DHHS FY 16/17 Budget Initiative: Fund for a Healthy Maine – Reprioritizing Resources

Background

- Since 1993, Maine has spent **more than $215 million** on tobacco prevention and control but the state did not net an attributable or substantial decrease in the prevalence of smoking.[1],[2],[3] *Note that the overall tobacco settlement revenue from 1999-2014 was more than $796 million.*[4]
- According to the 2015 report from the Robert Wood Johnson Foundation, *Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement 16 Years Later*, **Maine ranks 7th in state spending** for tobacco cessation.[5]
- Of the adults that smoke, **Maine's downward trends have mirrored national rates**. When Maine received its first federal grant in 1992-93, Maine's adult smoking rate was 27% and the US rate was a comparable 25%[6]. Today, both Maine and the US have a similar ratio: 20% and 19%.[7] (note that BRFSS data indicates that the Maine rate in 2011 was 22.8%)[8]
- The MaineHealth Index Report for 2013 notes: "Smoking rates **have not changed substantially** over the past decade."[9]
- In 2007, 35% of young adults in Maine smoked at rates similar to 1992 levels (35%).[10]

FHM by the Numbers

$215 million

Spent on tobacco cessation

7th

Maine's rank for cessation spending

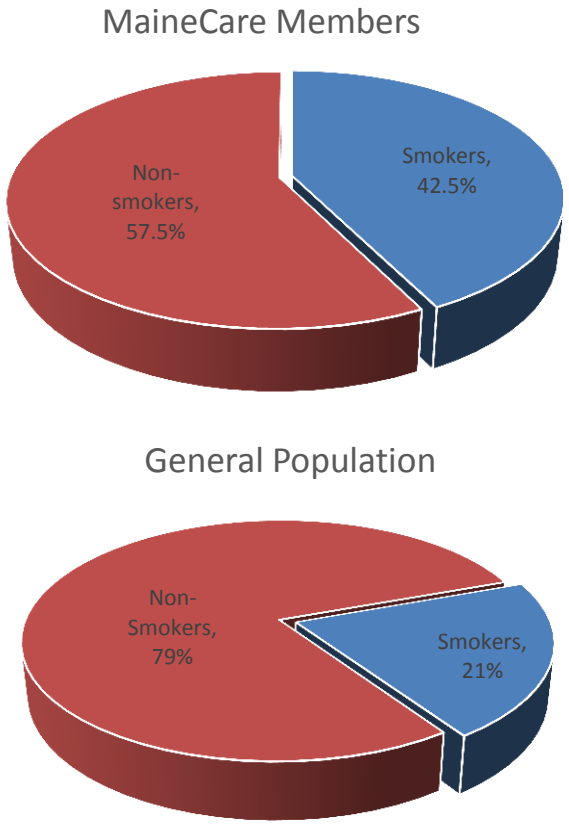
1%

Maine's smoking rate drop beyond the national average

Changing behavior: primary care interventions

- Tobacco cessation intervention is **one of the most effective forms of clinical preventive services** that can be provided by a primary care physician.[11]
- Tobacco screening and brief intervention from primary care providers is among the top three strategies to impact clinically preventable burdens.[12]
- The American Academy of Family Practice states: "In addition to reducing morbidity and mortality, smoking cessation is among the **most cost-effective measures in primary care**."[13],[14]
- The consistently reinforced screening for tobacco use by primary care providers, including face to face contact and follow up phone calls, is particularly important and effective **given the cycle of quitting and relapsing** that occurs with most smokers.[15]
- This approach underscores Maine DHHS' **continued investment in the QuitLine** and the related Nicotine Replacement Therapy options for smokers, **which are maintained in the Governor's budget proposal**. "Effective tobacco dependence treatment frequently requires tailoring, and often intensifying, the interventions (both counseling and pharmacotherapy) to meet the needs of the individual patient."[16]
- Studies show that **smokers are more likely to listen to a doctor** when it comes to smoking cessation and coupling discussions of smoking with PCP exams that reveal smoking-related health conditions can be especially persuasive in convincing smokers to quit.[17]

Targeting our spending



- According to a Healthy Maine Partnerships Tobacco Facts Brief[18]: "MaineCare/Medicaid recipients are **twice as likely to smoke (42.5%) as the general population (21%)**." These data have remained steady, showing little impact on the most vulnerable population.
- For those with **serious mental illness (SMI), the smoking rates are much higher** and range from 50-80%.[19] The risk of contracting tobacco related diseases is greater for this population, underscoring the need for linkage of behavioral health to primary care—one of the key objectives of the budget proposal. Because we are incenting primary care to become more involved with these populations, there is a greater likelihood that health homes will have a direct impact on smoking behavior than did public health over the past 20 years through coalition efforts.
- Estimated annual total MaineCare spending for smoking cessation is **already at $1,924,333** (of which $734,533 was the state share.)[20]
- "76% of tobacco users enrolled in MaineCare and 61% of tobacco users not enrolled in MaineCare reported they want to quit smoking or using other tobacco products (not significantly different). Of these:
    - A significantly higher rate of tobacco users enrolled in MaineCare (97%) **said they were seriously considering quitting** in the next 6 months compared to tobacco users not enrolled in MaineCare (79%)"[21].
- Maine was a top spender for many years under the Master Tobacco Settlement[22] compared to other states, but again, any impact on smoking rates can be correlated to other factors, such as the increased purchase price and inaccessibility for public smoking areas.
- **There are already robust public awareness campaigns through the federal CDC.** We do not need to recreate Maine-specific ads, just promote the hotline number. Local level treatment is what is needed, most effectively delivered through Primary Care.

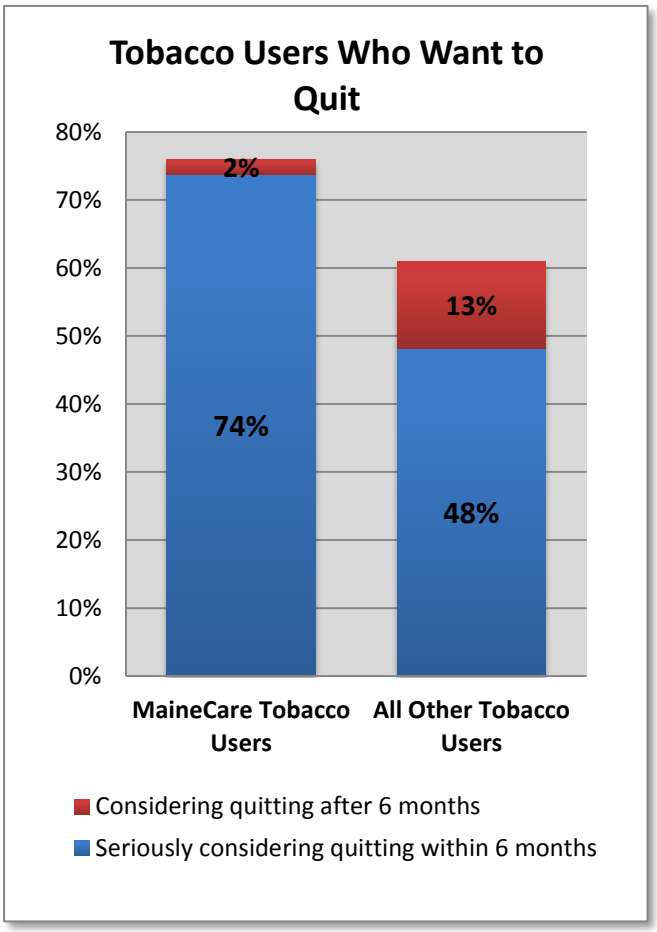
Change in policy/strategy is justified

- The federal policy now is that all people are required to have health insurance, which suggests that all people will visit their primary care provider. However, **coverage does not guarantee access**, which is why investment in reimbursement rates is needed. In health homes, we have tied the screening rate to the quality metrics that drive the PCP reimbursement rates.
- One of the primary missions of the local Healthy Maine Partnerships is "work[ing] with community partners to promote increased smoke-free outdoor settings"[23]—a task that can be completed with legislation.

- The share of FHM expenditures going to smoking cessation/prevention **nearly doubled** from 11.5% in 2001 to 22.1% in 2015, with marginal results.[24]
- Even after implementation of this budget proposal, FHM would retain approximately **$40 million per biennium** to support tobacco cessation and other activities unrelated to MaineCare and primary care funding.[25]
- The **Federal CDC currently distributes approximately $1 million** per year via its Healthy Communities Tobacco Control grant to fund smoking cessation/prevention activities in Maine. This is in addition to $79,000 per year for Maine's tobacco Quitline, which will remain in operation.

Why Primary Care?

- We are **investing in new health care infrastructure**, which is focused on both the health care and the health of its populations. Maine's Accountable Communities have an incentive to reduce expenditures related to high cost, preventable disease, particularly tobacco-related disease.
- A system-wide smoking cessation strategy through primary care could result in a **2.0-2.7% decrease in smoking rates**[26]. When it comes to smoking cessation, it is not the number of times one hears the message, but who is delivering it that matters.
- Primary Care is the most effective way to meet **the goals of the Fund for a Healthy Maine**, as enunciated under 22 MRSA §1511(6), including, but not limited to:
  - A. Smoking prevention, cessation, and control activities;
  - A-1. Prevention, education and treatment activities concerning unhealthy weight and obesity;
  - D. Health care for children and adults, maximizing to the extent possible federal matching funds;
  - G. Substance abuse prevention and treatment.



Initiative

The Governor's biennial budget proposal repurposes $20 million from the Fund for a Healthy Maine (FHM), including $8 million in tobacco cessation funding, to improve access to primary care providers for Medicaid recipients.

In addition to repurposing $8 million from the Fund for a Healthy Maine's tobacco prevention and control initiative, the budget proposes to move $12 million from third-party advocacy organizations and a now-duplicative immunization program to support access to primary care for people who rely on MaineCare.

Community/School Grants

Less than 10% of the Community/School Grants and Statewide Coordination funding is directed to schools; the greater proportion of the resources have been funding third-party, non-profit advocacy coalitions called "Healthy Maine Partnerships." This proposal would redirect 100% of the funding to the FHM Medical Care Services Account to strengthen primary care by increasing rates to primary care physicians and continuing funding for health homes.

SFY 16	$4,985,262
SFY 17	$4,993,683

The goals of Healthy Maine Partnerships include:

- Reduce smoking rates
  - See above; PCPs provide a more effective alternative, and smoking cessation awareness programs will still be maintained via MaineCare, CDC, and federal grants.
- Prevent obesity, substance abuse, and chronic disease.
  - Again, a function better left to primary care professionals.

This funding would be redirected to provide funding for both preventative and direct medical services to people on MaineCare through the Health Homes initiative and increased access to primary care providers.

Immunization Program

This proposal redirects funding in the FHM Immunization Program to the FHM Medical Care Services account to support the Health Homes and primary care initiatives.

SFY 16	$1,078,884
SFY 17	$1,078,884

It is important to note that this is a very small portion of the immunization program's overall $24 million budget for children's vaccine purchase. This budget consists of more than $12 million assessed annually on insurance companies and the balance comes from federal Vaccine for Children funds. Maine also receives about $300,000 from the federal CDC to administer Maine's Universal Childhood Immunization Program.

In the past several years, the program has had more vaccines than necessary on hand and has given them away free to any Maine resident, regardless of income or insurance status. The Obama Administration recently proposed cutting $50 million from a federal vaccine program because of reduced demand due to coverage options available through Medicaid and the Exchange established by the Affordable Care Act.

Savings

	SFY '16	**SFY '17**	**Total Savings over Biennium**
Community School Grants	($4,985,262)	($4,993,683)	($9,978,945)
Tobacco Prevention and Control	($3,980,000)	($3,980,000)	($7,960,000)
Immunization Program	($1,078,884)	($1,078,884)	($2,157,768)
Total	($10,044,146)	($10,052,567)	($20,096,713)

[1] Total state and federal tobacco control appropriations (in millions of dollars), taken from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6120a3.htm and Maine DHHS documents.
[2] *History and Overview of Tobacco Policy Initiatives in Maine, 1897-Present*. Published 2011, Maine Public Health Association, available online at: http://www.slideshare.net/HPPofME/history-and-overview-of-tobacco-policy-initiatives-in-maine-1897present
[3] Maine Tobacco Control Timeline, 1897-2008, Published 2011, Maine Public Health Association, available online at http://www.slideshare.net/HPPofME/maine-tobacco-control-timeline-18972008
[4] Taken from the State Tobacco Activities Tracking and Evaluation (STATE) System, US CDC. Available online at http://apps.nccd.cdc.gov/statesystem/TrendReport/TrendReports.aspx
[5] Taken from http://www.tobaccofreekids.org/content/what_we_do/state_local_issues/settlement/FY2015/2014_12_11_staterankings.pdf
[6] From America's Health Rankings Data Query, available at www.americashealthrankings.org/ALL/Smoking/disparities
[7] From America's Health Rankings 2014 Report, available online at http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/Americas%20Health%20Rankings%202014%20Edition.pdf
[8] From http://tobaccofreemaine.org/explore_facts/Maine_facts_and_stats.php
[9] P. 10, 2013 Health Index Report. Available online at: http://www.mainehealth.org/workfiles/mh_community/Health-Index-Report-2013.pdf
[10] http://econpapers.repec.org/paper/cdlctcres/qt5jz4q9m4.htm
[11] Solberg LI, Maciosek MV, Edwards NM, Khandchandani HS, Goodman MJ. Repeated tobacco-use screening and intervention in clinical practice: health impact and cost effectiveness. American Journal of Preventive Medicine. 2006;31:62–71. http://www.prevent.org/data/files/initiatives/prioritiesamongeffectiveclinicalpreventivesvcsresultsofreviewandanalysis.pdf

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[13] Curry SJ, Grothaus LC, McAfee T, Pabiniak C. Use and cost effectiveness of smoking-cessation services under four insurance plans in a health maintenance organization. New England Journal of Medicine. 1998;339:673-9.

[14] Kolawole S. Okuyemi, M.D., M.P.H.; Nicole L. Nollen, Ph.D., Jasjit S. Ahluwalia, M.D., M.P.H. Interventions to Facilitate Smoking Cessation. American Academy of Family Physicians. 2006. Downloaded from www.aafp.org/afp.
[15] Id.
[16] R. D. Hurt, Treating Tobacco Dependence in a Medical Setting, CA: A Cancer Journal for Clinicians(2009),59(5):314
[17] World Health Organization, Department of Mental Health and Substance Dependence. Encouraging People to Stop Smoking (2001). Available online at: http://www.who.int/mental_health/evidence/stop_smoking_whomsdmdp01_4.pdf
[18] Downloaded from: http://healthymainepartnerships.org/documents/TobaccoFacts.pdf
[19] Parks, et al. Morbidity and Mortality in People with Serious Mental Illness." National Association of State Mental Health Program Directors. 2006. P.5.
[20] From internal correspondence dated 1/21/2015. Wendy Waltz, MaineCare Financial Analyst.
[21] Adult Tobacco Cessation in Maine Fact Sheet. Maine DHHS, Center for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2012 data.
[22] Previously referenced: http://tobaccofreemaine.org/explore_facts/Maine_facts_and_stats.php
[23] Healthy Communities of the Capital Area, http://www.healthycommunitiesme.org/
[24] Maine Legislature, Office of Fiscal and Program Review, http://www.maine.gov/legis/ofpr/tobacco_settlement_funds/index.htm
[25] Id.
[26] Systems Change: Treating Tobacco Use and Dependence: Based on the Public Health Service (PHS) Clinical Practice

Guideline—2008 Update. December 2012. Agency for Healthcare Research and Quality, Rockville, MD.

http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/decisionmakers/systems/index.html