Muskie School of Public Service

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The Future of Medicaid: Building Sustainability through Program Innovation

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In 1965, Congress amended the Social Security Act, creating an entitlement to health care for the elderly and some people with disabilities through Medicare and for some low income families through Medicaid. By 2011, Medicaid was a larger program than Medicare covering 70 million people at a cost of $432 Billion dollars (2011).[1] Fully two-thirds of program expenditures support the elderly and people with disabilities.[2]

The size, scope and cost of the Medicaid program has been a discussion point in state capitols since its inception. Unlike Medicare, Medicaid is a shared responsibility of the state and federal governments, with the federal government paying at least 50% of its costs. The Federal matching rate is determined through a formula based on the per capita income of the state; the lower the income, the higher the match. Today the Federal government pays 61.55 % of Medicaid (known as MaineCare here) costs in Maine.[3]

Congress established broad federal guidelines but gave states flexibility to manage their programs to meet state need, providing some discretion around eligibility, provider payment, delivery systems and benefits. Indeed, participating in the Medicaid program is a state option – one state, Arizona, did not join the program until 1982. And when it did, it sought and received permission to waive certain requirements and enrolled most of its members in risk-based managed care. Waivers allow states additional flexibility to make fundamental changes to their programs, and every state operates at least one waiver today.[4]

Who is eligible?

Medicaid is an entitlement, initially established with income and asset-based eligibility, to provide medical assistance to individuals and families receiving cash assistance (generally Aid to Families with Dependent Children or AFDC). In 1996 the Congress severed the link between welfare and health care when it enacted welfare reform. AFDC was abolished and replaced with the Temporary Assistance for Needy Families, also known as the TANF block grant. The ability to receive or lose Medicaid eligibility was no longer automatic as a condition of receiving or losing welfare. Persons with disabilities, however, generally qualified for Medicaid when they became eligible for Supplemental Security Income (SSI). Medicaid continued to cover sub-sets of low income people and only covered childless adults in states that sought federal waivers to do so.

The Affordable Care Act (ACA) further de-links Medicaid from welfare by eliminating the asset test and providing coverage for all low income persons up to 138% of the Federal poverty level (FPL), including childless adults. The decision to extend Medicaid eligibility was left to the states following the 2012 ruling by the United States Supreme Court. Maine covered parents of dependent children who had incomes up to 200% FPL until March 2013

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when eligibility was reduced to 138% FPL and childless adults with incomes up to 100% FPL. With the full implementation of the ACA, states are allowed to eliminate coverage for optional populations, and Maine will eliminate coverage of childless adults after December 2013.

What services must be provided?

The Federal government requires states to provide 15 mandatory services and allows states the option to cover other services. (See APPENDIX A for a list of mandatory and optional services). Most states cover most optional services today, although they may impose limits and can eliminate or reduce those services. Medicaid allowed states to provide a more limited benefit to childless adults; that provision is included in the ACA and extends to all persons newly eligible for Medicaid. States that accept Federal funds to cover more low income people can provide them a more limited benefit.

The debate about whether Maine should expand eligibility pursuant to the ACA is beyond the scope of this paper. (NOTE: The Muskie School of Public Service Health Policy April 8, 2013 Colloquium addressed this issue; a brief on the topic can be found at http://usm.maine.edu/muskie/health-policy-colloquia-affordable-care-act.) Rather we will focus on specific cost drivers that exist in the program independent of ACA eligibility decisions. Indeed, the cost drivers within the program remain whether or not Maine accepts Federal funds under the ACA to extend MaineCare.

How do Maine's Medicaid costs compare to the national average?

Indeed, the cost drivers within the program remain whether or not Maine accepts Federal funds under the ACA to extend MaineCare

Maine's overall cost per member in FY2010 was higher than the national average. Costs per member across different age groups and categories of eligibility vary, but in the aggregate, Maine's costs were 7% higher than the national average. It should be noted that the data from 2010, while the most complete available for national comparisons, do not include hospital settlement payment for FY2010 that were paid in subsequent years. The data include settlement costs from preceding years, however.

Table 1: Annual Medicaid Cost per Member, FY2010[5]

Maine	$5,968
United States	$5,563

What is driving MaineCare expenditures?

Many factors drive program costs including the number and characteristics of the people enrolled, the scope and use of services, and the payment for services.

People served by MaineCare

Enrollment in Medicaid is affected by policy decisions on eligibility and the demographics of the population. Maine has made policy decisions in past years to extend eligibility for different populations. TABLE 2 shows that

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Maine, like many other states, has covered children and non-disabled adults above Federal eligibility requirements.*

Table 2: Number of States Providing Medicaid Coverage for Children and Non-disabled Adults at Different Income Levels based on the Federal Poverty Level, 2013[6]

	Children			Pregnant Women			
	<200%	200-249%	250%+	Up to 133%	134%-184%	Up to 185%	185%+
No. of States	4	**22 incl. ME**	25	7	5	16	**23 incl. ME**

	Parents			Low Income Non-disabled Adults		
	<50%	50%-99%	100%+	No coverage	Limited benefit	Medicaid benefits
No. of States	16	17	**18 incl. ME**	26	**16 incl. ME**	9

While policy decisions have allowed more people to be covered by MaineCare, Maine's enrollment has been growing at a slower rate than the national average, as shown in TABLE 3.

Table 3: Percent Change in Medicaid Enrollment June 2007 to June 2012[7]

	June '07-08	June '08-09	June '09-10	June '10-11	June '11-12
Maine	-2.9%	3.0%	6.7%	2.7%	-3.7%
United States	3.1%	7.8%	7.2%	4.7%	2.5%

Medicaid is a safety net. Because eligibility is based on income, as income falls eligibility for coverage increases. As evident in TABLE 3, Maine's enrollment increased during the Great Recession, especially during 2009-2010. Maine's unemployment rate during the recession peaked in December 2009.[8] During economic downturns, more individuals and families seek and qualify for coverage. As the economy improves and income increases, they may no longer qualify for benefits. This effect, known as "churning", is more pronounced in the non-elderly and non-disabled enrollment groups.[9] Older adults and people with disabilities, on the other hand, often live on fixed incomes, with their coverage linked to their eligibility for Supplemental Security Income status.[10] As a result, their eligibility for coverage is not as sensitive to changes in the state's economic environment.

Maine ranks 3rd among states in the percent of persons ages 65 and older and has higher rates of disability among low income people

While policy decisions have been made to control who may enroll in MaineCare, the demographics of the state presents a different challenge to controlling program growth. According to the U.S. Census Bureau, Maine's median age of 42.7 years is the oldest of any state, and we rank 3rd among states in the percent of persons age 65+.[11] Maine's percentage of children 18 and younger is 20% versus 24% in the nation. [12] In other words, Maine is a "gray" state with fewer young people. However, understanding MaineCare enrollment requires a look at poverty and disability as well since

* The ACA requires states to maintain children's eligibility levels through 2019.

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some eligibility categories are based on income and disability status. TABLE 4 shows that Maine has higher rates of disability among low income people than the national average.

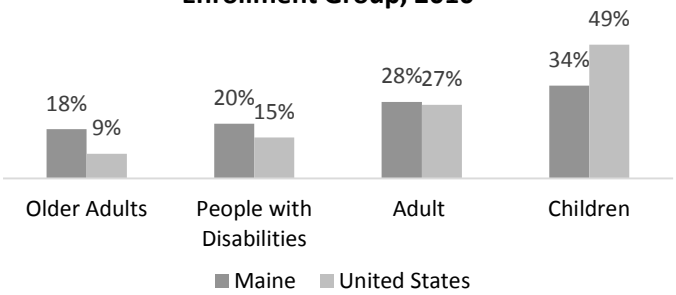
Table 4: Disability Rates of Non-institutionalized Populations by Age and Federal Poverty Level (FPL), Single-Year Estimates for 2010[13]

Population Group	Percent of People in Each Group with Disability	
	Maine	United States
Children under 18	6%	4%
Children under 18 with family income below FPL	10%	6%
Adults 18-64	13%	10%
Adults 18-64 with incomes below FPL	29%	19%
Adults 65+	38%	37%
Adults 65+ with income below FPL	54%	51%

The Census Bureau definition of disability is broad; not all people responding "yes" to having a disability would actually require medical assistance or qualify for MaineCare.† Additionally, the survey is conducted on the non-institutionalized population; as Maine is one of eleven states that do not have large institutions for people with intellectual disabilities (ICF-IDs), one would expect that Maine would have higher rates of these individuals represented in the survey. However, even among the states without ICF-IDs, Maine's rates of disability among people in poverty are still high.‡

These higher rates of disability may be reflected in MaineCare enrollment data as shown in CHART 1.

Chart 1: Distribution of Medicaid Enrollees by Enrollment Group, 2010[14]



Even among the states without ICF-IDs, Maine's rates of disability among people in poverty are still high

Clearly, Maine has a larger proportion of older adults and people with disabilities covered by Medicaid than the national average.

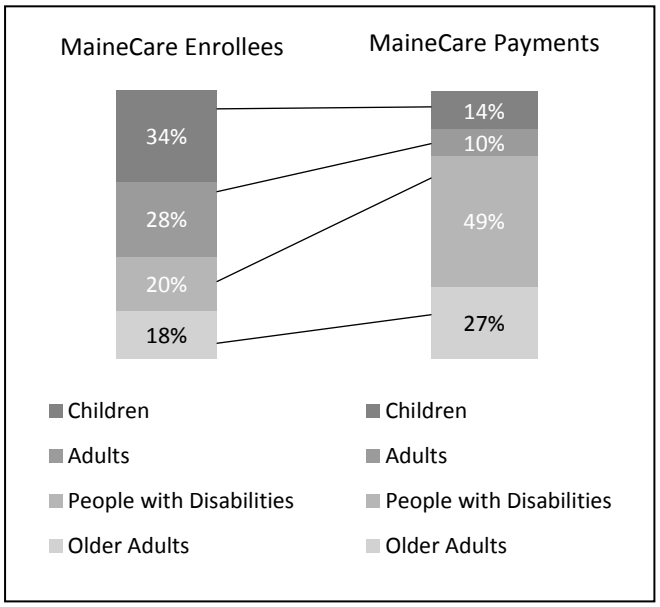
† The Census Bureau counted a person as having had a disability if they answered "yes" to having had a Sensory Disability (blindness, deafness, or a severe hearing or vision impairment); Physical Disability (a condition that substantially limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying); Mental Disability (a condition lasting six months or longer that made it difficult to perform learning, remembering, or concentrating); Self-Care Disability (a condition lasting six months or longer that made it difficult to perform dressing, bathing or getting around inside the home); or Going Outside the Home Disability (a condition lasting six months or longer that made it difficult to go outside the home alone to shop or visit a doctor's office.) The data include non-military, non-institutionalized persons for whom poverty status could be determined.

‡ Rates calculated for the states without ICF-IDs (AK, HI, ME, MI, MN, NH, NM, OR, RI, VT, and WV) showed Maine had the second highest rate of disability among adults 18-64 living in poverty. Only WV had a higher rate of disability (30%). RI had the third highest rate (27%). AK, HI, MN, and NM rates for this population were lower or equal to the national average of 19%.

Enrollment by different populations affects MaineCare expenditures

The types of services used by enrollment groups vary widely. Non-disabled children and adults make up the majority of enrollees, but they account for a minority of the costs. It is older adults and people with disabilities who account for most program costs as shown in CHART 2. Again, the data from 2010 do not include the hospital settlements that applied to 2010 but that were paid in subsequent years. Settlement payments from previous years, however, are included.

Chart 2: Distribution of MaineCare Enrollees and their Expenditures, FY2010[15]



Service use affects MaineCare expenditures

The Maine Department of Health and Human Services analyzed claims payments for all its members in FY2010 and found that just 5% of members accounted for 55% of total payments. This majority of this subset of high cost users were older adults and persons with disabilities. A summary of service use among these high cost members in FY2010 is as follows:[16]

- The home and community based waiver for members with intellectual disabilities was the largest claims expenditure for high cost members
- 71% of high cost members use long term services and supports, reflecting 53% of these members' claims payments
- 26% of high cost members used nursing facility care

Just 5% of members accounted for 55% of total payments

- General hospital services, including inpatient and outpatient services, represent 20% of high cost members' payments
- Mental health services were used by 42% of high cost members and accounted for 11% of claims

- The top four primary diagnoses accounting for 55% of high cost members' claims were all behavioral health related including:
    - Intellectual disabilities (25% of members, 27% of costs)
    - Other psychosis (37% of members, 15% of costs)
    - Neurotic, personality, and other non-psychotic disorders (44% of members; 10% of cost)
    - Organic psychotic conditions (15% of members, 3% of cost)

Long term services and supports: Over 70% of high cost members use long term services and supports (LTSS). A separate analysis by the Muskie School of Public Service examined the total and per member expenditures of these users, including adults with mental illness, older adults and adults with physical disabilities, adults with intellectual disabilities, children with mental illness, and children with intellectual disabilities. Annual expenditures per member served are shown in TABLE 5.

Table 5: Number Served, Total MaineCare Expenditures and Annual Cost per Member Served among Long Term Services and Supports Users by Population, FY2010[17]

LTSS Population	Unduplicated Annual Count of Persons Served	Total Annual Expenditures	Annual Expenditure per Member Served
Adults with mental illness	13,425	$305.2 M	$22,734
Older adults and adults with disabilities	14,855	$447.7 M	$30,138
Adults with intellectual disabilities	5,107	$391.0 M	$76,562
Children with mental illness	6,817	$139.9 M	$20,522
Children with intellectual disabilities	3,210	$115.0 M	$35,826

Over 70% of high cost members use long term services and supports

Adults with intellectual disabilities had the highest expenditure per person ($76,562). MaineCare spending for adults with intellectual disabilities is over twice the per person cost as it is for children with intellectual disabilities. A significant reason for this is that parents and family members provide care for these children, while the state's policy for adults with intellectual disabilities has supported independent living in the community. The single largest annual expenditure for adults with intellectual disabilities is for Home and Community Based Services Waiver services. Because Maine is one of several states that no longer have large public ICF-IDs, one would expect to see heavy expenditures for home and community based waiver services for this population.

TABLE 6, which includes the most current data available, shows that Maine spends more per person on home and community services than any other state among those that no longer operate large institutions for this population.

Table 6: Medicaid Section 1915(c) Home and Community Based Services for Persons with Intellectual Disabilities Waiver Participants in States without Large Institutions for this Population, 2009[18]

State	2009 Participants Served	2009 Spending per Participant	National Rank High to Low	Rank among States w/o Large ICF-IDs High to Low
Alaska	1,298	$61,269	7	3
Hawaii	3,569	$26,496	44	10
Maine	**4,013**	**$76,101**	**4**	**1**
Michigan	8,129	$50,279	14	6
Minnesota	14,546	$64,831	6	2
New Hampshire	3,055	$52,581	13	5
New Mexico	5,068	$48,713	16	7
Oregon	12,395	$41,564	26	8
Rhode Island	2,293	$41,203	27	9
Vermont[§]	NA	$54,316	NA	NA
West Virginia	4,269	$54,717	10	4

Acute care services: Acute care services account for 20% of the payments made for high cost members. In fact, combined inpatient and outpatient hospital spending for high cost members accounted for approximately 44% of total estimated payment to hospitals for all MaineCare members.[19] In other words, 5% of members accounted for nearly half of all hospital payments. As mentioned earlier, it is difficult to compare Maine's hospital expenditures in 2010 to other states due to the hospital settlement payments. Payments that settled past due expenses are not paid in the year that costs were incurred. However, settlements were paid in 2010 from previous years. Using available comparative data, Maine spends at least $1703 per member in annual inpatient hospital and outpatient services compared to the national average of $1233 per member.[20]

Maine spends more per person on home and community services than any other state among those that no longer operate large institutions for this population

Mental health services: Services for people with mental illness are another driver of costs. However, it is not just long term behavioral health or residential care, but also inpatient and outpatient services that are a significant source of expenditure for this population.[21] People with mental illness experience higher rates of physical illness than the general population, and their ability to access and use appropriate care may be compromised by their mental status.[22] As the DHHS information indicated, the four top diagnoses associated with high member costs are behavioral health related.

[§]Vermont's Home and Community Based Waiver program is administered through an 1115 Waiver; comparable 2009 data was unavailable. FY2011 data shown is from Vermont Agency of Human Services, Department of Disabilities, Aging and Independent Living, Division of Disability and Aging Services, Vermont Developmental Disabilities Services Annual Report, 2012.

Payment for services affects MaineCare expenditures

A third driver of costs is the actual payments made to MaineCare providers. States have flexibility to define benefits and impose limits on their use and have broad authority to set provider payment rates. As a result, there is wide variation in those rates among the states

In purchasing hospital and physician services, Medicaid operates in a broader health marketplace in which other payers are predominant. In those instances, Medicaid payment rates are often modeled on the market and are often compared to Medicare rates, for example. But in other services, particularly LTSS and disability, Medicaid is the predominant payer and, as such, has broader discretion in rate setting.

The Federal government defines how states set rates, requiring that payment rates must safeguard against unnecessary utilization, assure payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that they are available to the general population in the geographic area.[23]

States can reduce provider fees as a means of cost containment but must assure that the above Federal requirements are met. Some state decisions to reduce fees have been challenged in court. Confronted with difficult choices in tight budgets to cut eligibility for people in need or reduce benefits, states have often elected to reduce provider payments. As states contemplate how to set appropriate fee structures, good comparative data is lacking. As the Medicaid and CHIP Payment and Access Commission (MACPAC) concluded:

> *There is no easily accessible source of state payment methods, no comprehensive analysis of which are more or less effective and no uniform data that provides meaningful comparison of payment levels*[24]

How has Maine Addressed the Cost Drivers?

MaineCare Task Force

Like other states, Maine has struggled with managing these different cost drivers while providing high quality services to its MaineCare members. In 2012, the Maine Legislature established the MaineCare Redesign Task Force and charged it with developing strategies that will help sustain the program. Using the DHHS information on enrollees and their service use as well as information from health care consultants, the Task Force developed strategies intended to realize $35.22M in total state savings for the MaineCare program.[25] Many of the shorter-term recommendations include requiring prior authorization for high cost imaging and radiology, or adjusting provider fees based on outcomes such as hospital acquired conditions. Longer-term strategies include the Healthy Babies Initiative which seeks to reduce the incidence of poor birth outcomes for MaineCare members; Value-Base Purchasing through which providers are reimbursed for outcomes and quality; and Targeted Care Management for members accounting for the top 20% of expenditures. A complete list of the strategies can be found at http://www.maine.gov/dhhs/mainecare-task-force/documents/2012-report.pdf.

Maine is one of only six states to have been awarded a Federal State Innovation Model grant

State Innovations Model

Maine is one of only six states to have been awarded a Federal State Innovation Model (SIM) grant. Funded by the ACA, this grant provides Maine up to $36 million over a 42-month period to: 1) reduce per member

per month cost for the MaineCare population; 2) improve the quality of care for this population; and 3) improve the patient experience of care and increase patient engagement. Through implementing payment reform across public and private payers, spreading the patient-centered medical home model of enhanced integrated primary care, and achieving a transparent understanding of the costs and quality outcomes of patients across all payers statewide, the state predicts significant savings compared to the current trend of spending not just to Maine, but to the Federal government and private payers as well. Specifically, the state predicts savings over the grant period of: $472M (MaineCare), $554M (commercial), and $248M (Medicare).[26] Maine is building on many of its existing efforts as part of this initiative including the patient-centered medical home, health homes, and accountable communities.

Primary Care Medical Homes and the Multi-Payer Pilot

In 2010, Maine launched a major effort to transform the state's primary care delivery system. With support from the Maine Quality Forum, Maine Quality Counts and the Maine Health Management Coalition, practices were invited to participate in a multi-payer pilot to support and revitalize primary care to improve health outcomes and to reduce overall healthcare costs. Twenty-two adult and four pediatric primary care practices made up the initial cohort of participating practices which, through monthly per member payments, are able to build the infrastructure to support patient-centered care and exchange experiences through learning collaboratives. Initially planned as a three-year demonstration, the pilot was expanded to 75 practices and extended through 2014 with Maine's selection to participate in Medicare's Multi Payer Advanced Primary Care Practice (MPPCP) demonstration. The inclusion of Medicare brought a critical mass of support that allowed the creation of community care teams to provide intensive care coordination to the highest need patients served by demonstration practices. In its MPPCP application, Maine predicted 10% cost savings by 2014 based on reductions in emergency room use and avoidable hospitalizations.

Emergency Department Collaborative

What began in 2010 as a 30-patient, one-hospital pilot project to better coordinate care and deliver it in the appropriate setting has expanded to all hospitals Statewide and now encompasses nearly 2,000 patients. The Department and the Office of MaineCare Services (OMS) focused on those who were frequent users of the Emergency Department, some who had visited the ED more than 100 times in a year. Staff from the OMS, including a coordinator and a small team of nurses with physical and behavioral health care management skills have developed partnerships with hospitals, primary care providers, behavioral health providers, state agencies, emergency personnel, shelters, care managers and social service providers who are engaged in care management, in an attempt to not duplicate efforts. These partnerships have led to increased use of primary care, services being delivered in appropriate settings and better health outcomes. The program saved more than $8 million over State Fiscal Years 2012 and 2013.

Partners in Wellness

Recently, Maine DHHS began the Partners in Wellness Project, building off of some of the lessons learned in the Emergency Department collaborative, with a focus on the top 5 percent of utilizers who account for roughly 55 percent of MaineCare's cost. DHHS recognized that many of those who fall into this category depend on the social service system and state government to meet most - if not all - of their basic needs. The Department has brought together a team to launch a pilot project in Lewiston to coordinate services and share data and information across the system to better coordinate and care for top service utilizers.

The Supports Intensity Scale for People with Intellectual or Disabilities

In February of 2012, Maine began using a nationally recognized tool known as the Supports Intensity Scale (SIS) to assess needs for persons with intellectual disabilities. The tool is used by twenty-three states nationwide. The SIS determines the help consumers need for everyday living, as well as the frequency of support that is needed. A trained interviewer meets with the person and those familiar with him/her, including family members, advocates, guardians, case managers and service providers. Questions focus on needs at home, in the community and at school or work, as well as health and safety needs. Maine is in the process of completing SIS assessments of all who are receiving services through the Office of Aging and Disability Services to create baseline data and to use this information to guide rate structures.

Single Assessing Agency

A Request for Proposals has been developed to create a single assessing agency for the elderly who may be entering a nursing home or in need of community service, as well as persons with intellectual disabilities. This effort will merge the Supports Intensity Scale assessments and the two levels of nursing home Preadmission Screening and Resident Review (PASRR) assessments under one contracted provider. Currently, SIS assessments are done by state staff; the brief Level 1 assessments identifying mental illness, intellectual disability and other related conditions are completed by hospitals and provider agencies; and the more detailed Level II assessments are the responsibility of APS Healthcare. Integrating these services into a single assessing agency will provide efficiency, ensure consistency and establish an independent review of the needs of consumers. The Department expects to award the contract for this service in January, 2013.

Health Homes

The Affordable Care Act provides an enhanced Federal match to reimburse "health home" services to eligible members. This initiative targets certain high cost users with two or more chronic conditions and at risk for another condition or having a serious mental illness. Health Home services include care management of physical and mental health needs, care coordination and health promotion, help with transitional care, support to help self-manage physical and mental health conditions, referral to other services and the use of Health Information Technology.

Maine is implementing Health Homes in two Stages. In Stage A, eligible members include those with two or more chronic conditions and those with one chronic condition and at risk for another. During Stage A, Health Homes, which are required to meet national standards and implement electronic health records, are partnering primary care medical homes with a community care team. Stage A Health Homes receive a per member payment for each eligible member for coordinating care and providing prevention services and access to community support services. Stage A Health Homes began in January 1, 2013.

During Stage B, eligible adults with serious mental illness and children with serious emotional disturbance will join Health Homes that connect licensed community mental health providers and a primary care practice. Key features of Stage B Health Homes are the integration of behavioral and physical health with a team-based, comprehensive approach including a care manager, a peer support specialist, a licensed social worker and a health home coordinator. Stage B will begin in the spring, 2014.

The goal of Accountable Communities is to provide better care, better population health and lower costs

Accountable Communities

Maine is implementing an Accountable Communities Initiative whereby MaineCare will engage in shared savings agreements with provider organizations that, as a group, coordinate and/or deliver care to a specified population. Accountable Communities that demonstrate cost savings as well as achieve quality of care standards will share in savings. The initiative does not require a Federal waiver and will be offered statewide in the spring of 2014. The goal of Accountable Communities is to provide better care, better population health and lower costs using four strategies: shared savings based on quality performance; practice-level transformation; coordination across the continuum of care; and community-led innovation. Accountable Communities are an important component of Maine's SIM grant by building on the foundation of multi-payer PCMH Pilot and Health Homes. Savings will be calculated based on reductions in targeted budgets for each Accountable Community.

Money Follows the Person

In 2011 Maine was awarded up to $7.1 million through 2016 from the Centers for Medicare & Medicaid Services under its Money Follows the Person (MFP) demonstration grant program to return eligible MaineCare members living in institutional settings to their homes or community. Maine is one of 45 MFP states receiving enhanced Federal matching funds for up to 12 months for each qualified person who transitions. Participants of Homeward Bound, Maine's Money Follows the Person program, receive intensive Transition Assistance services facilitated by a Transition Coordinator, Home and Community-based Services, and other services. Household Start-up, Enhanced Care Coordination Services, Independent Living Services (e.g., environmental modifications and assistive technology) are some of the demonstration services that enable participants to successfully transition and remain in the community. The majority of the 41 individuals, ages 37 to 90, who have received Homeward Bound Transition Services since October 2012 have physical disabilities and complex medical needs. To date 10 participants have been moved from nursing facilities to Maine communities, another 22 are currently in the transition planning phase, with at least 8 more transitions projected by the end of 2013.

What are other States doing?

Maine is actively engaged in many cutting-edge practices to improve the effectiveness and efficiency of MaineCare. Other states are using many of the same strategies as well as pursuing additional innovations – including risk-based managed care, supports for persons with disabilities, partnering with the Centers for Medicare and Medicaid Services (CMS) to develop comprehensive strategies for integrating Medicaid and Medicare services and share in savings, and using evidence to inform and reward care aimed at health promotion and prevention.

Risk-Based Managed Care

Since the 1980's states have contracted with managed care organizations (MCOs), putting those plans at risk – providing a fixed amount of funding and specific performance targets to assure quality and appropriateness of care. Presently, over 29 million Medicaid enrollees are served through risk-based MCOs; only eight states, including Maine, do not contract with MCOs.[27] The research is mixed on the success of Medicaid managed care, but several factors are driving states to now expand managed care to broader populations, including the elderly and people with disabilities. First, managed care provides budget predictability. By establishing fixed rates to pay plans, Medicaid agencies know the annual cost of covering those members. Second, MCOs have more flexibility than state

government to hire staff and develop services. While the research is mixed, there are substantial protections required to safeguard quality, including annual external quality reviews – a protection not typically applied under fee-for-service Medicaid. States have concluded that the approach is worthy of continuing as legislatures and Governors continue to develop and support programs.

Managed Long Term Services and Supports: Managed long term services and supports (MLTSS) is a strategy that has been increasing in recent years. Programs vary greatly and include arrangements where contracted organizations are responsible for only LTSS; programs that make capitated payments for all or most Medicaid services including LTSS; and programs that serve people who are eligible for Medicaid as well as people who are dually eligible for Medicaid and Medicare.[28]

Between 2004 and 2012, the number of states with MLTSS programs doubled from 8 to 16 and the number of people receiving LTSS services through managed care increased from 105,000 to 389,000. In 2014, the number of states with MLTSS is projected to grow to 26. States have used both mandatory and voluntary enrollment approaches. Eight states have mandatory enrollment and seven have voluntary enrollment and one has both types. The most common populations included in MLTSS are older adults and adults with physical disabilities. Eight states include adults with children with disabilities, and eight states include persons with intellectual/developmental disabilities. Maine is not currently pursuing managed LTSS and has chosen a different model- the Accountable Community – to manage care for other populations, including persons using LTSS.[29]

Integrated Programs for Dually Eligible Beneficiaries

Significant numbers of high cost users are eligible for both Medicare, which covers primarily acute care and physician services, and Medicaid which primarily covers long term services and support. Coordinating care among the two programs complicates service delivery and creates several perverse incentives for cost shifting among the programs. In 2011 the Centers for Medicare & Medicaid Services launched an initiative to better align the financial incentives of Medicare and Medicaid through two new models. Under the capitated model, a state, CMS, and a health plan enter into a three-way contract allowing the plan to receive a blended (Medicare and Medicaid) payment to provide comprehensive care. Under the Managed Fee-For-Service Model, a state and CMS enter into an agreement by which the state can benefit from savings resulting from coordinating Medicaid and Medicare services. Although Maine chose not to apply under this initiative, results will help inform future strategies for better coordinating care for dually eligible beneficiaries and potentially working with CMS to share in savings.

Section 1115 federal waivers

Section 1115 of the Social Security Act allows states to use federal Medicaid and CHIP funds in ways not otherwise allowed absent the waiver. States must show a "research and demonstration" purpose to their waiver request which generally falls into one or all of the following categories: (1) expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible; (2) providing services not typically covered by Medicaid; and (3) using innovative service delivery systems that improve care, increase efficiency, and reduce costs. States must prove that the waiver will be budget neutral to the federal government and now must assure public comment prior to submitting the proposal to the federal government. Thirty-six states have current Section 1115 waivers, including Maine, whose waiver for including childless adults will terminate in December 2013.

Global Waivers – Phase I

During the Bush Administration, two states (Vermont and Rhode Island) were granted "Global Waivers" which allowed the states flexibility to redesign their Medicaid programs in exchange for a Federal funding cap. The waivers

were controversial. While other waivers allowed states to cap enrollment of specific populations, the global waivers moved away from an open entitlement to a fixed federal payment that put states at risk if costs exceeded expectations.

Vermont: Vermont's "Global Commitment waiver" was approved late in 2005, permitting the state to redesign its Medicaid program as part of a broader health reform initiative designed to improve public health and cover more uninsured. The waiver capped the amount of federal Medicaid funding for acute care services provided to the state's Medicaid population. A separate waiver capped long-term care. The state received new authority to cap enrollment for many Medicaid enrollees, increase cost sharing and reduce and restructure some benefits. The Federal government agreed to allow Vermont to use Federal Medicaid funds to support a broad array of its state funded, previously non-Medicaid reimbursed services. In this way the state received considerably more Federal dollars as part of the plan. Specifically, the state proposed making the state Medicaid agency a managed care organization that would charge premiums for its enrollees. If the state operated its managed care plan efficiently, there would be excess premium revenue. That premium revenue would be used to draw Federal match for non-Medicaid state funded services such as those supporting victims of domestic violence.[30] The financing strategy and just how the generous Federal cap was remained controversial.

Rhode Island: In 2008, the federal government approved Rhode Island's Consumer Choice Compact. Rhode Island merged a number of existing waivers into the new 1115 authority and, like Vermont, accepted a federal cap on spending.[31] Like Vermont, the state was allowed to cover those not otherwise eligible for Medicaid through the waiver and like Vermont, controversy surrounded the financing. The waiver allowed Rhode Island to mandatorily enroll Medicaid beneficiaries into managed care and to use any excess premium revenue much as Vermont did. The waiver was approved for a period 2009-2013. Rhode Island initially claimed considerable savings but a recent analysis concludes, "savings were not from efficiencies stemming from the global waiver but from increased federal spending and from measures the state could have implemented without the waiver."[32]

Global Waivers – Phase II

Oregon 1115 Waiver*:* In July 2012, CMS approved Oregon's 1115 Waiver that was critical to implementing its health system transformation and reducing spending growth in the program by 2%. This transformation includes delivery system reforms, commitments to reduce per capita spending, quality and performance benchmarks, enhanced flexibility in the use of Federal funds, and Federal investment in funding through the Designated State Health Programs. An essential component of this redesign is the establishment of Coordinated Care Organizations (CCOs) responsible for managing physical, behavioral and dental health for Medicaid beneficiaries. The state's effort to reduce per capita medical trend by 2 percentage points will be reached in the second year of the waiver. The CCOs must meet a number of quality metrics and there is a financial incentive for achieving performance benchmarks.

Oregon also has flexibility to use Medicaid dollars for flexible funding of services, e.g., non-traditional workers although funds have to be used for health-related care. Additional federal funds of $1.9 billion are available over five years through the Designated State Health Program. Other changes in the health care workforce will be supported, such as the establishment of a loan repayment program for primary care physicians who work in rural areas.

Early results of the program are promising, and 90% of Medicaid members are now enrolled with a CCO. In the first six months of reporting, emergency department visits have decreased by 9%; and 9 months of data shows that

emergency room spending is down by 18%. Hospital admissions for congestive heart failure declined by 29%; chronic obstructive pulmonary disease by 28%; and adult asthma by 14%. The use of electronic health record adoption has doubled.[33]

Using Evidence to Reward Practices

In 2011, the Arkansas Department of Human Services launched "Transforming Arkansas Medicaid" that included the *Arkansas Health Care Payment Improvement Initiative*. Arkansas' Medicaid program is working with two large private insurers, Arkansas BlueCross BlueShield and Arkansas QualChoice, to implement the reform.

The Payment Improvement Initiative began in the summer of 2012 with a goal to move away from fee-for-service payments and toward a system that rewards value and outcomes. Specifically, the state has identified certain episodes of care, established quality metrics regarding how care should be provided, and established a new method of payment to incentivize quality of care. The state describes the program as:

> *Patients experiencing one of the medical episodes will schedule office visits and be seen by their physician or mental health provider just as they are today. Providers will file claims as usual and be reimbursed as they are today. The change comes as providers are now able to input some basic information related to the care they provide into a Provider Portal. Using the portal, providers are able to access reports that show the overall quality of care they delivered during a set time period -- typically one year -- and at what average cost. Medicaid and the private insurers use the information from the portal along with claims data to determine which provider has the most responsibility for a given episode. That provider will be designated the "Principal Accountable Provider (PAP)." At the end of the set time period, each PAP's average cost per episode will be calculated and compared to "acceptable" and "commendable" levels of costs. If the average cost is above the acceptable level, the provider will pay a portion of the "excess" costs. If the average cost is acceptable but not commendable, there will be no payment changes. If the provider offers high-quality care below the commendable level, then he or she will be eligible to share in the savings with the payer.*

The collaborating partners are using input from providers, patients and others interested in the initiative to design and build infrastructure for of the introduction of new episodes. The goal is to have most episodes of care designed and launched within three to five years.[34]

The initiative began in June 2012 focusing on upper respiratory infections, ADHD, and perinatal care episodes. In September 2012, Arkansas Medicaid expanded the initiative to propose guidelines for congestive heart failure and total joint replacement. Like Maine, Arkansas received a State Innovation Model (SIM) grant in early 2013. With these funds, Arkansas will expand its payment model to 75-100 episodes of care over the next three years. They propose a two phased approach:

- In the first 9-12 months of the SIM grant, participating payers plan to develop a new, scalable infrastructure platform for launching and administering episodes. During this period, the initiative will expand by 5-10 episodes. It is anticipated that the experience gained from the initial roll out of the 5 conditions will allow for a more rapid implementation of new episodes of care.
- Through mid-2016, the initiative will expand through quarterly launches of 5-10 new episodes. The state expects the new infrastructure will facilitate the rapid launch and administration of these episodes.[35]

Data on the experience of the first cohort of episodes of care are expected in January, 2014.

Next Steps

On November 22 from 9 am- 12:30 pm at The Augusta Civic Center, the Muskie School will host a colloquium, "*The Future of Medicaid: Building Sustainability through Innovation*" that will feature remarks by Diane Rowland, Vice President at the Henry J. Kaiser Foundation and a national Medicaid expert. A panel of state policymakers will engage with Dr. Rowland about initiatives underway in Maine and be followed by a panel of experts from other states who will describe several innovations underway that promise to improve care while controlling the cost growth of Medicaid.

Endnotes

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Appendix A**

Federal Mandatory and Optional Services under Medicaid

Mandatory Services	Optional Services
• Inpatient hospital services • Outpatient hospital services • EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services • Nursing Facility Services • Home health services • Physician services • Rural health clinic services • Federally qualified health center services • Laboratory and X-ray services • Family planning services • Nurse Midwife services • Certified Pediatric and Family Nurse Practitioner services • Freestanding Birth Center services (when licensed or otherwise recognized by the state) • Transportation to medical care • Tobacco cessation counseling for pregnant women	• Prescription Drugs • Clinic services • Physical therapy • Occupational therapy • Speech, hearing and language disorder services • Respiratory care services • Other diagnostic, screening, preventive and rehabilitative services • Podiatry services • Optometry services • Dental Services • Dentures • Prosthetics • Eyeglasses • Chiropractic services • Other practitioner services • Private duty nursing services • Personal Care • Hospice • Case management • Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD) • Services in an intermediate care facility for the mentally retarded • State Plan Home and Community Based Services- 1915(i) • Self-Directed Personal Assistance Services- 1915(j) • Community First Choice Option- 1915(k) • TB Related Services • Inpatient psychiatric services for individuals under age 21 • Other services approved by the Secretary including services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital (CAH)

** http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html