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Testimony of Rep. Colleen Madigan introducing

LD 619, An Act to Ensure Coordination of Care for MaineCare Members

Before the Joint Standing Committee on Health and Human Services

Good afternoon Senator Baldacci, Representative Meyer and colleagues on the Health and Human Services Committee. My name is Colleen Madigan and I live in Waterville and represent House District 64. I am here today to present LD 619, An Act to Ensure Coordination of Care for MaineCare Members.

I don't need to tell you that our behavioral healthcare system has been plagued for many years. The people who are most affected by this are Maine residents in rural areas. Services are harder to access there or even unavailable. This bill hopes to address some of these shortcomings.

Coming home after a hospitalization can be tough. It is even tougher if you happen to live in a rural area. In this committee, we often hear that behavioral health conditions can be isolating. This includes substance use disorders, by the way. MaineCare pays for non-emergency transportation for MaineCare reimbursable appointments. However, what about appointments, groups and meetings that are not reimbursed by MaineCare? What if that is an AA or other peer recovery meeting that is vital to continued recovery? What about a cancer support group? I used to facilitate a monthly support group and potluck for kinship families. Most of the families were grandparents raising their grandchildren. What about a group like that? One way to reduce isolation and encourage connection and community is to get involved in things that interest you.

I propose that MaineCare pay for transportation to groups, classes and meetings as long as they are identified in a treatment plan. Arranging for all of these may often fall to a case manager. These collateral contacts, even when they are not identified providers, should be reimbursable, understanding all proper and necessary releases are in place. This ensures good coordination of care.

This bill also proposes that representative payee services be paid for by the Dept. of Health and Human Services. I would remind my colleagues that prior to a few years ago, the state employed caseworkers for the ID/DD population and the state provided this service. Now, private non-profits do it for free. But, this also includes agencies that provide this service for members who need it due to behavioral health, traumatic brain injury or dementia diagnosis. Coordinating this and developing plans and a budget takes time, time that a case manager cannot bill for. In developing this bill, I talked with agencies that have discontinued providing this service or are considering discontinuing this service. This would put some of our most vulnerable citizens at risk.

The next section of the bill, section 4, has already been fixed, according to my communication with community-based providers. The final portion of the bill concerns certified recovery coaches and certified intentional peer support specialists. For both mental health and substance use disorders, peers are often a lifeline. I think this is perhaps even more so in rural areas. The Dept. of Health and Human Services should develop a rate for these services to encourage wider access to peer services.

I think we need to be more creative and think outside the box in addressing the fractures in our behavioral health system. This is truer for rural areas. We cannot change demographics. Our population is changing, becoming less concentrated in rural areas. This has affected the viability of providing services and access to these services. We need to do better.

Thank you and I would be happy to answer any questions you may have.