Testimony of the
Department of Health and Human Services

Before the Joint Standing Committee on Health and Human Services

In Opposition to LD 230
An Act to Establish the Commission on Health Care Cost and Quality

Sponsored by Representative Anne Graham
Date: February 21, 2013

Senator Craven, Representative Farnsworth, and members of the Health and Human Services Committee I am Jim Leonard, Deputy director of the Office of MaineCare Services within the Department of Health and Human Services. I am here to testify on behalf of the Department in opposition to passage of LD 230, An Act to Establish the Commission on Health Care Cost and Quality for the following reasons:

1. LD 230 duplicates existing work of the Department to establish a state health plan through the Maine Center for Disease Control (Maine CDC) and the Office of MaineCare Service's payment reform initiatives.
    a) DHHS is in the process of creating a State Health Improvement Plan. This is part of the national accreditation for public health agencies that Maine CDC will be applying for in the next year. The requirements for a State Health Improvement Plan outlined in the national Public Health Accreditation Board standards overlap with the State Health Plan proposed in this legislation, but as outlined in this legislation, the State Health Plan would not fully satisfy the Accreditation Standards, creating the continued need for two planning processes.
    b) Input into the State Health Improvement Plan has been broad, with the Statewide Coordinating Council for Public Health involved in the planning process. Representatives from each of the nine public health districts -including health care systems, municipal and county governments, hospitals, community coalitions, educational institutions, agencies serving elders, and tribal health are represented. In addition, the major hospitals, the Maine Hospital Association, and the Maine Primary Care Association have been invited to provide input to this plan. Integration between public health and health care is a significant consideration in the priority selection for this plan and other public health partners.
    c) In a review of several states, we determined that some states do have commissions or plans that address health care cost or quality, some states have State Health Improvement Plans. The information seems inconclusive. In at least one case a cost/quality commission was repealed.
    d) DHHS along with a statewide multi-stakeholder group are responsible for planning and implementing a multi-payer payment reform initiative.
    e) Multiple payment reform strategies, including the oversight through a legislatively appointed committee will create additional obstacles and work for everyone and likely dilute the effectiveness of a single collaborative strategy that is based on transparency and accountability.
    f) Multiple payment reform and healthcare committees may have the un-intended consequence of creating competing structures which will weaken the effectiveness of an established multi-stakeholder process.

2. Staffing resources are not allocated and will take away from necessary resources within the Department.
    a) The bill as written does not provide adequate resources to staff to administer the work of the Committee, but looks to the Department to provide resources at a time when the Department has fewer available resources. This will place a burden upon the Department's staff by diverting its limited obligated resources to non-Department work.
    b) The work described within this bill would require use of scarce Department expertise. Department expertise will be less available if staff must fulfill ongoing requests for information to inform the work of this Committee. Healthcare systems and payment expertise are fully obligated to existing initiatives including payment reform development. Data analysis resources in the Department are very scarce, and often funded via federal grants that limit the flexibility of these personnel to redirect toward other efforts. Additional staff would need to be added to fulfill the data analysis needs.

3. Costs to provide staffing, information, and reports are not provided in this bill and would come out of the Department's resources
    a) Data compilation and analytics are very expensive. Information needed to inform a state health plan requires multiple data and analytic resources from across the Department. These costs have not been factored into the Department's budget or workforce.
    b) Report development and writing requires dedicated resources.
    c) Data analysis and report development are likely to require time from DHHS agency staff. These efforts would compete with other data analysis needs and with the resources required to assure public health Accreditation Standards are met regarding data and the State Health Improvement Plan.

4. The requirements to develop a state health plan as described in LD 230 are unduly burdensome and duplicate work of various state organizations and partners. Many of the activities outlined in the requirements of a state health plan are dependent upon significant resources that the state does not have. The last time a cost driver analysis was performed for a similar purpose the cost was over $300,000. Many of the analyses, like variation analysis and market failure studies, have already been performed.

In summary, LD 230 would duplicate existing efforts of the Department in work being done by the Maine CDC and MaineCare. It would also compromise existing commitments of the Department by shifting staffing and other resource allocations for meeting the requirements of the Commission on Health Care Cost and Quality. There will be significant costs generated to produce the deliverables and staff the Commission on Health Care Cost and Quality with no allocation in the bill to pay for these costs.

Thank you for the opportunity to present this testimony. I would be happy to answer any questions you may have and will plan to attend the work session.