well as illicit internet sales, and drugs that may be brought into the state from Canada or other states. Current estimates from the 2008 National Drug Threat Survey demonstrates that Maine law enforcement is feeling the pressure from prescription drug abuse more than other New England states.

Based on the responses to this assessment, the Maine law enforcement community ranks prescription drugs higher than illicit drugs in terms of the threat they pose to public safety, contributing the most to property crime and violent crime. While cocaine, heroin, and marijuana are still significant problems, trafficking in prescription-type pills has grown dramatically. Often illicit drugs and prescription drugs are combined recreationally.

Law enforcement has had and will have the need of resources to combat this problem, which is increasing. Partnerships with federal agencies and other states will be necessary to respond to trafficking that frequently originates out of state, out of the country, or via internet commerce. Nevertheless, a substantial proportion of the locally-trafficked supply of prescription drugs comes from within the state, and requires statewide response.

The Maine Drug Enforcement Agency is a multi-jurisdictional task force, which has had mostly federal grant support in its history. It is important to note that the prescription drug problem creates more pressure on those resources to address prescription drug trafficking.

## What More Can Be Done?

Policy solutions beyond the Prescription Monitoring Program, but in line with its thrust, include efforts to promote a medical and/or prescription "home" for patients where care can be coordinated. Prescription drug costs include some dollars that are unnecessary, including overlapping prescriptions from multiple

providers. They include the significant cost of doctor shopping to support prescription drug addictions, which themselves require treatment. They include diversion of prescription drugs for illicit sale.

Integrated information systems, with strong privacy protections, are needed to address these issues. For example, finding ways to provide MaineCare with information about prescription filling activity by its clients that overlaps with prescriptions Medicaid has already paid for may prevent some drug misuse.

Creative solutions are needed to reduce the accumulation of unused prescriptions in households, which threaten patient safety and the environment (see the policy brief on Maine's Aging Population, which discusses this in more detail).

Informed patients, health care providers and an informed public can go a long distance in helping to prevent abuse and injury. Multi-agency community-based overdose prevention efforts, currently funded in part with state dollars, have been effective in reducing overdose rates in some communities, because they reach and inform people in meaningful ways.

Finally, policies are needed that link public health and public safety in partnership to solve the prescription drug misuse and abuse epidemic. Because prescription drugs, unlike illicit drugs, potential link lawful and criminal activities, solutions will be needed that recognize and respond to those links, while maintaining (legitimate) patient confidentiality.

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# Public Health

January 2009

# Issue Brief

## Is Maine Prepared to Become the Healthiest State in the Nation?

Public health policies and systems seek to improve the health of populations. Our public health system in Maine assures that we have safe drinking water, are prepared to respond to disasters, and have community-based prevention programs to decrease injury, disease, and premature death. While the term public health is often misunderstood and linked with indigent care, the system encompasses far more and provides essential health improvement services. These include:

- Preventing epidemics and the spread of disease
- Protecting against environmental hazards
- Preventing injuries
- Promoting and encouraging healthy behaviors
- Responding to disasters and assisting communities in recovery
- Assuring the quality and accessibility of health services[1]
- Developing policies in the public's interest
- Assessing the health of populations

The Maine Center for Disease Control and Prevention within the Department of Health and Human Services has the primary responsibility for public health in our state and serves as the hub of our public health system. This system also includes public and private organizations that play an important role. The Institute of Medicine's 2003 report titled *The Future of the Public's Health in the 21st Century* identified five actors who, together with the government public health agencies, are in a position to act powerfully for health. While policymakers have not been singled out, they also play a critical role in the public health system.

### The State of the Public's Health in Maine

Maine's State Health Plan articulates the goal of making Maine the healthiest state in the nation.[2] While a laudable goal, is it do-able? The answer depends on how willing we are to invest in a population-based approach and build a public-private system for improving health in Maine.

As the State Health Plan indicates, Mainers suffer from high rates of preventable chronic illnesses. While the medical system plays a critical role in treatment and rehabilitation of individuals, to have the greatest impact on our state's health, we need to focus on disease prevention strategies and public health approaches that support behavior change. There are multiple determinants of health including access to medical care, genetic predisposition, social circumstances such as income, education and employment, environmental exposures, and individual behavioral choices.[3] However, what most people don't realize is that our behavioral patterns and social and environmental circumstances play a far more significant role in mortality than access to high quality medical care.

In Maine, approximately 70% of deaths each year are a result of: 1) heart disease and stroke, 2) diabetes, 3) chronic lung disease, and 4) cancer.[4] Given what we know about the leading causes of death in this country (e.g., tobacco use, poor diet, physical inactivity, alcohol use)[5] and the relationship of these factors to disease and death rates, we can make dramatic improvements in health by modifying behavioral patterns through proven public health prevention and intervention efforts. The question is whether we are willing to make the investments

**Fast Facts**

- There are multiple determinants of health including access to medical care, genetic predisposition, social circumstances such as income, education and employment, environmental exposures, and individual behavioral choices.
- In Maine, approximately 70% of deaths each year are a result of: 1) heart disease and stroke, 2) diabetes, 3) chronic lung disease, and 4) cancer.
- Current estimates reveal a dramatic decline in tobacco use among young people in Maine since 1997 – 64% among high school students and 73% among middle school students.

**Authors:** Dora Anne Mills, MD, MPH
Director, Maine CDC, Maine DHHS
287-8016, Dora.A.Mills@maine.gov

Brenda Joly, Ph.D.
Muskie School of Public Service
626-5003, bjoly@usm.maine.edu

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that require long-term commitments and adequate resources given that health improvements often come years down the road. And if so, what do we need to do to get there and what successes can we build on?

## New Challenges in Public Health: Emergency Preparedness

Given the events of 9/11, the Severe Acute Respiratory Syndrome (SARS) outbreak and the recent attention to natural disasters, it is clear that our communities, our state, and our nation need to be prepared to detect and respond to these situations. While chronic diseases continue to claim the lives of our family members, friends, co-workers, and neighbors, we also need to be mindful of new public health challenges so that our public health system can continue to protect the health of our population. Maine has taken on this challenge with federal funding that supports statewide efforts for bioterrorism and public health emergency preparedness. These funds are having a direct impact on our "ability to detect, treat and prevent injury and diseases that threaten the health of Maine citizens as a result of natural or man made events."[6] Our state public health agency is helping to protect our communities by building a coordinated system that will address natural disasters (e.g., pandemic influenza, floods, ice storms) and acts of terrorism.

Our capacity in Maine to respond to this new public health challenge has dramatically increased over the past several years and we are more prepared to protect the health of all Mainers. Examples of our increased capacity include:

- The establishment of a 24 hour statewide system of infectious disease reporting, tracking and investigation, including the location of field epidemiologists in each district;
- The creation of Regional Resource Centers for Public Health Emergency Preparedness in each of three care centers (Maine Medical Center, Central Maine Medical Center, and Eastern Maine Medical Center);
- The establishment of a Health Alert Network (HAN) that enables the 24 hour alerting of thousands of health care providers and public health workers with information on key public health events;
- The enhancement of our public health laboratory in the Maine CDC to test for all major biological, chemical, and nuclear terrorism agents.

The collective efforts highlighted above, and many others, would likely not have been possible without the influx of funds that Maine received. Promoting and protecting the health of our population is an ongoing responsibility with long-term investments, but it is critical if we truly want to be the healthiest and most prepared state in the nation.

## The Power of Public Health: A Success Story in Maine

Maine has been a leader among states in having committed a substantial portion of funds from the Master Tobacco Settlement Agreement to public health. These dollars are often referred to as The Fund for a Healthy Maine and are used to support public health initiatives that target smoking and other health improvement priorities.

This investment in public health is paying off. To date, one of our most powerful successes has been the reduction of youth tobacco use. Maine has implemented and evaluated a comprehensive approach that uses proven strategies to help prevent children and young adults from using tobacco. This hallmark approach includes policies, changes in the environment and a list of other strategies used to tackle the issue from multiple angles. Current estimates reveal a dramatic 64% decline in smoking among Maine high school students, and a 73% decline among middle school students in the 10 years since 1997. This remarkable decrease is particularly noteworthy given the fact that Maine was once known to have the highest youth smoking rates in the country. Given what we know about the addictive nature of tobacco and the research suggesting that nearly one in five deaths in this country are attributed to tobacco, a decrease of this magnitude is a significant accomplishment with benefits that are far-reaching.

So, what do we need to do to build on our successes and to make a commitment to the health of Maine's population? The Fund for a Healthy Maine directly impacts our ability to deliver essential public health services in our communities and continued use of these funds to support public health efforts is critical. The allocations for state fiscal year 2007 are depicted below.

## Are We Prepared to Become the Healthiest State in the Country?

While Maine's public health system has an enviable track record of community partners, Maine CDC, and other statewide entities working together to successfully address such health problems as youth smoking rates, teen pregnancy, and infant mortality, our system has also been challenged by fragmentation and the inability to address a myriad of public health issues. For instance, often driven by Federal requirements, community-based funding has been administered through a wide array of entities in Maine, with over 500 different grants addressing some aspect of public health.

With Maine's health care spending, the second highest in the nation, fueled in part by high rates of chronic illness, and with nearly half of health care cost increases attributable to five often preventable diseases (cardiovascular disease, diabetes, cancer, chronic lung diseases, and depression), it was imperative that we streamline our public health system if we are indeed to become the healthiest state in the nation. With public health system accreditation upon us in 2011 and future funding being tied to accreditation, we also face the challenge of need-

ing to build a more coordinated system for integrating quality improvement strategies required by accreditation.

**Ten Essential Public Health Services:**

- EPHS #1 Monitor health status to identify community health problems.
- EPHS #2 Diagnose and investigate health problems and health hazards in the community.
- EPHS #3 Inform, educate, and empower people about health issues.
- EPHS #4 Mobilize community partnerships to identify and solve health problems.
- EPHS #5 Develop policies and plans that support individual and community health efforts.
- EPHS #6 Enforce laws and regulations that protect health and ensure safety.
- EPHS #7 Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- EPHS #8 Assure a competent public health and personal health care workforce.
- EPHS #9 Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
- EPHS #10 Research for new insights and innovative solutions to health problems.

## Public Health Work Group

The 2005 State Health Plan charged the 40-member Public Health Work Group (PHWG) to implement a statewide community based public health infrastructure that works hand in hand with the personal heath care system. In 2006 the Legislature enacted a resolve charging the PHWG with developing core competencies, functions, and performance standards for comprehensive community health coalitions. In 2007 the Legislature again called on the PHWG to streamline administration, strengthen local community capacity, and assure a more coordinated system of public health. That legislation set forth requirements for membership on the Public Health Work Group to assure broad representation while limiting membership to forty people, who worked tirelessly over several years to make this plan a reality. In 2007 the Legislature also enacted legislation seeking a plan from Maine CDC, with input from the PHWG, to modernize the Local Health Officer system. The results of the PHWG's various efforts are summarized here.

## Public Health Work Group Results

The Maine CDC, which is situated within the Maine Department of Health and Human Services is the nucleus of Maine's public health system. For the first time the system links and coordinates local, sub-state, and state public health activities using existing resources more efficiently. This system also includes representation from and links to the state and county emergency preparedness system. The system uses the framework of the 10 essential public health services that is the standard framework for public health functioning and for upcoming accreditation.

**Maine's Public Health Geographical Framework and Some Major Components:**

Local – Local Health Officers, Healthy Maine Partnerships (comprehensive community health coalitions)

Districts – District Coordinating Councils, Maine CDC Public Health Units

State – Maine CDC/DHHS and Statewide Coordinating Council

## District

Districts were formed by the PHWG for those functions that are more efficiently and effectively provided at the district level than the local or state level as well as for issuing funds and for determining state public health system roles. Districts were formed based on four factors: population, geographical size, hospital service areas, and county borders. They are: Aroostook; Penquis; Downeast; MidCoast; Central; Western; Cumberland; and York. They are also the same districts as are used by law enforcement for the District Attorneys, by tourism for the Tourism Districts; and are aligned with the emergency medical system districts.

## Healthy Maine Partnerships = Comprehensive Community Health Coalitions

A major step in streamlining and assuring a more coordinated public health system was put in place in 2007 by integrating the existing Healthy Maine Partnerships and other community health coalitions into one statewide system of comprehensive community health coalitions that strengthen local public health capacity statewide. This streamlining resulted in over 100 state grants and contracts to health coalitions being bundled to 28 contracts. This network is also called the Healthy Maine Partnerships (or HMPs) and now provides statewide coverage for the essential public health services related to local health assessment, education, policy, and community mobilizing.

Currently, the majority of their funding focuses their efforts on tobacco, physical activity, nutrition, obesity, substance abuse prevention, and chronic disease prevention and management. As other funding becomes available to address other health issues, the Healthy Maine Partnerships (often in partnership with the DCCs) will continue to extend their capacity to deliver these essential public health services for other priority topics as well.

## Local Health Officers

The Local Health Officer (LHO) system provides a linkage between state public health and every local municipality. It is a system that has been in place for over 100 years. The Legislature charged Maine CDC/DHHS with proposing revisions to assure the laws governing LHOs are appropriate for the 21st Century. An Act to Modernize the Local Health Officer Statutes was enacted by the Legislature in 2008. The resulting revisions streamlined a myriad of statutory duties and removed redundancies, while strengthening and focusing the system on the municipal governmental functions related to controlling and reporting local public health nuisances and potential communicable disease threats.

## District Coordinating Councils (DCC)

As part of Maine's public health infrastructure, District Coordinating Councils (DCCs) are designated by the Maine CDC based on recommendations from each of the eight districts and with review and comment by the Statewide Coordinating Council. DCCs are the district-wide representative body for collaborative planning and decision-making for functions that are more efficiently and effectively accomplished at the district level and for assuring accreditation of the state's public health system in that district.

## District Maine CDC/DHHS Units

An effective and efficient statewide public health system requires coordinated planning and calls for certain other functions to be carried out at the district level. To improve the administration of state programs and policy and to assure state policy reflects the different needs in each of the eight DHHS districts, Maine CDC is out-stationing positions and co-locating existing district staff, and establishing District Maine CDC/DHHS units. These will be linked to District Coordinating Councils. The Maine CDC/DHHS Units are to include: Maine CDC Public Health Units within each DHHS district are forming, and consist of co-located Public Health Nurses, District Nurse Epidemiologists, Health Inspectors, Drinking Water Engineers, and District Public Health Liaisons. These Public Health Units may perform certain public health functions that are more efficiently and effectively provided by them, such as some district or county-level functions and some public health emergency functions.

In the case of public health emergencies, the District Public Health Liaisons will serve in the county emergency operations centers (EOC) as liaisons between state and local public health entities. In those districts that consist of multiple counties, the District Nurse Epidemiologist and/or Public Health Nurses may also serve as EOC liaisons as well as back-up to the District Liaison.

## Statewide Coordinating Council (SCC)

A Statewide Coordinating Council (SCC) will build on the work of the PHWG to implement a statewide public health infrastructure that streamlines administration, strengthens local community capacity, and assures a more coordinated system for delivery of essential public health services. The SCC will be the representative body for review and guidance to the Maine CDC on strategic state level policies related to federally-recognized national accreditation and the aligned system of Local Health Officers, Healthy Maine Partnerships, District Coordinating Councils, and on other policy issues directly related to public health infrastructure, roles and responsibilities.

## Summary of Public Health Infrastructure

Through an extensive collaborative process, Maine's public health stakeholders have examined its centralized but fragmented public health infrastructure at the sub-state level. By streamlining and coordinating existing resources, Maine's emerging local and district public health system is more efficient, more effective, more ready for accreditation, and most importantly, better able to serve the public's health needs.

## How Do We Become the Healthiest State in the Country?

So, how do we achieve our laudable goal of becoming the healthiest state? We begin by addressing our public health challenges and system deficiencies. To tackle these challenges we need to strengthen our public health constituency and work with all of our public health partners to advocate for and implement comprehensive solutions that will impact the health of all people in Maine. If Maine is to accomplish its goal, and if it does become the healthiest state in the country, our public health system will have another success to celebrate and all people in Maine will have another reason to be proud to live in this state.

## For More Information

State Public Health Initiatives (including The Fund for a Healthy Maine)
Contact: Dora Anne Mills, MD, MPH
Director, Maine Center for Disease Control & Prevention

State Health Plan
Contact: Trish Riley
Director, Governor's Office for Health Policy and Finance

## Websites of Interest

- Centers for Disease Control and Prevention: www.cdc.gov
- Public Health Foundation: www.phf.org
- National Association of City and County Health Officials: www.naccho.org
- Association of State and Territorial Health Officials: www.astho.org
- American Public Health Association: www.apha.org

- Maine Center for Disease Control and Prevention: http://www.maine.gov/dhhs/boh/

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- Maine Center for Public Health: www.mcph.org

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State Health Reform

January 2009

# Issue Brief

## Innovations in State Health Reform

### Overview

Since the 1970s, health care costs have been rising faster than general inflation and the proportion of the population without health insurance has been rising. Currently, the number of people in the country without health insurance is about 45.7 million.[1]

States have been at the forefront of efforts to expand the numbers of the insured. In recent years, some states have also focused considerable attention on efforts to improve health care quality and control the rate of increase in health care spending. Among the many roles that states take on as overseers and administrators of the health care system in the United States, three are central to state efforts at reform. The most widely used vehicles for reform are:

- State administration of the Medicaid and State Children's Health Insurance (SCHIP) Programs. Because Medicaid and SCHIP are matched with federal dollars, most state access initiatives start with expansions of these programs.
- State regulation of the private insurance market. Another area of considerable state policy attention has been insurance market regulation, particularly for small businesses and individuals. Regulatory strategies are being used to assure broad access to private insurance and to influence price and cost structures within these markets. Recently, some states have experimented with ways to combine access initiatives with insurance market regulatory oversight by providing carefully targeted subsidies for the purchase of private insurance.
- State licensing and regulation of health care providers. Traditionally, states, working together with professional organizations, have used licensure to assure minimum standards among health care providers. Regulation through Certificate of Need programs is used in some states to control rates of capital expenditure on the health system infrastructure. Now, some states are experimenting with ways of working collaboratively with providers and payers to develop new quality tools and test new methods of delivering health care in efforts to enhance health care quality.

Within the context of these broadly defined areas, more specific examples of Maine and other state efforts are discussed below.

### Expansions of Coverage Through Medicaid and SCHIP

In recent years, restructured federal rules have allowed states greater flexibility in determining eligibility for Medicaid benefits. States have used this opportunity to extend coverage to special populations, such as persons with AIDS, and to cover previously ineligible low-income groups such as adults without children. The SCHIP program, enacted in 1997, extends coverage to low-income children who do not qualify for Medicaid. Some states have sought to expand coverage, building off their Medicaid and SCHIP programs.

The SCHIP Program covers children at somewhat higher income levels than Medicaid and in the past several years has been used as a springboard by several states for the enactment of programs to broadly expand coverage to all children within the state. These programs differ from state to state. Some (CN, FL, NJ, NY, OH, PA, TN, WA and WI) cover uninsured children up to an established income

**Fast Facts**

- Average per capita health care spending in the U.S. more than doubled between 1990 and 2003, eroding private insurance coverage and putting budgetary strains on public health care programs.
- States are opening eligibility to higher income children and families as health costs rise. Seven states now cover children at or above 300% of the federal poverty level (~$51,000 for a family of 3).
- Nationally, only 53% of small businesses with 25 or fewer workers have employer-based coverage. States are using their leverage as insurance regulators, as well as direct subsidies to shore up the individual and small group markets.
- Massachusetts, with their coverage mandate, has increased insurance coverage by over 300,000 individuals and reduced the state's uninsured rate to below 5%.

**Author:** Elizabeth Kilbreth, Ph.D.
Muskie School of Public Service
(207) 780-4467
bethk@usm.maine.edu

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threshold (e.g., 300% of the federal poverty level) and allow higher income families to buy coverage in the program for their children, at cost. Others establish premiums on a sliding scale, based on family income (IL, MN, PA). Some states limit eligibility to currently uninsured children or children who have been uninsured for a minimum period or who cannot obtain affordable coverage due to a pre-existing condition.[2]

To the extent that these children's programs extend coverage subsidies to persons ineligible for SCHIP coverage under federal rules, states have had to find alternative sources of funding. Choices have ranged from tobacco settlement dollars, cigarette taxes to general fund appropriations.

## Initiatives Targeting the Private Insurance Market

States use the power of licensure to establish minimum standards for insurance carriers including minimum reserve requirements and overview of contracts and marketing materials. In addition, legislatures have established mandatory requirements for insurers with regard to benefits that must be included in all products. (These rules apply to all insurance products but not to employer benefit plans that are self-insured.) The federal government entered the insurance market regulatory arena in 1996 with the passage of the Health Insurance Portability and Accountability Act (HIPAA). In the small group market, HIPAA prevents the selective denial of coverage within a small business employee pool and requires that all groups (and individuals within the groups) have the option to renew their policies when the coverage term has ended. In addition, HIPAA limits the time length that insurers can impose waiting periods for coverage (after enrollment) for pre-existing conditions.

A number of states move beyond HIPAA requirements by also limiting insurance company discretion with regard to premium pricing in an effort to limit the extent to which insurers segment the market by risk.[3] Some, for example, bar differential pricing by gender. Others limit the differential in premium prices for different age groups or types of business. A few states require community rating whereby all individuals pay a premium based on the average cost of all covered lives within an insurer's small group product line. Some states apply these same, or similar, rules in the individual insurance market as well.[4]

Rapid increases in health coverage premiums throughout the insurance market have generated substantial debates in state legislatures as to appropriate responses and have led to a number of different initiatives specifically targeted to the small group (and sometimes, individual) markets. Among these initiatives are high risk pools, reinsurance programs and subsidized insurance products.

*High Risk Pools:* A high risk pool offers coverage to individuals with serious medical conditions who face excessively high premiums or who have been deemed uninsurable by carriers. High risk pools are usually administered, under contract, by a commercial insurer or administrative services organization and offer one or more benefit plans as determined by the governing body. In regulatory environments where insurers in the individual market are allowed to medically underwrite or deny coverage based on health status, high risk pools provide a safety valve, but usually at a cost substantially higher than market rates in the individual insurance market. Despite the higher premiums, because of the extensive medical needs of the enrollees, high risk pools generally pay out more in claims than they receive in premium revenues and must be subsidized. Usually, all health insurers in the state are required to pay an assessment into a fund to cover excess losses.

High risk pools have been in existence in some states as far back as the 1980s. In recent years, these pools have been proposed or adopted in states in concert with a legislative decision to deregulate the individual insurance market – allowing insurers to medically underwrite and, except where barred by HIPAA, to discretionarily deny coverage. The argument for deregulation is that insurers can offer a greater variety of different products targeted to specific market segments thus encouraging broader voluntary purchase of insurance coverage and stimulating competition in the insurance market. The argument against deregulation is that, even with a high risk pool, coverage becomes less available and more costly for those who need health services the most. In addition, segmenting the market does not reduce underlying costs, it just shifts the cost burden to a smaller number of individuals.

Thirty-three states currently operate a high risk pool.[5] Of these, seven have been established since 2003 as responses to recent market conditions. Most high risk pools (including those that have been operating for 20 or more years) have low enrollments – around 1/10 or 2/10 of a percent of the adult population under age 65. The one exception is Minnesota which has about 1% of its adult population enrolled.[6] Maine operated a high risk pool program from 1988 to 1994 and served around 450 individuals at its highest level of enrollment. The program was terminated when funding was shifted from a hospital assessment to the general fund and funding levels were insufficient to assure that program costs could be covered.

*Reinsurance Programs:* Reinsurance programs provide protection and some cost relief to insurers in the small group and/or non-group market by transferring to a different entity the liability for some portion of the claims experience for the enrolled population. Insurers (and self-funded employer benefit plans) can voluntarily purchase reinsurance by paying a commercial reinsurer a premium per covered person. Generally, these arrangements provide protection against individual catastrophic cases where the reinsurer will cover the costs (or some portion of the costs) above a pre-established threshold amount (e.g., after the primary insurer has paid out $30,000 for medical expenses for an individual in one contract period). The cost to the primary insurer for the premiums paid to the reinsurer is built into the premiums paid by enrollees.

There are a few programs where policymakers have used public funds or assessments across the insurance market to provide reinsurance as a mechanism to subsidize, or reduce costs, in the small group or individual market. In Arizona, the state

appropriated state funds to buy commercial reinsurance with a stop loss level of $100,000 for insurance products restricted to small groups and sole proprietors. Connecticut and Idaho have reinsurance programs, funded in part by assessments on all insurers, where carriers in the small group market can discretionarily reinsure individual enrollees, based on the carrier's assessment of risk. New York has a program where the state, itself, provides reinsurance to HMOs for a coverage program limited to small groups where at least a third of the workers earn less than $30,000, and sole proprietors and working individuals with incomes below 200% of the federal poverty level. In this program, the state covers 90% of claims costs between $5,000 and $75,000. The state limits, through regulation, the amount that the carriers can keep for administrative costs and profits to assure that savings are passed on to enrollees. This program has resulted in insurance products with premiums about 40% below the market for similar products.[7]

*Publicly Subsidized Insurance:* Ten states have launched programs that provide direct subsidies to lower the cost of insurance of employees, employers, or both, in the small group market.[8] Most of these programs limit eligibility to businesses that are not currently offering coverage and have not for at least 12 months. Some programs limit eligibility to businesses of under 10 employees – others are open to businesses up to 50 employees. Income eligibility for subsidies also varies. Some states establish a maximum average wage (e.g., the average wage cannot exceed $50,000). Others apply eligibility criteria to individual workers (for example, persons with household income below 200% of the federal poverty level). All the programs set a minimum requirement on the amount of the premium that the employer must contribute (usually 50%). Most states establish minimum credible coverage requirements and only contribute to policies that meet these requirements. Maine's DirigoChoice Program and New York's HealthyNY Program apply subsidies only to insurance products specified by a governing board.[9]

These programs have had only modest success in expanding coverage among small businesses. This may be due to structural barriers facing very small businesses. Small businesses have proportionately more part-time and/or part-year employees. In Maine, for example, more than 45% of workers in businesses smaller than 25 are either part-time or seasonal workers.[10] These workers are frequently ineligible for employer sponsored plans and, when eligible, face particularly high premiums since employers usually pro-rate their premium contributions.

An alternative subsidy strategy undertaken by a limited number of states is to target individuals rather than small businesses with a state-sponsored insurance plan offering sliding scale subsidies. The state of Washington's Basic Health Plan, a prototype that has been operating since the late 1980s, caps eligibility at 200% of the federal poverty level. Pennsylvania sponsors a similar program, AdultBasic, with similar eligibility guidelines. Both programs cap enrollment based on budgetary limitations and maintain waiting lists, adding individuals as enrollment declines through attrition. Vermont, Massachusetts and Maine (discussed in more detail below) all sponsor subsidized, sliding scale individual enrollment plans as part of their larger reform efforts.

Individual plans are advantageous to low income residents in that the coverage is portable and not linked to a particular job. However, these plans are costly to states because there is no employer contribution toward the premium costs of enrolled individuals.

## Comprehensive Reforms

Maine, Vermont and Massachusetts have recently enacted health system reform in a comprehensive manner, addressing issues of access, cost and quality simultaneously. These three states have all received federal Medicaid waivers to expand Medicaid to previously ineligible populations. In addition, all three states have implemented programs that provide coverage with sliding scale subsidies or discounts, based on ability to pay, for individuals and families with incomes slightly above Medicaid eligibility thresholds. With regard to many other particulars, the programs in these three states diverge. Most notably, Massachusetts is the only state in the nation that has enacted an individual mandate that requires all residents (with a few specified exceptions) to enroll in or purchase health insurance coverage. A brief overview contrasting elements of these state programs is provided below.

*Access Expansions:* All three states have used their Medicaid, State Children's Insurance Programs (SCHIP) and state access initiatives to create seamless eligibility for state citizens up to 300% of the federal poverty level. Those eligible for Medicaid or SCHIP have minimal cost sharing requirements while individuals and families enrolled in the state access initiatives pay premiums on a sliding scale based on income and have income-adjusted copayments or deductibles.

All three states have formed partnerships with private insurers or managed care companies to offer their coverage programs. The carriers insure the products, process claims, have a network of providers, and carry out some disease management functions. The states determine eligibility and manage the subsidy functions.

Some points on which these programs differ from each other are the following:

- In Massachusetts and Vermont, individuals must be uninsured to be eligible for the state-sponsored initiatives. In Maine, currently insured individuals can elect to enroll in the DirigoChoice Program – unless their employer dropped coverage, in which case they must wait 12 months. Maine chose this strategy so that under-insured individuals could purchase more comprehensive coverage and so that small employers who offered coverage but had low participation rates could offer discounted coverage to their low-income employees.
- The Massachusetts sponsored program – Commonwealth Care, is available to individuals and families only (no groups). Vermont enrolls individuals and families in its program, Catamount Health, but alternatively, will subsidize the premiums of employer-sponsored coverage

for eligible individuals, when they have an employer plan available to them that is cost-effective. Maine allows both small businesses and individuals to enroll in the Dirigo-Choice program.

- In Maine and Vermont, individuals with incomes above the eligibility threshold for subsidies may purchase coverage through the state programs at cost. In Massachusetts, enrollment in Commonwealth Care is limited to persons with incomes below 300% of the poverty level. An agency called the Connector has been established to approve affordable plans with credible coverage available through the private market. The Connector serves as a point of entry for individuals ineligible for the Commonwealth Care program in accessing coverage and provides a mechanism to pool contributions from employers for individuals with more than one job.

- Massachusetts and Vermont both instituted a financial assessment on employers for employees who are not insured through an employer-sponsored health benefit plan. Determined on an FTE basis, the assessment affects both employers who provide coverage but may have part-time or other workers who are not eligible, and employers who do not offer coverage. The assessment in each of these states is set well below the cost of insurance coverage so that the state-subsidized programs must draw on additional sources of funding. In Maine, participation in the DirigoChoice plan (or other insurance) is voluntary and no assessment is levied based on employment of uninsured workers. However, the Maine program is funded in part through an assessment on insurance claims and self-funded employer plans' claims volume – an assessment that is triggered by a showing of cost-savings in the health care system that matches or exceeds the value of the assessment. This Savings Offset Payment mechanism has been controversial and cumbersome. In the last legislative session the legislature replaced it with an increased tax on certain beverages and a fixed assessment on premiums. This reform was reversed through referendum in November, reverting the program to the prior Savings Offset Payment funding structure.

*Cost and Quality Initiatives:* All three states have initiated efforts to improve quality of care, efficiency, and to reduce costs. An interest shared across the three states is the development of an integrated electronic medical record system that would make patients' medical histories and test results immediately available to the range of providers participating in a patient's treatment. In Vermont, a 1% levy on insurance premiums was enacted by the legislature to fund the development of the necessary infrastructure and training for such a system.

Maine and Vermont are both testing, on a pilot basis, a medical home model of care which shifts both medical management responsibilities and reimbursement for care to a team model, based on each patient's comprehensive health care needs. Vermont's health reform law includes a "Blue Print for Health" which will facilitate a disease management approach for individuals with chronic illnesses regardless of insurance program (Medicaid, private insurance, or Medicare).

Massachusetts has passed a law that prevents hospitals and other facilities from charging for the costs of care in cases of certain serious and avoidable medical errors. The state is establishing uniform billing and coding among providers and payers to reduce administrative costs. They have also established a Special Commission on Health Payment Reform which will investigate strategies for restructuring the health care payment system to provide incentives for efficient and effective care.

Maine's reform law established the Maine Quality Forum (MQF) which has multiple initiatives underway. Among its activities are efforts to increase transparency and public awareness of differences in quality and volume of services among providers across the state. The MQF is also engaged, together with providers and consumers, in developing standardized treatment protocols and in measuring performance against agreed upon standards. Working together with coalitions, the MQF is engaged with a number of pilot projects which include but are not limited to: efforts to reduce hospital infection rates; reduce the incidence of pressure ulcers in hospitals; and improve quality and safety in small, rural hospitals. Maine's health reform also addresses health care costs directly by limiting the total new dollars that can be invested in certain health system capital projects. In addition, the state has negotiated voluntary benchmarks with the hospital industry to slow the rate of growth in hospital spending.

## Conclusion

The states, through their various initiatives have often served as a laboratory for reforms to be considered at the federal level. With the new administration and its commitment to health care, the interest in state reforms may be particularly pronounced. Maine's DirigoChoice Program (as well as the Catamount Health Plan in Vermont and the Commonwealth Care Program in Massachusetts) may well serve as prototypes for Obama Administration's stated interest in public insurance alternatives for persons without access to employer health benefits.

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3. FamiliesUSA. Understanding How Health Insurance Premiums are Regulated: Adjusted Community Rating. http://www.familiesusa.org/issues/private-insurance/rate-regulation-43-adjusted.html
4. States with community rating or modified community rating with rate bands include: CT, ME, MD, MA, NH, NJ, OR, PA (only for some Blue Cross, Blue Shield Plans and HMOS), RI, and WA.
5. States with high risk pools include: AL, AK, AR, CA, CO, CT, FL, ID, IL, IN, IA, KS, KY, LA, MD, MN, MS, MO, MT, NE, NH, NM, ND, OK, OR, SC, SD, TN, TX, UT, WA, WV, WI and WY.

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Workforce

January 2009

# Issue Brief

## Maine's Health Care Workforce

Affordable, quality health care is critical to Maine's continued economic development and quality of life. Yet substantial shortages exist at almost all levels of the health care workforce in Maine. These shortages can impact the cost and availability of care, two areas of growing concern for everyone who relies on the health care system.

Maintaining a strong health care workforce is a serious challenge for the state of Maine. Understanding current conditions and needs throughout the state, and addressing the gaps through education, incentives and collaborative partnerships, will help to attract, build and maintain a strong and qualified pool of health care professionals to serve Maine's population.

### Maine's Unique Challenge

Maine has an aging population with changing health care needs and a high degree of chronic illness. **Maine has the highest median age in the United States, at 41.2 years. The Census Bureau projects that 26.5% of the state's population will be 65 or older by 2030.**[1] With age comes an increase in utilization of health care services. In addition, problems such as obesity, tobacco use and poor nutrition continue to impact the health of Maine residents.

**The health care industry is Maine's largest industry, employing over 75,000 people in 2004 and accounting for 14% of total wages paid in the state.**[2] Maine's health care workforce is also aging, and many will reach retirement age and move from being health care service providers to recipients of these services. Hiring alone will not fill this gap. Increasing the pipeline of an educated, skilled and substantial health care workforce, as well as expanding training program capacity and accessibility, will be critical to meeting Maine's needs.

The challenge of providing adequate health care access is particularly acute in Maine's rural areas, where wages are lower and opportunities for professional development are more limited. Recruiting health care professionals to live and provide badly needed services in the most rural parts of the state is one of the state's greatest challenges, and most pressing needs.

The good news is that average health care wages in Maine are 12% higher than the all-industries average, at $35,690, with lower relative turnover. Demand for jobs in the health care sector remains strong.

**The 10 fastest growing occupations in the U.S. include seven occupations related to health, and two-thirds of the fastest growing jobs in Maine are related to health care.** Many of these skilled professions – such as licensed practical nurses – require two years or less of post-secondary education. Particularly at a time of a weakened economy, new opportunities in health care careers for those facing job losses or cutbacks could benefit both the state's health care workforce shortfall and the individuals affected.

### Current State of Maine's Health Care Workforce

The U.S. Department of Health and Human Services has developed criteria for Health Professional Shortage Areas in order to determine areas of critical need across the country. Notably, all 16 of Maine's counties have geographic areas or minor civil divisions with a HPSA designation.[3]

**Fast Facts**

- Maine has the highest median age in the U.S., at 41.2 years
- 26.5% of Maine's population will be 65 or older by 2030
- Health care is Maine's largest industry, employing over 75,000 people
- Health care jobs account for 14% of total wages paid in the state
- Two-thirds of the fastest growing jobs in Maine are related to health care
- All 16 of Maine's counties have areas designated as Health Professional Shortage Areas (HPSA)

**Author:** Danielle N. Ripich, Ph.D.
President
University of New England
DRipich@une.edu
(207) 602-2306

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The disparity between the demand for skilled health care workers and the anticipated supply in Maine was outlined in "A Call to Action" report conducted by the Health Care Workforce Leadership Council in 2001 and included in a final report presented to the Maine Legislature in 2004. This trend continues in 2009 and includes a significant deficit in jobs for registered nurses and nurse practitioners, as well as for technicians in radiology, health information, and pharmacy.[4]

- **The New England Regional Healthcare Workforce Collaboration's September 2008 report identified physicians (and in particular, primary care physicians), nurses, oral health and mental professionals, pharmacists and physician assistants, as the professions for which strategies addressing rural supply shortages and recruitment/retention needs should be developed.[5]**

In addition, demand for workers in allied health – such as physician assistants, occupational therapists, and physical therapists – remains strong as Maine's population ages and service utilization increases. Training capacity does not currently meet demand in these fields. At the University of New England, for example, over 1,000 applicants were received for 43 available slots in its Physician Assistant program in 2008.

Outlined below are four healthcare occupations where supply and demand in Maine present particular challenges.

### *Nursing*

According to the Maine Department of Labor (DOL) 2006 Healthcare Occupations Report, Maine has a greater share of jobs in nursing and residential care facilities than the rest of the country (30.5% vs. 23.4% of the healthcare work force, respectively), largely attributed to the state's older population. Nursing needs within mental health services, in particular, are acute – within that job pool exists a much larger concentration of mental health professionals vs. the national average, relative to population size. Between 1994 and 2004, nursing job growth in Maine's residential mental health, community care facilities for the elderly, and other residential care exceeded 100% in each area.[6]

The report states that attracting and retaining a sufficient number of nurses in Maine is a challenge. In 2005, 6.3% of all RN positions were vacant. The average age is 49, an age at which many are at or nearing retirement, so attrition is a significant factor in projecting nursing workforce needs in the state. Only about 25% of RNs are 41 years old or younger. Similar problems exist in supply and demand for licensed practical nurses (LPNs). Replacing retiring workers remains a key challenge for employers in Maine. Developing and supporting policies to retain existing nurses, as well as attracting a new generation of qualified professionals to enter the field, is critical to addressing the gap between supply and demand.

Maine colleges and universities offer a number of educational opportunities in nursing, including programs at several entities in the University of Maine system, Husson University, St. Joseph's College, University of New England, and five community colleges.

### *Physicians*

As in most other workforce areas outlined in this brief, Maine's expanding and aging population continues to influence the need for physicians in the state. Other factors, such as individuals' health insurance options, residency opportunities in Maine, and reimbursement policies, are affecting demand for physician services.

A recent article in the *Journal of the American Medical Association* predicts a substantial shortage of primary care physicians (PCPs) nationwide by 2025. It states that the projected 40,000 PCP shortfall is likely to be felt even more acutely in underserved areas and among vulnerable populations such as the elderly and those in rural areas.[7]

The reimbursement policies of MaineCare and Medicare present a challenge in the delivery of healthcare services, particularly among PCPs in the most rural parts of the state. There are a larger percentage of Medicare and MaineCare patients in rural areas of Maine, and low reimbursement levels together with increased administrative demands present a cost burden to many PCPs.

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- Maine's only medical school, the University of New England College of Osteopathic Medicine (UNECOM) in Biddeford, has 310 graduates practicing in Maine, 68% of whom are primary care physicians. UNECOM graduates comprise 9% of Maine physicians, 15% of Maine primary care physicians, and 24% of Maine physicians serving in rural areas.[8]
- Maine Medical Center has established a medical school partnership with Tufts University School of Medicine that will begin in 2011 and offer a combined diploma from MMC/TUSM. The program will reserve 20 of its 36 seats for Maine residents or those in adjacent locales to encourage and emphasize rural and small town practice.

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Providing incentives to students who attend medical school in Maine will help to ensure that a larger proportion remain and practice here. Policies that support and enable access, particularly in underserved areas, should also be considered to improve health outcomes across the state. The *JAMA* article cites a successful program through the National Health Services Corps (NHSC) that provides clinicians with scholarships and student loan reimbursement in exchange for working in underserved areas for at least two years; physicians who participate in a NHSC program for at least four years are substantially more likely to remain in an underserved area after leaving the program.

**Positive Impact of Primary Care Physicians**

- The addition of one primary care physician per 10,000 population in the U.S. resulted in 3.5 fewer people dying each year.
- Each 10th percentile increase in primary care physician supply equals a 4% increase in odds of an early-stage breast cancer diagnosis.
- In U.S. Standard Metropolitan Statistical Areas, an increase of one PCP/10,000 would decrease:
  - Inpatient admission by 5.5%
  - Outpatient visits by 5.0%
  - ER visits by 10.9%
  - Surgeries by 7.2%
- Increasing the number of primary care physicians in a state by 1 per 10,000 population was associated with a rise in that state's quality rank of more than 10 places and a reduction in overall spending of $684 per Medicare beneficiary.

Source: American College of Physicians (2008)[9]

*Pharmacists*

**According to the Health Resources and Services Division (HRSD) Report to Congress, Maine has just 52.2 pharmacists per 100,000 people, one of the lowest ratios in the country (vs. the national average of 68.1).**[10] A scoring system developed by the Pharmacy Manpower Project, Inc., ranks Maine's demand index for pharmacists close to the highest level, with a score of 4.4 out of 5. The Northeast region also has high demand, with an index of 3.94.

The HRSD report cites expanded responsibilities and administrative duties of pharmacists, the aging population and an increased growth in prescription medication usage as among the reasons contributing to the pharmacist shortage. Moreover, in rural areas, pharmacists may be the most accessible (or only) healthcare professionals, so this shortage is more problematic.

The DOL Health Occupations Report projects 2.5% annual employment growth for pharmacists. Job vacancies for pharmacists in 2005 increased markedly vs. 2002, while the job vacancy rate also increased to 3.7%. This trend is expected to continue. Pharmacists who choose to work in Maine are rewarded with higher-than-average wages vs. the national average.

The HRSD report suggests that a contributing factor to a pharmacist shortfall in some states with low ratios is the lack of a school of pharmacy. Two universities in Maine are moving to address the shortfall. The University of New England will enroll its first class of Pharm.D. (Doctor of Pharmacy) students at its new College of Pharmacy in September 2009, and is expected to graduate close to 100 pharmacists per year by 2013. Husson University in Bangor has also launched a School of Pharmacy and expects to admit 65 students in its inaugural Pharm.D. class in the fall of 2009.

*Oral Health Professionals*

Oral health is recognized as a critical component of overall health and wellness. Poor oral health and periodontal disease are associated with health conditions such as stroke, heart disease, diabetes, and negative outcomes for pregnant women.[11] Securing access to local, affordable oral health care is therefore important to state health planning from both a prevention and treatment perspective. Maine ranks in the bottom half of states (31st) in percentage of residents who have visited a dentist within the past year[12].

**Maine's dentist to population ratio is one to 2,165 residents, significantly lower than the national ratio of one to 1,656 people. Further analysis shows an even lower ratio — one dentist to every 3,160 residents — when considering only those dentists who are general practitioners.**[13] Given that 67% of Maine's dentists are 45 years and older and a full third of Maine's dentists are approaching retirement age, it is critical to invest in the infrastructure necessary to educate and retain dentists for the current — and future — Maine workforce.[14] Finally, trends in dental education demonstrate that in the year 2014 more dentists will be retiring from the workforce than

graduating from dental school.[15] This information indicates that all sectors of society, not just those in the lower socio-economic groups, will have difficulty accessing dental services.

Dental assistants and dental hygienists are on the top ten list for growth in the U.S. between 2004 and 2014.[16] These occupations are growing quickly because the demand for dental services is expanding. Dentists will be in demand and will need to increase productivity by employing allied health personnel to meet society's oral health needs.

## Addressing Maine's Health Care Workforce Needs

Maine will continue to experience a serious shortfall in its health care work force if it does not address three critical areas:

- **The health care training program capacity in Maine must be expanded and made accessible to people in rural areas.** Our colleges and universities need to expand not only classroom space and find enough qualified faculty, but also increase the number of clinical training sites in Maine (such as hospitals, clinics, and other sites). Options to consider to make training accessible in rural areas include satellite clinical campuses and distance learning programs (using IT capacity).

- **Maine must increase retention and incentives for its healthcare work force.** The state should expand scholarships, loan forgiveness and debt relief programs, increase reimbursements for primary care physicians and others, and offer tax incentives to practice and remain in rural areas.

- **Maine must continue to build awareness of health careers among a variety of populations,** including K-12 students, undergraduate college students, mid-career workers who want to change careers, older Mainers who want to remain in the work force, and individuals who face job losses in other professions. Generating interest in and exposing people to the opportunities available in health care occupations will help to grow the workforce pipeline as our existing workforce ages and reaches retirement.

## Collaborating to Meet the Challenge

For years, numerous individuals and groups within the state have actively worked to address Maine's health care workforce issues. Health care providers and educators are making significant inroads through training and education.

In 2005, the Legislature formally identified the need to develop a comprehensive way of collecting and reporting data, which led to the 2006 Health Occupations Report. The Legislature established the Maine CDC Health Workforce Forum, which comprises stakeholder groups, including employers, professional associations, and policymakers, who are coordinating and connecting the individual efforts already under way.

The Forum is looking at health care, long-term care, and public health workforce issues, and draws upon the expertise of the stakeholders to collaborate on solutions and make long-term recommendations. The goal is that an organized collaboration of professionals across many service areas will lead to an effective and systemic approach to solving the state's critical health care workforce shortages.[17]

## For More Information

New England Rural Health Roundtable:
www.newenglandruralhealth.org

Maine Primary Care Association:
http://www.mepca.org/

Maine Area Health Education Center (AHEC) Network:
http://www.une.edu/com/ahec/

Maine Office of Rural Health and Primary Care:
http://www.maine.gov/dhhs/boh/orhpc/

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Health Care Overview

**Legislative Policy Forum on Health Care**

**January 30, 2009**

*Strategic solutions for Maine's health care needs*

# An Overview of Health Care in Maine

*Wendy J. Wolf, MD, MPH*
*President & CEO*
*Maine Health Access Foundation*

**www.mehaf.org**

## Legislative Policy Forum Sponsor: The Maine Health Access Foundation

- Maine's newest and largest private non-profit health care foundation
- Created in April 2000 from the sale of Blue Cross & Blue Shield to Anthem
- The MeHAF mission is to ***promote affordable and timely access to comprehensive quality health care, and improve the health of every Maine resident.***
- MeHAF supports strategic solutions for Maine's health care needs through grants and other programs, particularly projects that serve the uninsured and medically underserved.
- Since 2002, MeHAF has awarded over $35 million in grant & program support to nonprofits across the state to advance our mission

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## Legislative Policy Leaders Academy
## Rationale for a day focused on health care issues

- Health care issues affect a significant part of local, state and federal legislation;
- Health care is one of the largest nondiscretionary cost drivers for government (federal and state) spending;
- Providing health care coverage to employees is a growing proportion of employer costs, and controlling health care cost is now cited as business' most pressing economic issue;
- Jobs in health care will be a growth sector for Maine – but also help drive higher spending;
- Poor health and medical expenses are one of the leading causes of personal bankruptcy;
- Health and well being significantly impact your constituents.



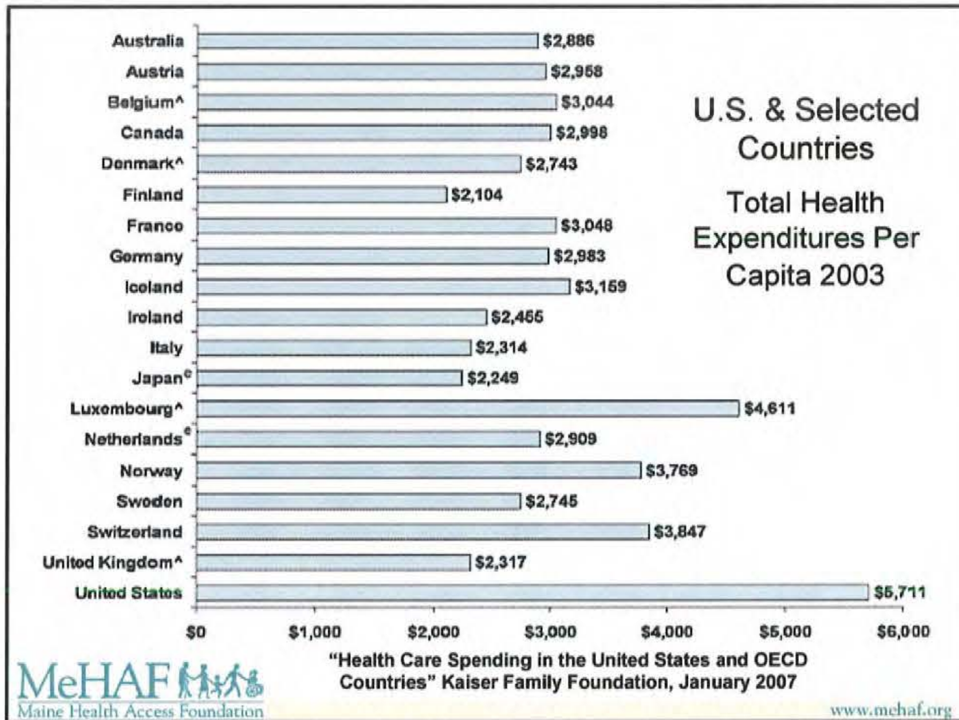
## America's health care system: Best in the world?

**"When it comes to spending money on health care, America is number one. Not only does the U.S. pay more, it gets less in return – fewer patient visits and shorter hospital stays."**

***Managed Care Magazine, Sept 2004***

**Other nations devote just 9 or 10% of national income to health care, while insuring everyone and enjoying longer life spans and lower infant mortality. Despite our national level of spending on health care, the U.S. ranks 24th in overall health attainment – just above Cyprus.**

***World Health Organization, The World Health Report 2000: Health Systems: Improving Performance***


U.S. & Selected Countries
Total Health Expenditures Per Capita 2003
Australia $2,886
Austria $2,958
Belgium^ $3,044
Canada $2,998
Denmark^ $2,743
Finland $2,104
France $3,048
Germany $2,983
Iceland $3,159
Ireland $2,455
Italy $2,314
Japan $2,249
Luxembourg^ $4,611
Netherlands $2,909
Norway $3,769
Sweden $2,745
Switzerland $3,847
United Kingdom^ $2,317
United States $5,711
$0 $1,000 $2,000 $3,000 $4,000 $5,000 $6,000
"Health Care Spending in the United States and OECD Countries" Kaiser Family Foundation, January 2007
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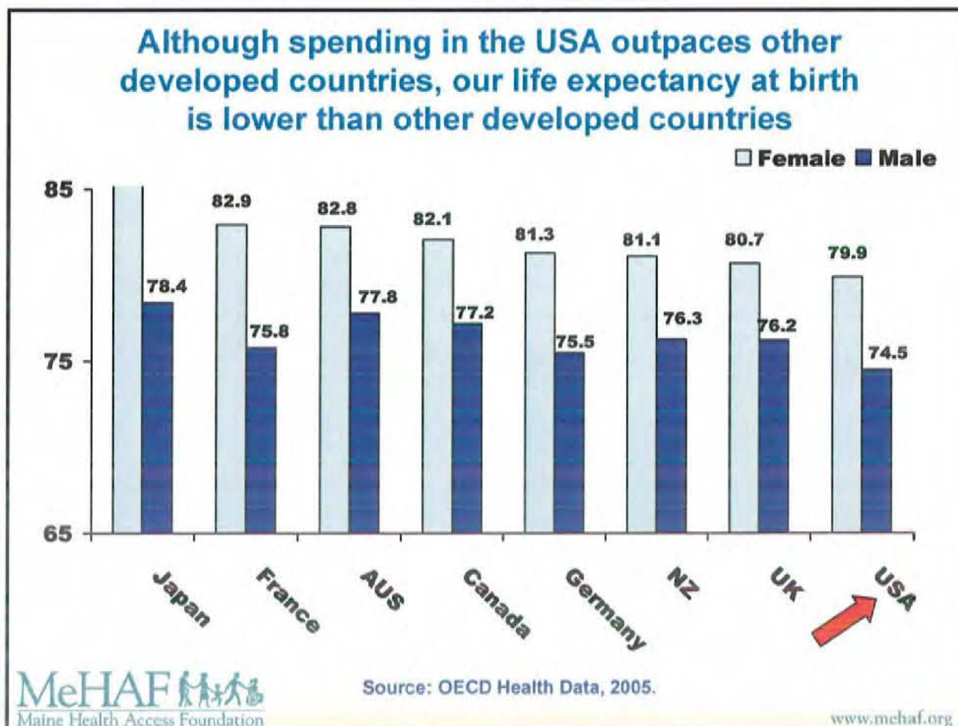
Although spending in the USA outpaces other developed countries, our life expectancy at birth is lower than other developed countries
Female Male
85
75
65
82.9 82.8 82.1 81.3 81.1 80.7 79.9
78.4 75.8 77.8 77.2 75.5 76.3 76.2 74.5
Japan France AUS Canada Germany NZ UK USA
Source: OECD Health Data, 2005.
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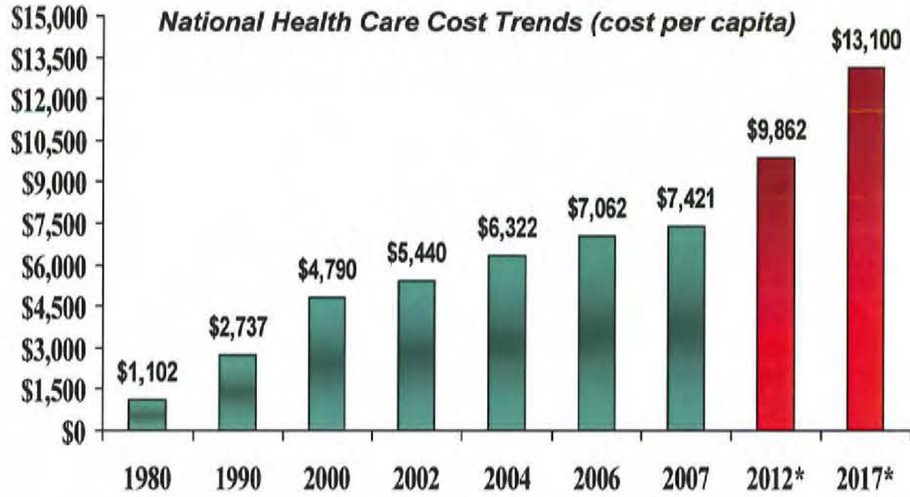
...and we are paying more and more for our care
National Health Care Cost Trends (cost per capita)
$15,000
$13,500
$12,000
$10,500
$9,000
$7,500
$6,000
$4,500
$3,000
$1,500
$0
$1,102
$2,737
$4,790
$5,440
$6,322
$7,062
$7,421
$9,862
$13,100
1980
1990
2000
2002
2004
2006
2007
2012*
2017*
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, DHHS, United States.
Health Affairs, Jan/Feb 2009
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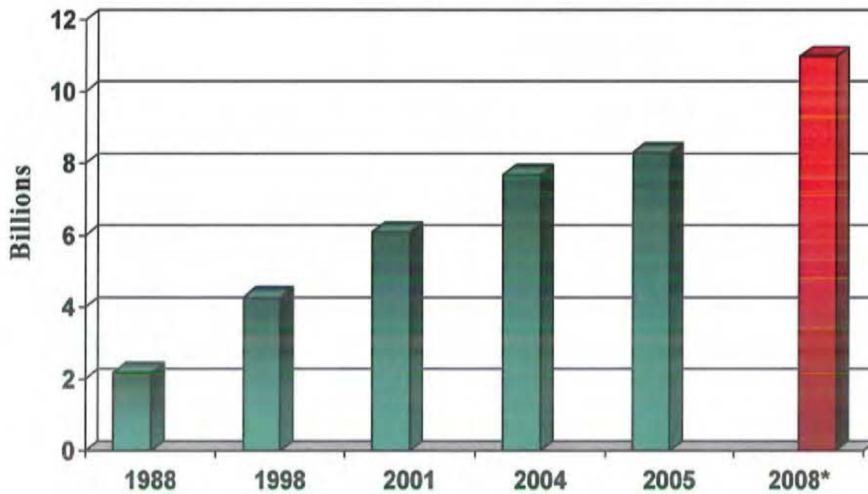
Overall Health Care Expenditures in Maine
Billions
12
10
8
6
4
2
0
1988
1998
2001
2004
2005
2008*
*Projections based on national and Maine-specific data at 13% per year from 2001 -2004, and CMS projections at 5% for health care costs and 7% for Rx drugs from 2004-2008
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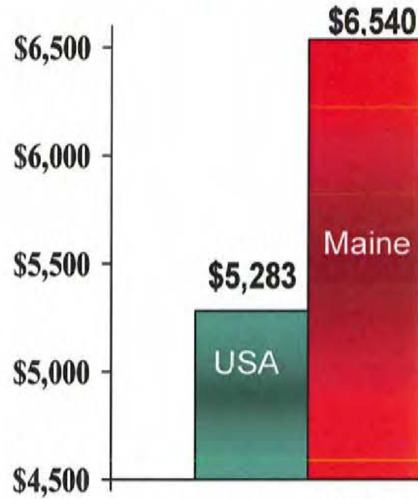
## Personal Health Care Spending Per Capita Maine versus US (2004)




Source: Centers for Medicare and Medicaid Services, Office of the Actuary, DHHS, United States

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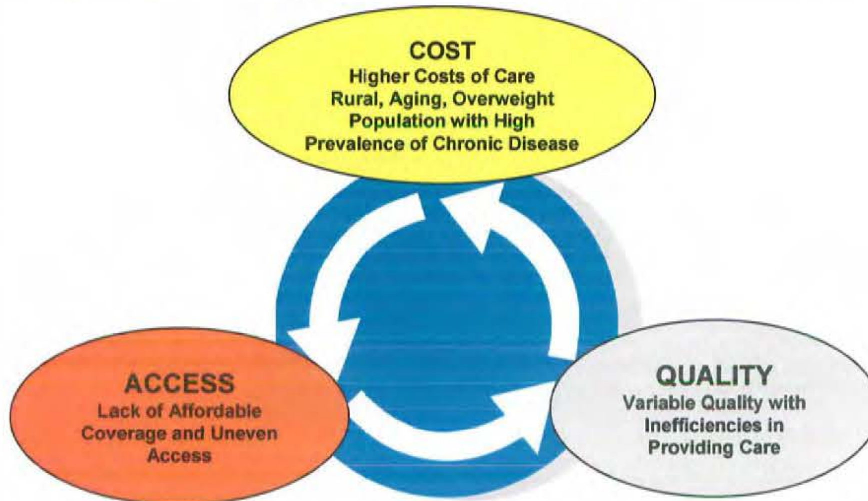
## Understanding Maine's Health Care Challenges



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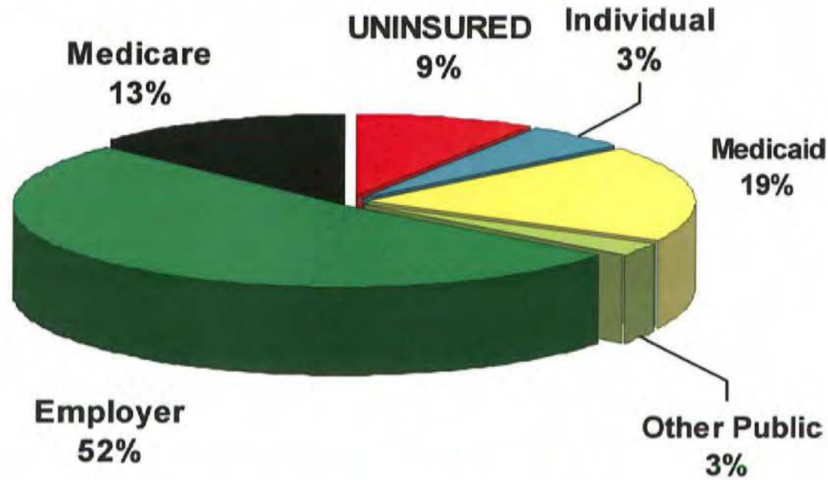
## ACCESS: Health Care Coverage in Maine (2006-2007)




Source: Kaiser State Health Facts online: statehealthfacts.org

*NOTE: the Census Bureau uses 2 year blended data for state to counter the effect of small sample size in their annual data collection*

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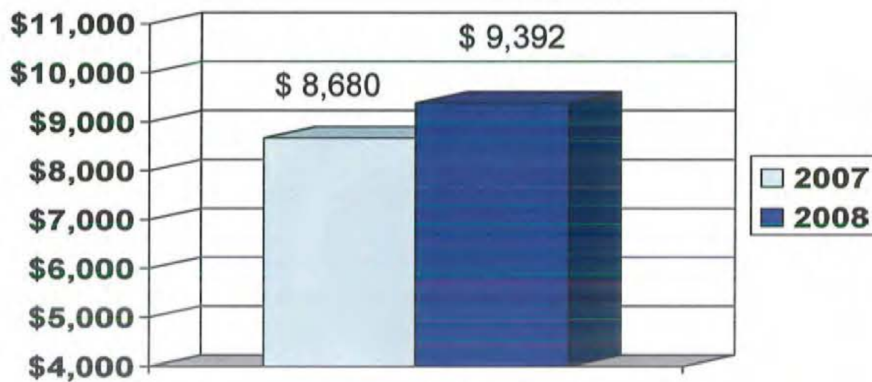
## The cost of health benefits is outpacing profits for Maine's businesses




**Average total health benefit cost per employee for Maine businesses**

Data Source: Mercer, 2008

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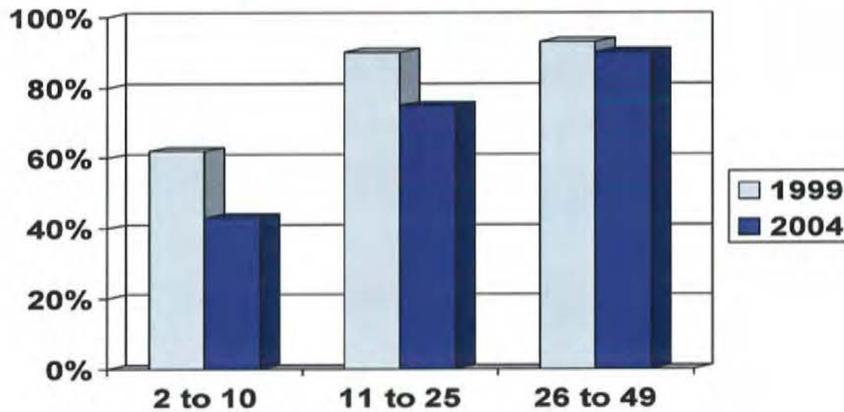
## ...which means Maine's employers are struggling to provide health insurance




**Maine small business survey shows that from 1999 to 2004, the percentage of firms offering health benefits is declining (1999-2004)**

Data Source: "Maine Small Business Health Insurance: A 2004 Survey. Maine Center for Economic Policy 2005

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## Many Maine people do not have health insurance

People who lack health insurance primarily live in ***working*** families employed in low-income jobs

- The uninsured are less likely to be offered employer-sponsored health insurance:
  - 9 out of 10 workers with wages ≥ $15/hour are offered coverage;
  - Only 5 out of 10 workers with wages ≤ $7/hour are offered coverage.
- People in low income families pay proportionately more for health care
  - 3.8% of annual income for workers with advanced degrees; versus
  - 7.2% for workers who did not complete high school.

Data from U.S. Dept of Labor, Consumer expenditure survey

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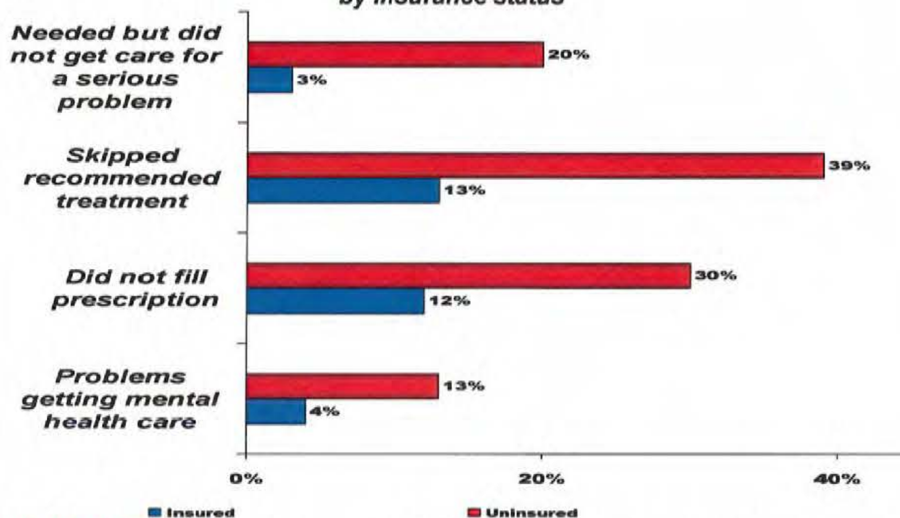
## Being uninsured has significant consequences

***Percent of adults (ages 19-64 years) experiencing barriers to care, by insurance status***




Insured   Uninsured

Kaiser Commission on Medicaid and the Uninsured. The Uninsured and their Access to Care, 2000.

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## Even with our system of emergency and hospital charity care, there are consequences to being uninsured

- Risk of death among uninsured people ages 50-64 is 43% higher (even after risk and income adjustment). *Health Affairs July 2004*
- Uninsured people with cancer spend about 2.5 times more out of pocket and receive about half the care that those with private coverage receive. *Health Affairs April 2004*
- Even after an auto accident with major trauma, the uninsured receive 20% less care and have a higher mortality rate compared to patients with insurance. *MIT Sloan School of Management study Dec 2002*

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## Many Maine people rely on health insurance coverage through public programs: Medicare & MaineCare (Medicaid)

**Medicare** is a ***federally funded*** program with **no** state contribution or management.

- Medicare covers persons ≥ 65 years, and other select groups, such as individuals with disabling conditions, renal dialysis costs and others.
- As a federal program, payment, policy and program regulation are federal responsibilities.

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## MaineCare (Medicaid) provides coverage for 1 out of every 5 Mainers

- Jointly funded by the state and federal government.
- The federal government establishes minimum requirements and the state has flexibility in determining eligibility, program structure, and payment for services.
  - Under Medicaid certain groups must be covered and states can expand beyond the federally-specified minimums. Medicaid is a *means-tested* program (targeting low income people).
  - Certain medical care must be covered but states can add services.
- Nationally and within Maine, Medicaid is the largest public payer of long term care and disability services.

- Medicaid (MaineCare) brings in federal matching payments so that for every $1.00 spent on MaineCare beneficiaries:
  - Maine spends 36¢
  - The federal government spends 64¢

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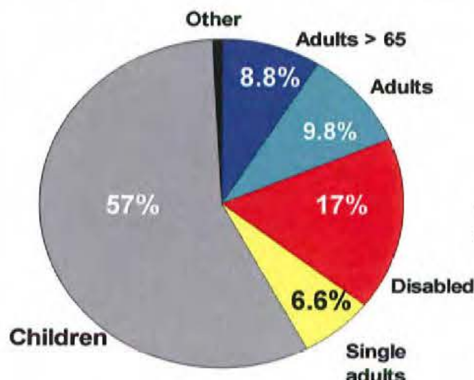
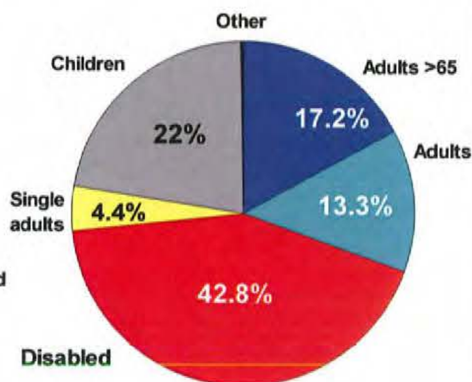
## Medicaid (MaineCare) enrollment and combined federal and state expenditures (FY 2008)

**ENROLLMENT (Average monthly)**




**EXPENDITURES**




Source: ME Department of Health & Human Services / MaineCare

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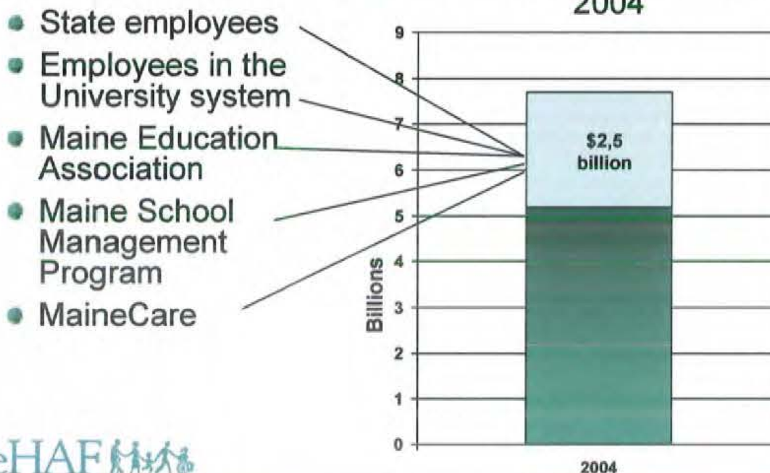
## However, publicly-funded coverage in Maine includes many other groups that together drive a large proportion of our health care expenditures

- State employees
- Employees in the University system
- Maine Education Association
- Maine School Management Program
- MaineCare



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## COST: Why is health care so costly in Maine?

- Inefficient, costly care for the uninsured
- Significant cost shifting
  - Uncompensated care for the uninsured
  - Inadequate government reimbursement
- Rural, older population
- Poor health status with high rates of chronic disease
- Advances in medical technology and costly new treatments
- Rising demand for services
- Higher provider costs with consolidation and shortages
- Inconsistent quality
- Poor information
- Mandates

## Inefficient, Costly Care for Those Who Are Uninsured

- Individuals who are uninsured still receive medical care, but pay for their care out of pocket, or receive uncompensated ("charity") care from facilities.
- Because health care costs are borne out of pocket, the uninsured are less likely to receive preventive services, and delay seeking care until advanced stages of illness.
- This "inefficient" way of addressing health needs increases the cost of care.

***In 2005, Maine's hospitals provided $77 million in charity care and incurred $126 million in bad debt that were then "shifted" to other premium payers.***

## Cost shifting: Inadequate Government Reimbursement

- **The Maine Hospital Association estimates that for every dollar spent rendering care to Medicare beneficiaries, hospitals receive $0.85 in reimbursement.**
- **The Maine Hospital Association estimates that for every dollar spent rendering care to Medicaid beneficiaries, hospitals receive $0.76 in reimbursement.**

*These shortfalls contribute to higher insurance costs for other recipients through cost-shifting.*

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## Mainer's Health Behaviors and Lifestyle Drive the High Cost of Care

- Nearly 40% of health care spending increases are caused by five largely preventable diseases:*
  - Cardiovascular disease
  - Cancer
  - Chronic lung disease
  - Diabetes
  - Mental health
- In Maine, 75% of residents die from the four leading preventable chronic diseases
- Maine leads the nation in smoking, poor nutrition, and inactivity – all factors that contribute to chronic disease
  - 55% of adults are overweight
  - 38% of teens and 76% of adults do not exercise
  - Tobacco addiction is well above national average
  - High school substance abuse rate is higher than national average

*Source: Thorpe, KE, et al. *Which Medical Conditions Account for the Rise in Health Care Spending?*. Health Affairs Web Exclusive, Aug, 2004.

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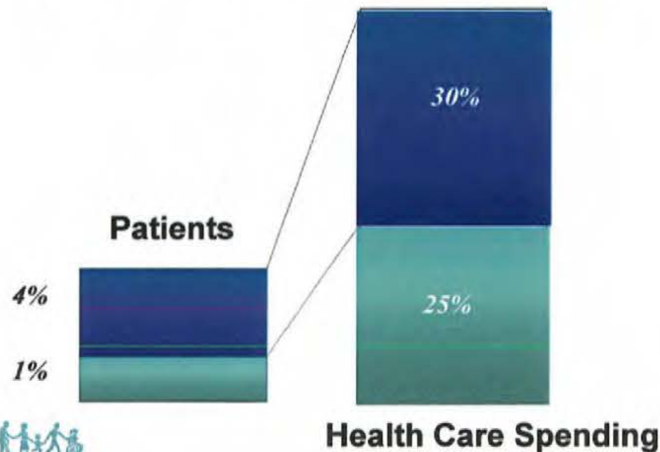
## The greatest proportion of health care costs come from those with significant chronic illness

***In our health care system a small proportion of patients account for the majority of health care cost***

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## Advances in Technology and Drugs Also Drive the High Cost of Care

**Major drivers of costs from national data:**

- **Drugs, advanced medical devices and care**
- **Provider costs**
- **Consumer demand**

**Drivers of health care costs (Maine data):**

- **High rates of chronic illness**
- **Hospital care is a large driver of expenditures:**
  - **Highest # of inpatient hospital days/1,000 in NE (ME hospital admissions 30% > NH and 35%> VT)**
  - **High hospital inpatient costs (6th highest cost per wage and case-mix adjusted discharge in the US)**
  - **Maine had the most surgeries/1000 population in New England**
- **Pharmaceuticals**

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## QUALITY: Inconsistent quality fuels higher health care cost

- Midwest Business Group on Health estimates that administrative inefficiencies and the overuse, underuse and misuse of medical services wastes **$0.30** of every health care dollar.
- National studies show that nearly 1/3 of Medicare spending goes to services that do not help people improve their health.

*JE Wennberg, Variations in Use of Medicare Services; Commonwealth Fund, December 2005.*

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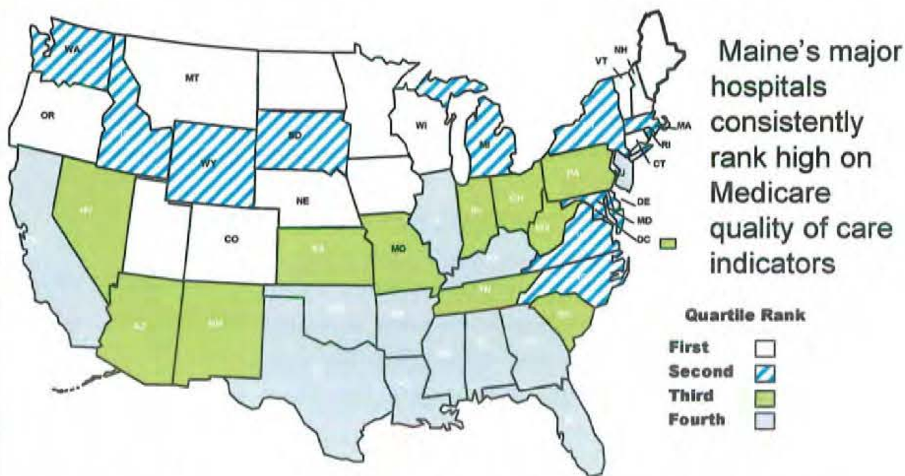
## Maine does fare well on national measures of quality of care

**(rankings based on 22 Medicare performance measures: 2000-2001)**




Maine's major hospitals consistently rank high on Medicare quality of care indicators

Source: S.F. Jencks, E.D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (Jan. 15, 2003): 305–312.

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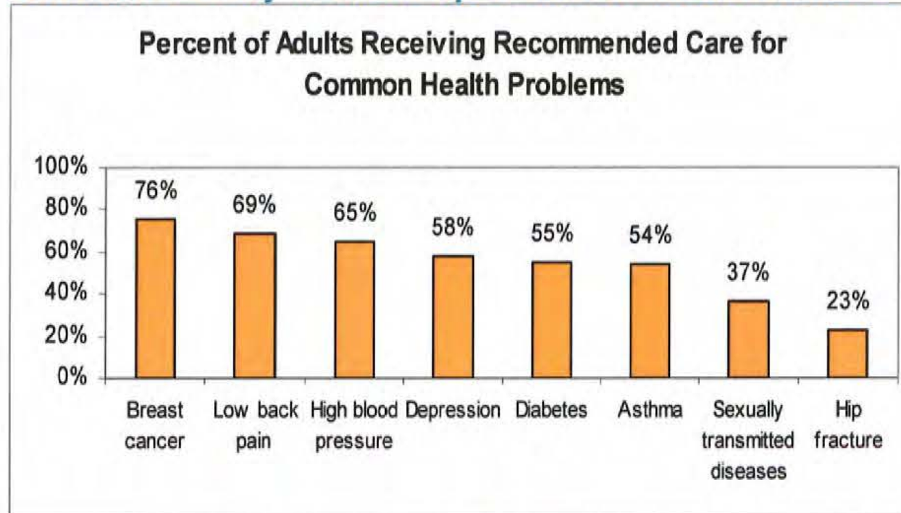
## Too often our health care system fails to render care recommended by medical experts for common conditions



Source: McGlynn, et al., *The Quality of Health Care Delivered to Adults in the United States.* New England Journal of Medicine, June 26, 2003.

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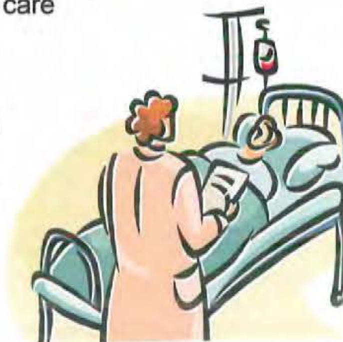
## We don't always get the right care – and care doesn't always improve health

- National studies of regional variations in medical practice showed that 2002 per capita Medicare spending was $10,550 in Manhattan compared to $4,823 in Portland (OR).
  - Medicare enrollees in NY spent more than twice as much time in the hospital and had twice as many doctor visits
  - Additional cost did not result in better care or greater satisfaction
- Quality and safety were worse in regions where Medicare spending was greatest with death rates 2-5% higher in regions spending more.



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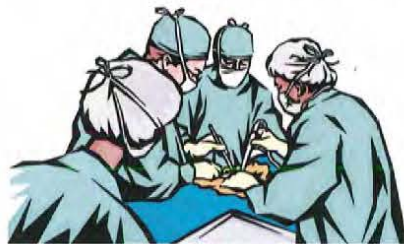
## Example: Controlled trial of arthroscopic surgery for arthritis of the knee

- Common surgical procedure for knee pain relief
- Randomized placebo-controlled clinical trial to test effectiveness
- Intervention group did NOT differ from placebo group in residual pain, better function



*Each year there are 650,000 arthroscopic knee surgeries at a cost of about $5,000 each for a total of $3 billion annually*

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Source: NEJM Vol 347, July 2002

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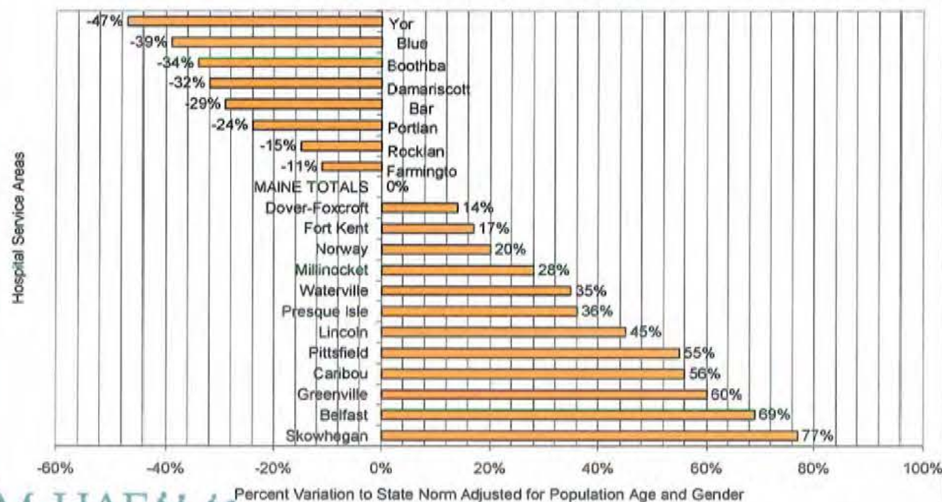
## Maine also has significant regional variations in medical practice that don't necessarily mean better quality of care

**Variation in Admission Rates for Hysterectomy (All Non-Cancer) by Hospital Service Area, Maine 2000-2004**

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## Maine also has significant regional variations in cost that don't necessarily reflect better quality

| Procedure | Low Charge | High Charge | % difference High/Low Charge |
|---|---|---|---|
| C-Section | $4,699 | $8,964 | 190% |
| Hysterectomy | $4,882 | $11,284 | 231% |
| Appendectomy without Peritonitis | $4,976 | $9,002 | 180% |
| Lap Chol | $5,687 | $15,108 | 265% |

Data adjusted for Case Mix Severity
Maine Health Information Center, "Maine Hospital Inpatient Surgical Performance Report," 12/02

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## Patients and families need access to better information to become engaged in care, make better decisions, and help with strategies for cost containment

- There is a lack of consumer information to guide making informed health care choices and balance this with consideration of the cost of care.
- Individuals also largely fail to link the role of their personal behavior in determining both health and health care costs.

*"I suppose the enemy is us, the American people. We want more medical technology, we want it in our community and we want it now."*

*-Drew Altman*

*President of the Kaiser Family Foundation*

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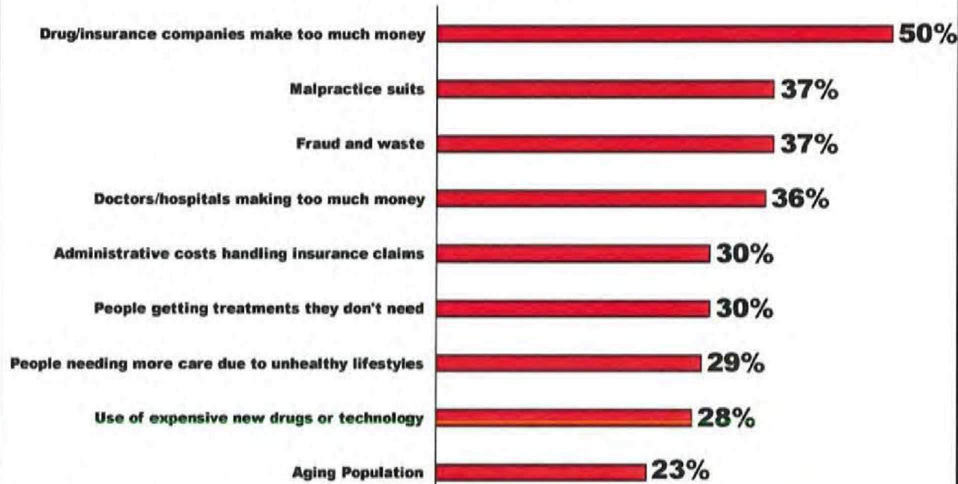
## Public Perception on the Factors Driving the Cost of Care

*Percent saying each is "one of the single biggest factors in rising health care costs"*




Source: ABC News/Kaiser Family Foundation/USA Today *Health Care in American Survey* conducted September 7-12, 2006

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## Legislative and Regulatory Requirements also add to the high cost of care

- Legislative and regulatory requirements placed on insurers and health benefit plans raise cost, particularly within the small group and individual market.
- The Maine Bureau of Insurance website lists all insurance mandates since 1975, and estimates the maximum cost as the % of premium for groups larger than 20 to be:
  - 8.52% for indemnity plans
  - 7.82% for HMO plans

*List of mandates can be obtained from http://www.maine.gov/pfr/legislative/documents/mandatecumcost2005.doc*

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## Insurance administrative cost also add to the high cost of care in Maine

- Nationally, in the private health care market, Americans spend close to 24 cents on every health care dollar on overhead.
- Private insurance administrative costs in Maine is approximately 12-15%.
- In publicly-funded systems, administrative costs are lower:
  - MaineCare's administrative cost is typically < 5%.
  - Estimates of Medicare administrative costs are approximately 2-3%.

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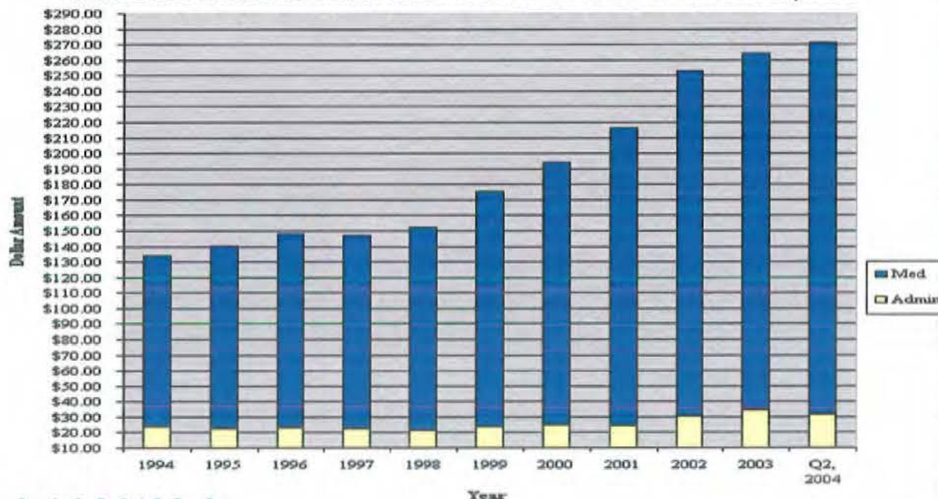
## The majority of insurance and premium expenditures pay for health care services

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## How can legislative leaders lead improvements in quality, safety, better patient engagement while controlling costs?

- Improve our focus on wellness and prevention for our communities – *make it part of every discussion.* We can't get in front of health care costs until we start preventing illness.
- Move into the 21st century with health information technology to arm patients with information, improve quality, and reduce medical errors and administrative waste.

- Improve quality by providing evidence-based information to doctors, nurses, hospitals, insurance companies, and employers about higher quality, more effective care.
- Stop paying for unnecessary care by developing consensus guidelines for necessary care.

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## How can health care leaders in Maine promote quality, safety, better patient engagement and contain costs?

- Bring down the silos between different care sectors (physical, mental, behavioral and oral health).
- Work with policy makers to make data-driven decisions.
- Put a moratorium on new mandates unless they are supported by science and are cost-effective.
- Educate patients and providers about using less expensive, yet equally effective care options. We should all work together to reduce the demand for services of marginal value.
- Work with the public so they can think ahead about the kind of care they want, particularly at the end of their lives.

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Bios/Contact Info

## POLICY LEADERS ACADEMY
## LEGISLATIVE POLICY FORUM ON HEALTH CARE – JANUARY 30, 2009
## Speaker, Moderator, Panelist & Writer Biographies

**ANN ACHESON, Research Associate, Margaret Chase Smith Policy Center, 5784 York Complex, #4, University of Maine, Orono, ME 04469-5715, ann.acheson@umit.maine.edu, 207-581-1567**
Ann Acheson is a research associate and Editor of *Maine Policy Review* at the Margaret Chase Smith Policy Center, University of Maine, and a faculty associate in the Anthropology Department. She received her Ph.D. in Anthropology from Cornell University, with a specialization in psychological anthropology. Dr. Acheson has over 30 years experience in applied social/behavioral science research and evaluation, which includes 14 years at Bangor Mental Health Institute and positions in the Maine Office of Substance Abuse in Augusta and at Community Health and Counseling Services in Bangor. Since coming to the Margaret Chase Smith Policy Center in 1999, she has worked on several major health and social service research and evaluation projects. Her recent work focuses on health and social policy, particularly poverty and substance abuse. She is the author of two reports produced under sponsorship from the Maine Community Action Association: *Poverty in Maine, 2003* and *Poverty in Maine, 2006*, as well as several articles on Maine poverty.

**GLENN BEAMER, Ph.D., Director, Margaret Chase Smith Policy Center, 5784 York Complex #4, University of Maine, Orono, ME 04469-5715, glenn.beamer@umit.maine.edu, 207-581-1646**
Dr. Glenn Beamer is Director of the Margaret Chase Smith Policy Center and Associate Professor of Political Science at the University of Maine. His research interests have focused on federalism, health politics, and income policy. Glenn Beamer's articles have appeared in the *Journal of Health Politics, Policy, and Law*, *State Politics & Policy Quarterly, PS: Political Science and Politics, Labor History*, and the *Review of Policy Research.* His first book, *Creative Politics: Taxes and Public Goods in a Federal System*, was published by the University of Michigan Press. He is currently writing a book manuscript, *From Welfare to Anywhere*, that investigates state income and health policy responses to federal devolution. He received the All-University Outstanding Teaching Award at the University of Virginia in 2001.

**WILLIAM H. BEARDSLEY, President & CEO, Husson University, One College Circle, Bangor, ME 04401, beardsleyw@husson.edu, 207-941-7138**
William H. Beardsley earned his Ph.D. at Johns Hopkins University. He has served as CEO of Husson University since 1987. Husson offers doctoral, masters and baccalaureate degrees to 3,000 students through schools of health, pharmacy, science and humanities, education, business and the New England School of Communications. Dr. Beardsley chairs the Maine Development Foundation, is a member and past chair of the Finance Authority of Maine and the Maine Higher Education Council. He served on the Board of Norumbega Medical Associates and was a member of the Blue Ribbon Task Force on Maine Healthcare Costs. He is past director of the Divisions of Finance and Economics and Energy and Power Development for the Department of Economic Development for the State of Alaska. He also served as a state planner and aide to the Governor of Vermont.

**JOHN R. BENOIT, President, Employee Benefits Solutions, 1085 Brighton Avenue, Portland, ME 04102, jbenoit@holdenagency.com, 207-775-3793**
John Benoit is President of Employee Benefits Solutions, Inc. (EBS), a subsidiary of the Holden Agency. As president of EBS, John provides support and advice to large and small employers with health, dental, disability, and life insurance employee benefit plans. John has worked in the insurance industry since 1984, primarily in the field of employee benefits. In 1994, John founded the Maine Health Management Coalition, a mixed model (purchaser and provider) coalition that has been the model for similar groups in other states. He also served as co-founder and past co-chair of the Maine Healthcare Purchasing Collaborative. He served as a member of the Governor's Health Action Team, which worked on the development of Dirigo Health. He is currently a member of the Chamber Purchasing Alliance Board of

Directors, as well as the Home Health (VNS) Board. He serves on the Broker Advisory Council for a number of health insurance carriers, and was a graduate of the first class of the Hanley Health Leadership Development Program in 2008. John is a graduate of Bowdoin College, and resides in Scarborough with his wife Holly and their three children.

**ELISE J. BOLDA, Ph.D., Associate Professor of Health Policy and Management, Muskie School, University of Southern Maine, PO Box 9300, Portland, ME 04104, elise.bolda@maine.edu, 207-780-4847**
Dr. Bolda has more than 30 years experience in national, state and local long term care program development, evaluation and policy analysis. She currently serves as the National Program Director for the Community Partnerships for Older Adults Program, a national initiative of the Robert Wood Johnson Foundation to help communities develop leadership, innovative solutions, and options to meet the needs of older adults over the long term. Elise has consulted with long term care policy makers in Maine, North Carolina, Georgia and West Virginia. Prior to her work bridging policy and research, Elise served as Long Term Care Planner for the State of Vermont bridging policy and working with vulnerable older adults in their own homes and in nursing homes. She co-founded 2 para-transit systems and Vermont's first adult day program working in partnership with community leaders, service providers and interested community residents. Dr. Bolda received her BA from the University of Vermont, and her M.S.P.H. and Ph.D. from the Department of Health Policy and Administration at the University of North Carolina at Chapel Hill, School of Public Health.

**SCOTT B. BULLOCK, CEO, MaineGeneral Health, 149 North Street, Waterville, ME 04901, sbullock@mainegeneral.org, 207-872-1600**
Since 1999, Mr. Bullock has been the President and CEO of MaineGeneral Health--an integrated healthcare system that includes a 288-bed acute care hospital on three campuses, three nursing facilities with 269 long-term care beds, physician practice corporation with over 40 FTE physicians, home care company, and retirement community. Mr. Bullock led the merger of Mid-Maine Health Systems and Kennebec Health System to form MaineGeneral Health/MaineGeneral Medical Center on July 1, 1997 which formed Maine's third largest health system with $350 million in net revenue and 3,800 employees. Mr. Bullock developed the $44 million Harold Alfond Center for Cancer Care which opened in July 2007 and completed $16.2 million capital campaign; completed multiple renovation and expansion programs; developed strategic affiliation with MaineHealth/Maine Medical Center, including cardiology program with joint venture cath lab; installed progressive IT systems including ambulatory EMR with 43,000 patient records, PACS, and Eclipsys SCM/KBC with CPOE; formed Kennebec Region Health Alliance, a 220 member Physician Hospital Organization which negotiates managed care contracts and provides chronic disease management services; supported improvements in quality and patient safety through balanced scorecard; participation in Maine Quality Forum, Maine Health Management Coalition, and Institute for Healthcare Improvement initiatives. Mr. Bullock received his Bachelor's degree and Master of Health Administration from Duke University.

**JIM CLAIR, CEO, Goold Health Systems, Inc., PO Box 1090, Augusta, ME 04332, jclair@ghsinc.com, 207-622-7153**
Mr. Clair's career spans over 25 years, split between managing privately-held companies, mostly in the healthcare space, and the public sector. Over this time he has worked in a variety of managerial roles, presently as the CEO of a rapidly-growing and privately-held firm headquartered in Augusta, Maine. Mr. Clair currently serves as Chief Executive Officer of Goold Health Systems, a healthcare management company with offices in Augusta, Maine, Des Moines, Iowa and Cheyenne, Wyoming (2009). He is responsible for all day-to-day operations, along with all strategic and tactical business issues. The company doubled in size within the last five years, and now has a significant footprint as a healthcare

business process outsourcing vendor, primarily in the State Medicaid Pharmacy space. Goold was recognized in 2007 by INC Magazine by naming the firm one of its 5,000 fastest-growing, privately-held firms. Mr. Clair has focused particularly on refining GHS' project management approach, enhancing its application development process, maximizing operational efficiencies and increasing its business development capacity. Prior to joining GHS, Mr. Clair accumulated over seventeen years of public sector experience with his previous employer, the Maine State Legislature. Serving on the non-partisan staff during his entire tenure, Mr. Clair focused on fiscal matters, having served as the chief-of-staff for the Joint Standing Committee on Appropriations and Financial Affairs, then Director of the Office of Fiscal and Program Review. He culminated his tenure at the State House as the Executive Director of the Legislative Council, serving in effect as the COO for major administrative duties, including one phase of a major renovation to the historic Capitol building. He also currently serves as the President of Goold Health Analytics, LLC, a sister company to GHS that provides clinical and project consulting services in the healthcare space. Mr. Clair is also Partner in a small private equity/management company based in Maine. Mr. Clair holds a Master of Public Administration degree from Syracuse University, a Master of Science degree from the State University of New York and a Bachelor of Science degree from the University of Massachusetts.

**ANDREW F. COBURN, Ph.D., Professor/Dir., Inst. for Health Policy, University of Southern Maine, PO Box 9300, Muskie School of Public Service, Portland, ME 04104-9300, andyc@usm.maine.edu**
Andrew Coburn is Professor of Health Policy and Management, Director of the Institute for Health Policy. His research and teaching address the national and state-level problems of health insurance coverage, health care access and utilization. He is also a national expert on rural health having testified many times in Washington on rural health issues. He recently served on the Institute of Medicine's, Committee on the Future of Rural Health Care. Dr. Coburn holds undergraduate and graduate degrees from Brown, Harvard and Brandeis Universities.

**DEVORE S. CULVER, Executive Director, HealthInfoNet, P.O. Box 360, Manchester, ME 04351-0360, dculver@hinfonet.org, 207-430-0676**
Dev Culver is the Executive Director and Chief Executive Officer for Maine's HealthInfoNet, a public-private partnership of providers, employers, consumers, payers and state government tasked with building the state's health information exchange (HIE). In providing overall leadership of one of the nation's first statewide health information-sharing networks, Mr. Culver is responsible for strategic planning, business planning, system design, operations, government relations, vendor negotiations and fund raising. Prior to HealthInfoNet, Mr. Culver served as CIO for Eastern Maine Healthcare, a seven-hospital integrated delivery network (IDN). During his 16-year tenure, he implemented new technology to enhance access to clinical data and medical records, and reduced medication errors and associated costs through the development of clinical decision-support, medication order and administration management systems. In 2004, Mr. Culver joined Eclipsys Corporation and then later Cerner Corporation in senior management positions responsible for the installation of advanced clinical information systems and the delivery of consulting services to healthcare clients in a multi-state region. Mr. Culver is one of Maine's most experienced health information technology leaders, and has served on the State's Information Systems Advisory Board and was co-chair of the Governor's Task Force on Telemedicine. At the national level, Dev is currently serving on the CCHIT task force on health information exchange networks, and the AHIMA State Level Health Information Exchange Steering Committee. These two initiatives are funded by ONC (the federal Office of the National Coordinator of Health Information Technology). Mr. Culver graduated from Brown University and holds a Masters in Management from Northwestern University.

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**JOSHUA CUTLER, M.D., Director, Maine Quality Forum, 53 State House Station, Augusta, ME 04333, josh.cutler@maine.gov, 207-287-9900**

Josh Cutler is director of the Dirigo Health Agency's Maine Quality Forum. The tasks of the Maine Quality Forum include measuring and reporting on health care quality, facilitating quality improvement and promoting best practices, and advancing the adoption of electronic health information systems. A native of Bangor, Dr. Cutler practiced interventional cardiology for nearly thirty years in Washington, D.C., and Portland, Maine. He is a founding board member and past president of the Maine Heart Center, a physician-hospital partnership for the provision of inpatient cardiac services involving several practices and hospitals in southern and central Maine. He was a member of the Cardiology Study Group of the Maine Medical Assessment Foundation, Dirigo Health's Commission to Study Maine's Hospitals, and is currently a member of the Advisory Council on Health Systems Development, an advisory group to inform development of Maine's State Health Plan. He is a graduate of Harvard College and Duke University School of Medicine and is board certified in internal medicine, cardiology, and interventional cardiology.

**WESLEY R. DAVIDSON, M.S., CSW_IP, CEO, Aroostook Mental Health Center, PO Box 1018, Caribou, ME 04736-1723, wdavidson@amhc.org, 207-498-6431**

Mr. Davidson is currently Chief Executive Officer of Aroostook Mental Health Services, Inc. (dba AMHC). His professional experience spans 37 years of active involvement in the development and delivery of community based mental health and substance abuse services in rural settings. Mr. Davidson is currently an active member in the International Initiative for Mental Health Leadership (IIMHL); and serves on the Board of Directors for the Mental Health Corporations of America (MHCA) and the Mental Health Risk Retention Group, Inc. (MHRRG). He is also active in a number of state organizations such as the Maine Health Access Foundation, Maine Association of Mental Health Services (MAMHS), and the Maine Association of Substance Abuse Programs (MASAP) all of which play significant roles in supporting the development and delivery or behavioral health services.

**NORMAN M. DINERMAN, MD, FACEP, Medical Director, LifeFlight of Maine, PO Box 811, Bangor, ME 04401, ndinerman@emh.org, 207-973-8005**

Dr. Dinerman is the Medical Director of the Access Management System, and the Medical Director of the Critical Care Transport Medicine System at Eastern Maine Medical Center. In these positions, he provides medical oversight of the system for transfer of patients to Eastern Maine Medical Center, as well as the statewide LifeFlight of Maine air and ground critical care transport teams, the MedComm Communications Center, and Capital Ambulance. He is an active participant in national, local and statewide activities which bear upon "peri-hospital" care of patients. He continues to practice clinically as an emergency medicine physician in the Department of Emergency Medicine at Eastern Maine Medical Center. Dr. Dinerman served as the Chief of the Emergency Medicine Service at Eastern Maine Medical Center for eighteen years, completing his tenure in this position on Oct. 31, 2006. From June 1992 to June 1996 he served as the State EMS Medical Director for Maine. From March 1979 until October 1988 he served as the Associate Director, Department of Emergency Medicine, Denver General Hospital, Denver, Colorado, as well as the Director and Physician Advisor for the Paramedic Division for the Denver Department of Health and Hospitals and Physician Advisor to the Denver Fire Department. During the same period he served as the Agency Disaster Coordinator for the Denver Department of Health and Hospitals. He is a former member of the National Association of EMS Physicians where he served as the Chairman of the Legal Affairs Committee. He has served as a member of the EMS Technical Assistance Team for the National Highway Transportation Safety Administration on multiple occasions. He lectured as a charter faculty member of the National EMS Medical Directors' Course and Practicum for more than twelve years. Dr. Dinerman is a native of New York City and received his undergraduate education at Columbia University and his medical degree from Yale University. He

completed his internship and residency in Internal Medicine at the University of Colorado Health Sciences Center, Denver, Colorado. He is Board Certified in Internal Medicine and Emergency Medicine. He is the author of a number of articles on prehospital care and disaster medicine and has lectured extensively on these subjects. He has a deep and abiding interest in the academic, operational, and particularly, the political aspects of EMS systems in America. His personal motto remains "passion, creativity and irreverence in the service of evolution"…..

**ANTHONY L. FORGIONE, President/CEO, Seventy Five State Street, 75 State St., Portland, ME 04104, forgione@75state.org, 207-772-2675**
Anthony Forgione has been a licensed health care administrator since 1978. He is currently president/CEO of Seventy Five State Street, a 159 unit not for profit assisted and independent living community in Portland. Previously he has served as Director of Health & Human Services for the City of Portland, Administrator of the Barron Center and Administrator of Portland City Hospital. He developed Maine's first facility based adult day program, drafted successful legislation to fund adult day services, developed one of the nation's first dementia care units and launched an innovative independent housing with services model program. Forgione is Board Chair of Home Health Visiting Nurses, past president of Maine Health Care Association and a corporator at MaineHealth. He has developed and taught courses in long term care policy and administration at Saint Joseph's College and has been appointed by the Governor and the Legislature to numerous health care commissions. Forgione graduated from Deering High School in Portland and received a BS in Economics and a BS in Business Administration from the University of Maine. He holds a certificate in Long Term Care Administration from George Washington University. Tony and his wife Nancy live in Ocean Park, Maine. He believes that the best part of any endeavor is enjoying the people with which you work and achieving goals together.

**LESLIE A. FORSTADT, Child and Family Development Specialist, University of Maine Cooperative Extension, 5717 Corbett Hall, Orono, ME 04469, lforstadt@umext.maine.edu, 207-581-3487**
Leslie Forstadt, Ph.D. is the Child and Family Development Specialist with the University of Maine Cooperative Extension (UMaine Extension) and a research fellow with the Margaret Chase Smith Policy Center. Her primary work supports UMaine Extension in statewide education, providing research-based opportunities that include parent home visiting, parenting classes, and health and safety information. Leslie is a guest co-editor of an upcoming issue of Maine Policy Review focused on early childhood. Since completing her doctorate from the University of Iowa in 2006, she has focused her work on investment in children 0-3 from an educational, health, research, and policy perspective.

**KIMBERLEY FOX, Senior Policy Analyst, Muskie School of Public Service, University of Southern Maine, USM Wishcamper Center, 34 Bedford St, P.O. Box 9300, Portland, ME 04104-9300, kfox@usm.maine.edu, 207-899-0783**
Kim Fox is a Senior Policy Analyst at the Muskie School of Public Service of the University of Southern Maine where she currently leads research on Medicaid policy issues, health care reform, childhood obesity, and prescription drug access and medication management. She has nearly twenty years of experience in health services research and state health policy with particular focus on the dual-eligible population, state pharmacy assistance programs and Medicare Part D, and state health insurance coverage initiatives and their impact on access to care. Prior to joining the Muskie School, she worked at the Center for State Health Policy (CSHP) at Rutgers University and Baruch College of Public Affairs. She has extensive experience in health policy research and planning for at-risk populations, having served as Deputy Director of Planning at HIV CARE Services division of Medical and Health Research Association, Deputy Director of Policy Research at the Center on Addiction and Substance Abuse, and Senior Research Analyst at the United Hospital Fund of New York City. She received her Masters degree in Public Administration from the Maxwell School of Citizenship at Syracuse University.

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**JOHN A. GALE, Research Associate, Muskie School of Public Service, University of Southern Maine, Wishcamper Center 434, Portland ME 04104, jgale@usm.maine.edu, 207-228-8246**
John Gale is a Research Associate at the Maine Rural Health Research Center and the Institute for Health Policy at the University of Southern Maine. His research focuses on rural hospitals; behavioral health and primary care delivery systems; access, financing, and reimbursement issues; and the study of the health care safety net in rural communities. Mr. Gale has been a member of the evaluation team for the Medicare Rural Hospital Flexibility Program since its inception. He serves on the boards of the National Association for Rural Mental Health and the New England Rural Health Roundtable as well as the Policy Congress of the National Rural Health Association. He is participating in the steering committee for the national Rural Health Clinic Technical Assistance Project and the Primary Care Access Advisory Committee for the Missouri Foundation for Health. Prior to joining the University, Mr. Gale served as a senior manager in health care organizations that included a large multi-disciplinary mental health and substance abuse treatment practice and a multi-site, multi-disciplinary academic primary care practice.

**BRENDA HARVEY, Commissioner, Dept. of Health & Human Services, 11 State House Station, Augusta, ME 04333, brenda.harvey@maine.gov, 207-287-4205**
Brenda M. Harvey, MSEd, CRC is the Commissioner of the Department of Health and Human Services. Prior to this appointment in April, 2006, she served as Acting Commissioner for four months. Harvey was the DHHS Deputy Commissioner, Integrated Services for the previous 18 months and her background in public service is rich. She rose through the ranks at the former Department of Behavioral and Developmental Services (BDS), moving from Director of the Office of Program Development to Deputy Commissioner to Acting Commissioner leading that Department in the merger with DHS. Prior to her decision to join state government, she was employed by Maine Medical Center where she managed a department and several large multi-site federally funded projects. Harvey received the William Twarog Manager of the Year Award in 2001, which is considered the state's highest management distinction, as well as a Governor's Teamwork Award. She served as the Chair of Governor McKernan's Mental Health Advisory Council and as the principle investigator of federal grants to implement evidence-based services in the mental health system and another that focused on the transition of youth with severe emotional disturbances. A published author and national presenter, Harvey served as the Commissioner Advisor to the Older Persons Group in the National Association of State Mental Health Program Directors and was a national delegate to the Association of Persons in Supported Employment. She is currently the Principle Investigator for a CMS Real Choices Grant to restructure service delivery systems for DHHS clients. Commissioner Harvey is a graduate of the University of Maine and earned her MSEd in Rehabilitation at the University of Southern Maine. She's a graduate of Leadership Maine (Theta Class) and a faculty member for the Maine Management Institute. She is the proud parent of a college student and a springer spaniel dog named Molly.

**M. MICHELLE HOOD, President & CEO, Eastern Maine Healthcare Systems, 43 Whiting Hill Road, Brewer, ME 04412, mhood@emh.org, 207-973-7045**
Michelle Hood became the President and CEO of Eastern Maine Healthcare Systems in April 2006, coming to Maine from Billings, Montana where she was President and CEO of the Sisters of Charity of Leavenworth Health Systems, Montana Region, as well as the President and CEO of its flagship hospital, St. Vincent Healthcare. Michelle received her Bachelor of Science in 1978 at Purdue University and her Master of Health Care Administration at Georgia State University in 1981. Her early career included roles of Associate Hospital Director at Emory University Hospital in Atlanta, Georgia, Executive Vice President and Chief Operating Officer of St. Vincent's Hospital in Birmingham, Alabama, and Chief Administrative Officer of Norton Hospital in Louisville, Kentucky. With responsibility to more than 7,800 EMHS employees and a quarter of a million citizens, Michelle's primary function is to provide vision – vision that anticipates both advances and obstacles in the complicated and ever-changing

landscape of healthcare. Her eye must be on development at the national level and in their very specific application to a vast, rural, and sparsely populated state. With her eye on the horizon, she must ensure secure employment for those thousands of EMHS employees who, in turn, provide access to current, high quality, specialty-level care for the people of Maine. Michelle is helping to strengthen Maine's ability to provide the best possible healthcare to everyone in need by recognizing opportunities to capitalize on existing resources, finding ways to fill resource gaps, making connections, and building creative partnerships that work for Maine communities. Michelle and husband, Russell, have two grown children.

**DAVID H. HOWES, MD, President & CMO of Portland, Martin's Point Health Care, P.O. Box 9746, Portland, Maine 04104-5040, president@martinspoint.org, 207-791-3710**
As President and Chief Medical Officer, David H. Howes, MD, has led the Portland based Martin's Point Health Care since 1996. Martin's Point a nonprofit health care organization offering both direct care in Maine and New Hampshire and health plan services in Maine, New Hampshire, Vermont and New York. Dr. Howes also is widely recognized for his leadership role in advancing the principle that to improve health care in the United States we must begin with a reemphasis on the delivery of primary care. He is a founding board member of Maine HealthInfoNet, serves on the board of the Maine Health Management Coalition, and recently joined the board of directors for the Maine State Chamber of Commerce. Dr. Howes received his medical degree from Dartmouth Medical School in Hanover, NH. After completing his residency, Dr. Howes began his medical career as a family physician serving the residents of a fishing community along the Maine coast. He joined Martin's Point in 1989 as Unit Medical Director in Bath, ME. He is Board Certified in Family Practice

**LENARD W. KAYE, Director and Professor, University of Maine Center on Aging and School of Social Work, 25 Texas Avenue, Camden Hall, Bangor, ME 04401, len.kaye@umit.maine.edu, 207-262-7922**
Lenard W. Kaye, D.S.W./Ph.D. is Professor of Social Work at the University of Maine School of Social Work and Director of the UMaine Center on Aging. A prolific researcher and writer in the fields of gerontology and geriatrics, he has published extensively on specialized topics in aging and health including home delivered services, productive aging, rural practice, family care giving, controversial issues in aging, support groups for older women, issues facing older men, and congregate housing. His research and writing on older men's care giving experiences and help-seeking behaviors, is widely recognized and frequently cited. Dr. Kaye recently served on the National Advisory Committee for Rural Health and Human Services of the U.S. Department of Health and Human Service as well as the advisory boards of a wide range of national and local health and human service programs serving older adults. He is President of the Maine Gerontological Society, sits on the editorial boards of the Journal of Gerontological Social Work and Geriatric Care Management Journal, and is a Fellow of the Gerontological Society of America. He is the principal investigator of the U.S. EPA-funded Safe Medicine Disposal for ME program.

**NEVA KAYE, Senior Program Director, National Academy for State Health Policy, 50 Monument Square, Portland, ME 04101, nkaye@nashp.org, 207-874-6524**
Neva Kaye is a Senior Program Director at the National Academy for State Health Policy (NASHP). She has 24 years of experience in state health policy. Neva joined NASHP in 1994 as director of the organization's Medicaid Resource Center. In her current position, she manages major programs on Medicaid, directs the Assuring Better Child Health and Development (ABCD) program, and is leading a project to identify the polices and strategies that states can use to advance medical homes. She provides technical assistance to states in such areas as children's health, purchasing, quality improvement, eligibility, and reimbursement strategies. Before joining NASHP, Neva served as director of Wisconsin's

Medicaid managed care program. Neva is the primary author of NASHP's report, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs.* Neva holds a BS in industrial engineering and psychology from the University of Wisconsin.

**NANCY KELLEHER, State Director, AARP Maine, 1685 Congress Street, Portland, ME 04102, nkelleher@aarp.org, 207-776-6304**

Nancy B. Kelleher is the AARP State Director for Maine. For the past four years, Nancy was the Associate State Director for Advocacy, spearheading legislative efforts to provide protection for Mainers on issues such as access to affordable health care and prescription drugs, predatory lending and homeowner protections, funding for home care services and repeal of the older worker penalty. Kelleher works on behalf of the 240,000 AARP members in Maine for greater access to affordable health care, financial security and opportunities for all who want to make the second 50 years of their lives as exciting as the first 50. Prior to AARP, she was Senior Director for Advocacy and Communications on behalf of Sweetser, a provider of mental health services to 20,000 children and adults across the State. Nancy also worked in the Speaker's Office of the House of Representatives where she handled administrative and policy issues for three Speakers. In the 119th Legislative Session she was named the Chief of Staff for Speaker Steven Rowe of Portland. Nancy has also worked in a number of other non profits organizations in either management or advocacy positions. She has served on several state positions including the Deputy Secretary of State for Corporations, Elections & Commissions for Dan Gwadosky, the former Secretary of State and as Director of the Division of Community Services, a cabinet level position under Governor Joseph E. Brennan. Nancy serves on the Elder Abuse Task Force of Maine, the Stakeholders Group on HealthINFO Net, the Advisory Committee for University of New England's Geriatric Education Center, the Elder Issues Partnership, and the Aligning Forces for Quality Project. She also volunteers and serves as President of the Scarborough Public Library Board of Trustees. She has served in a variety of volunteer capacities for groups dealing with women and families and housing issues. In 2002 she was named a YWCA Woman of Achievement. She and her husband Edward live in Scarborough, Maine. They are the proud grandparents of four.

**ELIZABETH KILBRETH, Associate Research Professor, Muskie School of Public Service, University of Southern Maine, PO Box 9300, Portland Maine, 04104, bethk@usm.maine.edu, 207-780-4467**

Elizabeth Kilbreth, Ph.D., is a research professor and Senior Research Associate at the Muskie School of Public Service, University of Southern Maine. She teaches public policy and health politics within the Muskie School's Health Policy and Management masters degree program. For much of the past 20 years, she has focused her research on analysis and evaluation of organizational and financial strategies to assure access to appropriate health care. Most of her work has focused on state health policy reform. Currently, Beth is the lead investigator of a study of health reforms in Maine, Massachusetts and Vermont which will assess the impact of the programs on reducing rates of uninsurance and will examine the numbers and types of services used by low-income program enrollees. She is also engaged in an analysis of Emergency Department use across the state of Maine.

**DENNIS P. KING, CEO, Spring Harbor Hospital/Maine Mental Health Partners 123 Andover Road, Westbrook, ME 04092, kingd@springharbor.org, 207-761-2202**

Dennis King is Chief Executive Officer of Spring Harbor Hospital in Westbrook, Maine, and Vice President of Behavioral Health for MaineHealth. Dennis was founding CEO of The Acadia Hospital in Bangor, ME. Among other responsibilities, Dennis is the past President of the National Association of Psychiatric Healthcare Systems (NAPHS), past Chair of the Maine Hospital Association, member of the AHA Section for Psychiatric & Substance Services Governing Council, and Chair of the Maine Community College System Board of Trustees. Mr. King is a member of the Gorham Savings Bank Board of Directors. All told, Dennis has more than 25 years experience in the mental health care field.

Spring Harbor Hospital was featured in the October 2003 issue of *American Governance Leader* magazine in the article "Bringing Patients and their Families onto the Governing Board: One Hospital's Success Story".

**KALA EVELYN LADENHEIM, Ph.D., 74 Old Brunswick Road, Gardiner, Maine 04345, drkala@roadrunner.com**
Kala Ladenheim is an independent Maine-based health policy expert DBA Maine Health Policy dot Info. Past significant leadership roles in Maine include President/CEO of the Maine Center for Public Health and Executive Director of the Maine Health Policy Advisory Council. Recent and current Maine projects include a study of the interplay of financing and public health infrastructure development in Maine, and a new MeHAF funded study of the return on investment for certain oral health services. For 15 years, Ladenheim worked with legislators and other state policymakers around the country, through positions at the Intergovernmental Health Policy Project at the George Washington University and as a Program Director for the Forum for State Health Policy Leadership at National Conference of State Legislatures (NCSL). Ladenheim specializes in state-level access and financing issues and the interplay of cost, access and quality: comprehensive health financing and system reforms; health care for the uninsured, insurance market reform, managed care, HIPAA, ERISA, risk pools, quality measurement and reporting initiatives, disparities and information technology. As director of NCSL's health information technology champions group (Project HITCh) she worked with state and federal policy groups around health information technology issues. She has produced a series of research reports on state experiments in insurance reform for small groups and individuals, including high risk pools. Other recent projects deal with quality, cost and disparities. These include *Managing Medicaid Costs: A Legislator's Tool Kit,* (2001); a review of state legislation related to racial disparities in coverage, care and access; a list serve for legislators about state policies for healthcare safety, quality and information technology; and a legislators' guide to monitoring effects of changes to Medicaid programs. Ladenheim has taught health policy at Johns Hopkins University, The George Washington University and other graduate and professional programs.

**DAVID LAMBERT, Associate Research Professor, University of Southern Maine, P.O. Box 9300, Muskie School of Public Service, Portland, ME 04104-9300, davidl@usm.maine.edu**
David Lambert, Ph.D., is an Associate Professor in the Health Policy and Management Program, Muskie School, University of Southern Maine where he teaches courses in health economics and mental health policy. Lambert has 20 years of experience conducting mental health services research at the local, state, and national levels. This work includes studiers on integrating primary care and mental health, dual diagnosis, recovery models, best practices of mental health managed care, implementing evidence based services, and the prevalence and consequence of substance abuse across rural areas. He currently serves on SAMHSA's National Advisory Work Group to Reduce Stigma in Mental Health and is Past-President of the National Association for Rural Mental Health.

**MARCIA LARKIN, Director, Community Support Dept. Penquis, P.O. Box 1162, Bangor, ME 04402-1162, mlarkin@penquis.org, 207-973-3691**
Marcia Larkin has spent seventeen years of her career employed by agencies that provide transportation services to the residents of Maine. Marcia began her tenure at Penquis in 1994 serving as a dispatcher in the transportation department. At Penquis, Marcia has held the position of lead dispatcher, dispatcher supervisor, and division manager. In 2004 Marcia was appointed to serve as the Director of the Community Support Department. The Community Support Departments offers transportation programs to residents who reside in Penobscot and Piscataquis Counties. In 2008 the Lynx provided or arranged 321,339 trips which accounts for 9,046,957 miles. Marcia also serves as the Director of the Foster Grandparent program serving 14 counties in the State of Maine, and the Retired and Senior Volunteer Program for Waldo, Lincoln and Knox Counties.

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**JENNIFER D. LENARDSON, Research Associate, Muskie School of Public Service, University of Southern Maine, Wishcamper Center 432B, Portland ME 04104, jlenardson@usm.maine.edu, 207-228-8399**
Jennifer Lenardson, M.H.S., is a Research Associate at the Muskie School of Public Service, conducting qualitative and quantitative research across health policy topics that include access to care for vulnerable populations, rural health, and health care financing and organization. She is a member of the Flex Monitoring Team, assembled to evaluate the performance of the Medicare Rural Hospital Flexibility Program. She has recently examined the availability of detoxification and substance abuse treatment services in rural areas and is currently examining health insurance coverage between urban, rural-adjacent, and rural, non-adjacent areas. Ms. Lenardson received her M.H.S. in Health Policy from the Johns Hopkins Bloomberg School of Public Health. Prior to her employment at the Muskie School, Ms. Lenardson was an analyst for the Project HOPE Center for Health Affairs.

**STEPHEN J. MEISTER, MD, Pediatrician, Edmund Ervin Pediatric Center, 271 Water Street, Augusta, ME 04330, stephen.meister@mainegeneral.org, 207-621-2304**
Stephen J. Meister, MD, is a pediatrician with the Edmund Ervin Pediatric Center in Augusta. A graduate of Tufts University School of Medicine in Boston, he served his internship and residency at The Children's Hospital of New York at Columbia Presbyterian Medical Center in New York City. He later was awarded a Masters in Health Management and Policy from The George Washington University. During his active duty in the US Navy, Dr. Meister directed an emergency department in a forward placement with the First Marine Division during the 1990-91 Gulf War, served as Division Head of the Pediatric Acute Care Clinic, and Teaching Staff Pediatrician at the Naval Medical Center in San Diego. He is a Diplomat of the American Board of Pediatrics, a Fellow of the American Academy of Pediatrics, an instructor in Pediatric Advanced Life Support, a member of the International Society for Stress Trauma Studies and a member of the Maine Medical Association. In 2003 and again in 2007, Dr. Meister received recognition by the American Academy of Pediatrics with a Special Achievement Award for his work with the Pediatric Rapid Evaluation Program, a program developed to evaluate the medical and mental health needs of children entering foster care in Maine. He is the author of presentations on the assessment of stress/trauma in children.

**DORA ANNE MILLS, MD, MPH, Director of the Maine CDC, Department of Health and Human Services, 11 State House Station, Augusta, ME 04333, dora.a.mills@maine.gov, 207-287-3270**
Dr. Dora Anne Mills is a native of Maine. She was raised in Farmington, graduating from Mt. Blue High School and Bowdoin College. Before returning to Maine in 1992, she graduated from the University of Vermont, College of Medicine, completed her internship and residency at the Children's Hospital of Los Angeles, and traveled and worked in Tanzania, Ivory Coast, Nepal, and India. While practicing pediatrics in her hometown in the early to mid 1990s, she commuted to Boston to earn a master of public health (MPH) from Harvard University. She was appointed to her current position in 1996. During her tenure as Maine's public health director, she has worked on various issues, including tobacco, obesity, infectious disease control, public health emergency preparedness, and public health infrastructure. She also has written a myriad of articles, including "Public Health and Foreign Policy", the featured article in the 2006 "*Bowdoin Forum Journal of International Affairs*", various articles for the *Maine Policy Review,* and op ed pieces for Maine newspapers. She has received the highest honors from the Maine Public Health

Association and the Maine Medical Association, as well as the prestigious Nathan Davis Award for Outstanding Government Service from the American Medical Association. She is married to Michael Fiori, has two young children, and enjoys skiing, hiking, and lake activities with them.

**GINO A. NALLI, Assistant Professor, Muskie School of Public Service, University of Southern Maine, P.O. Box 9300, Portland, ME, 04104-9300, gnalli@usm.maine.edu, 207-780-4237**
Gino Nalli, MPH is Assistant Research Professor and Chair of the Graduate Program in Health Policy and Management. He is also currently serving as Interim Director for the Institute of Health Policy at the Muskie School. Professor Nalli holds a BA from Binghamton University (1972) and an MPH from Yale University (1976). Professor Nalli developed Maine's first cost profile for Governor King's Year 2000 Blue Ribbon Commission on Health Care. He has consulted to the Maine Health Care Performance Council as well as the Governor's Office of Health Policy and Finance. He has also examined organizational and financing arrangements around tiered provider networks in different US locations. In 2002, he was awarded the USM Faculty Senate honor for excellence in teaching and the Henri Benoit Award for leadership in the private sector by the Portland Regional Chamber of Commerce. Current activities include working extensively with health care providers and purchasers in the development of a performance based reimbursement model. Prior to joining Muskie, Professor Nalli was a senior consultant with Watson Wyatt, an international actuarial and benefits consulting firm. Other experience includes president and chief operating officer of a regional health maintenance organization.

**TRISH RILEY, Director, Governor's Office of Health Policy & Finance, 15 State House Station, Augusta, ME 04333, trish.riley@maine.gov, 207-624-7442**
Trish Riley serves as Director of Governor Baldacci's Office of Health Policy and Finance leading his effort to develop a comprehensive, coordinated health system in Maine and to assure affordable health insurance for all Maine citizens. She was the principal architect of Dirigo Health Reform. Before joining the Baldacci Administration, Riley served as Executive Director of the National Academy for State Health Policy and President of its Corporate Board from 1989-2003. Previously, Riley held appointive positions under four Maine governors, including service directing the aging office, and directing Medicaid and state health agencies, including health planning and licensing and certification programs. Riley has published and presented widely about state health reform. She serves as a member of the Kaiser Commission on Medicaid and the Uninsured, and was a member of the Institute of Medicine's Subcommittee on Creating an External Environment for Quality. She also previously served as a member of the Board of Directors of the National Committee on Quality Assurance. Riley has served on Maine's Commission on Governmental Ethics, Maine's Commission on Children, the Board of Directors of the Mitchell Institute, established by Senator George Mitchell to advance the aspirations of Maine's youth, and, until December 2002, was a Board member of the Maine Health Access Foundation, Inc., created through a Blue Cross conversion. Riley holds a B.S. & M.S. from the University of Maine.

**DANIELLE N. RIPICH, Ph.D., President, University of New England, 11 Hills Beach Road, Biddeford, ME 04005-9526, dripich@une.edu, 207-620-2306**
Danielle N. Ripich, Ph.D., assumed the University of New England presidency July 1, 2006. Prior to coming to UNE, she was the dean of the College of Health Professions, Medical University of South Carolina (MUSC), where she was also a professor in the University's College of Medicine, Department of Neurology. She is internationally known for her language research. Dr. Ripich is UNE's fifth president. Under her leadership over the past two years, the university has seen substantial growth, as well as the construction of four new buildings, including the Pickus Center for Biomedical Research and the new College of Pharmacy. President Ripich is widely recognized for her work in child language and with Alzheimer's disease and other forms of dementia. She has written extensively in her field, including edited books, several book chapters, manuscripts in peer-reviewed journals, and has served as an editorial

consultant to numerous medical and language journals. Before becoming Dean at MUSC, President Ripich was chair of the Department of Communication Sciences and associate dean of the College of Arts and Sciences at Case Western Reserve University. President Ripich earned a Ph.D. in speech pathology from Kent State University. She also received bachelors and master's degrees in speech pathology from Cleveland State University. She has served in numerous professional association leadership positions. President Ripich has been the recipient of many honors awards and fellowships, including a Congressional Fellowship from the American Association for the Advancement of Science.

**DIANA SCULLY, M.S.W., Director, Office of Elder Services, Department of Health and Human Services, 11 State House Station, , Augusta, ME 04333, diana.scully@maine.gov, 207-287-9204**
Diana Scully returned to State Government in August 2004 after 17 years in the private sector. In January 2006, she was appointed Director of the Office of Elder Services in the newly merged Department of Health and Human Services. She oversees adult protective services, community services for older Mainers, and long-term care services. In 1989, Diana established Vantage Point, a Hallowell-based consulting firm, providing management services, governmental relations, grant-writing, facilitation/strategic planning and policy analysis to 60 public and private nonprofit organizations in Maine. Prior to 1989, Diana served as a nonpartisan legislative assistant at the Maine Legislature and in various positions in the former Department of Human Services (Director of Special Projects, Director of Welfare Employment and Director of the Bureau of Rehabilitation.) In the 1970s, Diana worked as a Research Assistant at the National Institute for Mental Health, a Policy Analyst at the National Conference of State Legislatures, and a Peace Corps Volunteer in the Philippines. She received a B.A. from Wellesley College in 1971 and an M.S.W. from the University of Michigan in 1974. Diana serves on the Board of Trustees of the Maine Health Access Foundation.

**JONATHAN SHENKIN, CEO, Pediatric Dentist, Penobscot Children's Dentistry Associates, 792 Stillwater Avenue, Bangor, ME 04401, jshenkin@aol.com, 207-947-6733**
Jonathan Shenkin, President-elect, Maine Dental Association. Jonathan Shenkin, DDS, MPH is currently the President-elect of the Maine Dental Association and a pediatric dentist in Bangor. He also serves as an Assistant Clinical Professor of Health Policy, Health Services Research and Pediatric Dentistry at Boston University. As well, he is an Adjunct Assistant Professor of Public Administration at the University of Maine. Dr. Shenkin received his dental degree from Columbia University, and his Master of Public Health degree and a Certificate in Health Care Finance from the Johns Hopkins University. His pediatric dentistry residency was completed at the University of Iowa, and he completed a dental public health residency at the National Institutes of Health (NIH). Dr. Shenkin has a varied history of advocacy for children, most notably in Maine for spearheading a campaign in Bangor to ban smoking in cars when children are present. He also served on the Maine legislatures Commission to Study Public Health. Dr. Shenkin has authored several studies, and has collaborated with both the NIH and the Centers for Disease Control. Dr. Shenkin has received multiple national and state awards and honors for his advocacy, research and publications.

**MARCELLA SORG, Research Associate, Margaret Chase Smith Policy Center, 5784 York Complex #4, Orono, ME 04469-5784; marcella_sorg@umit.maine.edu, 207-581-2596**
Dr. Sorg is a medical and forensic anthropologist specializing in health policy, particularly as it concerns public health, public safety, and the investigation of death and injury. Dr. Sorg directs the Center's Rural Drug and Alcohol Research Program. She is a board-certified forensic anthropologist, serving northern New England states since 1977.

## POLICY LEADERS ACADEMY
## LEGISLATIVE POLICY FORUM ON HEALTH CARE – JANUARY 30, 2009
## Speaker, Moderator, Panelist & Writer Biographies

**ERIK N. STEELE, D.O., Vice President and Chief Medical Officer, Eastern Maine Healthcare Systems, 895 Union Street, Suite 12, Bangor, ME 04401, esteele@emh.org, 207-973-7931**
Erik N. Steele, D.O., is a physician practicing family medicine and emergency medicine in several eastern Maine area hospitals. He has been the Vice President and Chief Medical Officer for Eastern Maine Healthcare Systems since January, 2005. Because of his strong belief in the value of an educated health consumer, Dr. Steele is a regular columnist in the Bangor Daily News, writing columns that often focus on issues of healthcare cost and quality. He also appears on WABI TV's *Healthy Living* as a health consultant, focusing on important health issues that concern you and your family. He is Co-chair of the Maine Governor's Council on Physical Activity.

**ALAN WEIL, Executive Director, National Academy for State Health Policy, 1233 20th St., NW, Ste. 303, Washington, DC 20036, aweil@nashp.org, 202-903-0101**
Alan Weil has been executive director of the National Academy for State Health Policy (NASHP) since September 1, 2004. NASHP is a non-partisan, non-profit organization, with a mission of helping states achieve excellence in health policy and practice. NASHP has a staff of 32 with offices in Portland, Maine and Washington, DC. Before coming to NASHP, Alan Weil was the director of the Assessing the New Federalism (ANF) project at the Urban Institute. One of the largest privately funded social policy research projects ever undertaken in the United States, ANF monitors, describes and assesses the effects of changes in federal and state health, welfare, and social services programs. Mr. Weil was formerly the executive director of the Colorado Department of Health Care Policy and Financing. This cabinet position is responsible for Colorado's Medicaid and Medically Indigent programs, health data collection and analysis functions, health policy development, and health care reform. Mr. Weil is the editor, with colleagues, of two books: Welfare Reform: The Next Act and Federalism and Health Policy. He has authored chapters in a number of books and published articles in a variety of peer-reviewed journals. He is a frequent speaker on Medicaid, welfare reform, and federalism. Mr. Weil was an appointed member of President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which drafted the patient's bill of rights. He is a member of the Kaiser Commission on Medicaid and the Uninsured and the Commonwealth Fund Commission on a High Performance Health System. He is a member of the editorial boards of Health Affairs, and State Health Watch, and is a member of the board of directors of the National Public Health and Hospitals Institute. He serves on the National Advisory Committee for the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization program (HCFO). As the chief health policy adviser to Colorado Governor Roy Romer, Mr. Weil led Democratic staff in negotiations of the 1996 National Governors' Association policy on Medicaid reform and the 1993 NGA policy in support of universal health insurance. Prior to his work with Governor Romer, Mr. Weil was the program director of the Colorado Children's Campaign and legal counsel in the Massachusetts Department of Medical Security. Mr. Weil received his bachelor's degree in economics and political science from the University of California at Berkeley. He holds a master of public policy degree from the John F. Kennedy School of Government at Harvard, and a J.D. from Harvard Law School.

**JOHN H. WELSH, President, Rumford Hospital, 420 Franklin Street, Rumford, ME 04276, jwelsh@rh.cmhc.org, 207-369-1032**
John H. Welsh, MSPH, FACHE, is President of Rumford Hospital. John has 37 years of experience in hospital administration in both teaching and community hospitals. He has served as Board Chair for the Maine Hospital Association, Member of the Hospital Study Commission, and Regent for Maine for the American College of Healthcare Executives. John is also a MDF Leadership Maine Beta class graduate.

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**WENDY J. WOLF, MD, MPH, President & CEO, Maine Health Access Foundation, 150 Capitol Street, Suite 4, Augusta, ME 04330, wwolf@mehaf.org; 207-620-8266, ext 101**
Dr. Wolf is the founding President and CEO of the Maine Health Access Foundation which is the state's largest health care philanthropy. After graduating from Ohio State College of Medicine she trained in pediatrics and pediatric cardiology at Children's Hospital of Los Angeles. During the twenty years Dr. Wolf spent in academic medicine as a pediatric cardiologist, she blended patient care with clinical, educational and basic science research. She has authored numerous scientific publications and presented her research at national and regional meetings. After obtaining an MPH from the Harvard School of Public Health in 1998, Dr. Wolf joined the U.S. Department of Health and Human Services as a Senior Advisor to the Administrators for the Health Resources and Services Administration and the Agency for Healthcare Research and Quality where she helped develop national policy for the State Children's Health Insurance Program. During her tenure with DHHS she received former Secretary Shalala's Award for Distinguished Service. Dr. Wolf is a nationally recognized speaker on health care policy and professional development.