

Issue Brief

Key National and State Medicaid Issues

MaineCare is the name of Maine's Medicaid program. Nationally and in Maine, the direction of the Medicaid program is a perennial issue for policy makers. Why is there so much interest in a state-federal partnership program that provides health and related services to poor persons? One reason is scale. The program provides coverage to 1 out of 5 Maine citizens, and the state's share of the cost (roughly 37%, with the federal government paying 63%) represents the state's second largest General Fund expenditure, after General Purpose Aid to Local Schools. Like health care generally, the program's cost increases consistently outpace general inflation, causing some to question the long term sustainability of the program in its current form.

Many contentious issues from the general health care debate are played out in Medicaid. Should consumers be given greater responsibility for and control over their health care spending? Should high-cost consumers be taken out of the general insurance pool or left in? Does Medicaid reduce cost-shifting by covering people who would otherwise be uninsured, or increase cost shifting by paying below-market rates to providers?

The debate is often heated because so many people have a stake in it. Since its inception in 1965, Medicaid has evolved beyond the original health program for poor families receiving welfare. It is the largest public payor of long term care and disability services. Nearly everyone in the State has some personal connection to a friend or family member receiving Medicaid-supported long term services in their homes, a nursing home, residential care facility, or supported living arrangement

for persons with mental or physical disabilities. Many non-profit social service providers, particularly those providing mental retardation supports, mental health services, independent living services or long term care, rely on Medicaid for most or all of their revenue.

Medicaid Overview

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 coverage. The matching formula for services takes into account the relative income across states. Because Maine's median income is below the national average, the federal government provides a relatively high matching rate for MaineCare services, not quite 63% in SFY 2006. This means that for every \$100 of services purchased by MaineCare, the federal government pays about \$63 and the state pays about \$37. The federal government pays a flat 50% matching rate to all states for administrative costs. In SFY 2006, total MaineCare costs were around \$2.4 billion. Of this, the state paid \$644 million, and the federal government paid over \$1.7 billion.¹ The federal incentive has prompted Maine and most other states to add services and population

Fast Facts

- MaineCare is the name of Maine's Medicaid program.
- MaineCare provides coverage to 1 out of every 5 Maine citizens.
- In 2006, the federal government paid about 63% of MaineCare's \$2.4 billion cost, or about \$1.7 billion.
- The State's share of MaineCare funding is the second largest General Fund expense, after support for local education.
- Medicaid is the largest public payor of long term care and disability support services in the state and nationally.
- Older persons (65+) and persons with disabilities make up 25% of MaineCare membership. Their expenses account for 66% of MaineCare spending.

Authors: Paul Saucier
Muskie School of Public Service
(207) 780-5176, pauls@usm.maine.edu

Katie Rosingana
Muskie School of Public Service
(207) 626-5027,
krosingana@usm.maine.edu

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groups to the Medicaid program over time, especially those that were previously funded with 100% state dollars.

Many eligibility categories. Medicaid is a means-tested program. In order to qualify, a person must have low income, expressed as a percentage of the Federal Poverty Level (FPL), and must fall into one of several categories defined by the federal government. States have some flexibility in extending eligibility for each categorical group beyond a required minimum level. As a result, Medicaid eligibility limits differ from state to state. The basic federal categorical groups include people 65 and over, people who meet Social Security disability criteria, children, parents with minor children living at home, and pregnant women. Some states, including Maine, Massachusetts and Vermont, have received special federal permission to extend coverage to individuals who do not fit one of these categories. These individuals are referred to variously as “non-categoricals” or “childless adults.”² Because of the strong federal financial incentive, all state efforts to expand insurance coverage, including the large effort currently underway in Massachusetts, maximize Medicaid eligibility to bring as much federal funding to the effort as possible.

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(called “optional”) by including them in their State Medicaid Plans. Maine and every other state cover several optional services to maximize federal matching funds and to stay current with evolving health care delivery trends. Since the program was first authorized in 1965, the provision of health services has shifted from institutional settings to outpatient settings, and to take advantage of these changes, the federal government has authorized new benefits in the optional category. Many optional services, such as prescription drugs and home health services, are central to health treatment today.³

Service delivery options. In the realm of 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, and despite paying less than commercial rates for many services, the MaineCare program enjoys high participation among most types of providers. In addition to traditional healthcare providers, Medicaid also funds a large array of long term care and disability support service providers that reflect the program’s role as the largest funder of disability

and long term care services. These are services that are generally not covered by commercial health plans or Medicare, such as long term nursing home stays, home care services, and personal assistance services.

When created in 1965, Medicaid was modeled after the predominant fee-for-service delivery system of the time. As employer-based coverage has moved to various forms of managed care, so have many state Medicaid programs, particularly those with urban centers.

Sustainability and Flexibility at Center of National Medicaid Debate

The national debate about Medicaid can be boiled down to two major issues: fiscal sustainability and the degree of flexibility states should have to design and manage their individual programs.⁴ Nationally, Medicaid is expected to spend \$350 billion in 2007, and the Congressional Budget Office has estimated growth of 7.7% a year over the next decade.⁵ In part, Medicaid spending is fueled by the same cost pressures that affect all health-care spending. But because Medicaid is the largest payor of long term care and disability support services, it experiences additional cost pressures not generally seen in commercial insurance. A recent national study found that, although long term care users (of all ages) comprised only 7% of Medicaid beneficiaries in 2002, they accounted for 52% of Medicaid spending.⁶

The state flexibility debate is linked to the cost issue, but also raises broader implications about the delicate balance of state and federal authority currently built into Medicaid law. States argue that if they had greater flexibility to design their eligibility and benefit rules, they could afford to cover more people at a lower per person cost. Federal proposals for greater flexibility have generally been tied to capping the amount of financing provided by the federal government. In other words, the price a state would pay for greater flexibility would be to forego the open-ended opportunity to draw down federal matching funds.

With states reporting the lowest Medicaid growth rate in years, some analysts argue that the Medicaid sustainability question is overblown. But the growth rates of the past few years very likely reflect the counter-cyclical nature of the program. In good economic times, income goes up and Medicaid enrollment goes down. Unfortunately, this means the converse is also true. When the economy declines, Medicaid enrollment goes up, at the very time when states can least afford the costs.

Irrespective of their views on sustainability, governors have lent bipartisan support to greater state flexibility, arguing that they must have more discretion if they are to effectively manage a program that consumes an increasing portion of their budgets. But calls for

flexibility are rejoined by some national advocacy groups, where there is concern that state flexibility is little more than a euphemism for cutting services.

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

States have some flexibility within existing federal regulations to establish eligibility, benefits and provider payment rates. Until recently, that flexibility was largely limited to exceeding minimum requirements contained in federal law. Provisions contained in the Deficit Reduction Act of 2005 (DRA) gave states substantial

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new flexibility for certain population groups, however.⁷ Prior to the DRA, if a state offered a Medicaid benefit, it generally had to be offered to all eligible beneficiaries. States were also limited to offering the

mandatory and optional benefits listed in federal regulations. Under DRA, states can instead offer to certain beneficiaries a benefit package modeled after one of several “benchmark” coverages, which include the Blue Cross Blue Shield plan offered to federal employees, the health plan offered to state employees, the coverage offered by the largest HMO in the state, or other coverage determined appropriate by the federal Secretary of Health and Human Services. Furthermore, a state can offer different benefit packages across beneficiary categories or geographical areas. DRA flexibility can be gained by amending the State Medicaid Plan, a process that requires formal review by the federal government but is much less cumbersome than seeking waivers of existing law. West Virginia has had a State Medicaid Plan amendment approved under the DRA to design a tiered benefit package for purposes of encouraging personal responsibility (*see sidebar description*).

States desiring more comprehensive reform than that available under the DRA can seek a §1115 waiver. This mechanism can be used to waive most provisions of federal Medicaid law, but the overall proposal must cost the federal government no more than it would have cost under the regular program. §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. For some time, the federal Office of Management and Budget has insisted on hard caps to ensure cost neutrality, which means the federal government imposes a firm limit on the funding it will provide for the waiver program, whether or not actual expenses come in as projected. If the waiver program covers a small sub-population

Using the Deficit Reduction Act’s Benefit Flexibility to Encourage Personal Responsibility: West Virginia’s State Medicaid Plan Amendment

In May, 2006, West Virginia was the first state to receive approval under provisions of the Deficit Reduction Act of 2005 to change Medicaid benefits for existing beneficiaries and differentiate benefits across groups. The State is using a new tiered benefit approach to encourage personal responsibility and good health behaviors.

Most children and parents will be moved to new benefit packages. The Basic Plan is the default, and is more limited than West Virginia’s traditional plan. Those who sign and adhere to a member agreement get the Enhanced Plan, which includes coverage for mental health counseling, anti-smoking and anti-obesity programs, cardiac rehabilitation, diabetes management assistance, prescription drugs over the Basic Plan limit of 4, and home health visits.

Physicians will monitor and report on adherence to the agreement, which includes attending routine medical check-ups and screenings, attending scheduled physician appointments, taking medications as prescribed and visiting the ER only for medical emergencies. Those who do not adhere will revert to the Basic Plan.

For more on West Virginia’s program and its implications, see Kaiser Commission, 2006, *West Virginia’s Medicaid State Plan Amendment: Key Program Changes and Questions*.

of beneficiaries, the state takes on a relatively small risk. But if all or most beneficiaries are included, like in Vermont and Florida, a state needs to be confident it can really deliver the innovative approach within the available budget.

Vermont and Florida are getting much attention because their §1115 waiver reform programs are far-reaching, approved, and currently being implemented. But the two efforts are very different, underscoring the degree of flexibility available to states. The approaches are conceptually and philosophically different, and reflect the market realities of each state. Florida, with a large population and robust competition among dozens of health plans, seeks to use Medicaid’s purchasing power to make an array of health plan choices available to beneficiaries and, in a substantial departure from traditional Medicaid, make the beneficiaries themselves responsible for making choices that meet their needs. Vermont, where the population density and healthcare market

more closely resemble that of Maine, has established its Medicaid agency as a managed care organization, taking on directly the risks and potential rewards of managing beneficiary care within a capped global budget. The programs' key features are described in the table below.

Current Issues in Maine

Sustainability and flexibility were both acknowledged as issues by Maine's recent Blue Ribbon Commission on the Future of Maine Care. Is it time for Maine to take a serious look at comprehensive

Medicaid reform? As MaineCare lurches from one State budget to another, the options for cost containment in the traditional 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, or reduce rates. 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 payors. Some believe that the program has become too large and complex for incremental budget adjustments to be effective. But for others, the risks inherent in capped federal funding, the political challenges of creating

Comprehensive Reform in Florida and Vermont: Two Different Applications of State Flexibility Under §1115 Medicaid Waivers

	Major Program Features	Risk Dynamics	New Options for Beneficiaries
<p>Florida's Medicaid Reform Waiver</p> <p>Approved Fall, 2005.</p> <p>Pilot implementation began Fall, 2006.</p>	<ul style="list-style-type: none"> • Shifts program from defined benefit to defined contribution. • State sets aside a per person, risk-adjusted contribution that consumers use to buy a plan from the market, and looks to market to create choice and value. • State accepts a per capita cap from the federal government, and allows plans to define benefits and control utilization within available state contribution. 	<ul style="list-style-type: none"> • The State accepts risk from the federal government for expenses that exceed the per person cap. • The State passes its risk to health plans in the form of defined contributions, and the plans must manage within those amounts. • Health plans manage their costs by defining benefits and managing utilization. • Beneficiaries are no longer guaranteed a standard benefit package, and are responsible for choosing a plan that meets their needs. 	<ul style="list-style-type: none"> • Deposits will be made to personal Enhanced Benefit Accounts for beneficiaries who engage in healthy practices, such as smoking cessation and weight loss. • Beneficiaries have a choice among competing health plans. • Beneficiaries with employer-sponsored plans may opt out of Medicaid and get subsidy support for the employer plan, but are responsible for any applicable copayments and deductibles.
<p>Vermont's Global Commitment Waiver</p> <p>Approved and took effect Fall, 2005</p>	<ul style="list-style-type: none"> • State accepts a global cap on federal contributions, and assumes direct responsibility for managing within the cap by establishing itself as a managed care organization. • State may define benefits, increase cost sharing and cap enrollment, and may apply savings to non-Medicaid health services. 	<ul style="list-style-type: none"> • The State accepts risk from the federal government for any expenses that exceed the global cap. • The State manages the risk itself, and has flexibility to define benefits, cap enrollment and use other strategies to contain costs. • Beneficiaries are no longer guaranteed a standard benefit package, and in the State's policy debates, they may compete with other health initiatives for which Vermont may now use its federal funding. 	<ul style="list-style-type: none"> • Not specified at this time. • Within its federal agreement, the State may choose to provide additional services not currently funded by Medicaid, and may expand eligibility.

winners and losers, and the sheer effort required to design and implement comprehensive reform are simply too great. If Maine does decide to pursue large-scale change, the experience of other states points to one paramount need: clear reform goals that enjoy widespread consensus. In the meantime, several MaineCare issues will likely be debated with or without a reform agenda in mind. They include the following:

What will be the impact of lost provider tax revenue? One of the innovative ways that states, including Maine, have financed Medicaid services has been to enact taxes on institutional Medicaid providers (hospitals, nursing homes, and residential care facilities). The revenue is used to provide required state matching funds to attract federal Medicaid financing. Maine currently taxes nursing home and residential care facilities at 6%, the maximum rate allowed under federal rules. Section 403 of the Tax Relief and Health Care Act of 2006 temporarily reduces the maximum to 5.5% between January 1, 2008 and September 30, 2011. Maine will need to make this downward adjustment, but doing so will be far less challenging than what the President had proposed in his budget proposal: capping the tax at 3%.

Should Maine contract with a fiscal agent to process claims? As of December, 2006, Maine was one of 15 states that operates its own claims processing system. The remainder, including 4 New England states, contract out the service. Following a series of well-publicized challenges with Maine's in-house claims system (MECMS), the administration is now considering the use of a fiscal agent, and has sought authority in the Governor's budget proposal to do so. Key issues to pay attention to are cost, effectiveness, and impact on the program's ability to manage its initiatives (many of which depend on good access to timely data). The market for Medicaid fiscal agents is dominated by a few large national companies that have a substantial track record to examine. If anything was learned from the MECMS experience, it's that selecting the lowest bidder is not always in the State's interest.

What are the benefits of promoting more managed care? Does it really save money? 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. Now, the program is again looking at risk-based models for behavioral health and perhaps other populations or services.

Does MaineCare underpay providers? This is a perennial debate, and the answer depends in part on what one considers the appropriate base of comparison. The legislation creating the Dirigo Health program (P.L. 2003, c. 469) directed the Maine DHHS to conduct a comprehensive review of MaineCare reimbursement rates. The resulting report found that MaineCare rates are generally lower than those paid by commercial insurers and Medicare. However, the report also found that MaineCare rates are similar to those paid by Medicaid programs in the other New England States, with the exception of physician fees. MaineCare physician fees are lower than those paid by other New England Medicaid programs. At issue is whether MaineCare should pay rates closer to those paid by commercial payors. 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.

What can Maine do to address long term care and disability costs? MaineCare has a few things underway or authorized in this area. To better manage the chronic care needs of the program's highest cost beneficiaries, it has contracted with Schaller Anderson, a national care management company, to operate a pilot program. The pilot, however, will serve only 200 beneficiaries. If found successful, it would need to be expanded significantly to impact the program overall. In a previous session of the Legislature, DHHS received authorization to implement a Long Term Care Partnership project, an option closed off by Congress in the early 1990s, but recently opened to new states under the Deficit Reduction Act of 2005. The approach is a public-private partnership between private long term care insurance and Medicaid designed to encourage the purchase of private long term care insurance. The DRA made it possible to implement a program by filing a State Medicaid Plan amendment. Finally, the Governor's budget proposes to change payments for certain disability services to a system of scheduled rates that would make them more similar to payments in other New England states.

Can MaineCare treat smokers differently than non-smokers? As demonstrated by West Virginia, it is possible under the Deficit Reduction Act to create tiered benefits for certain groups of beneficiaries for purposes of encouraging healthy behaviors. What is not known yet is whether the approach will actually change behavior, how the medical community will respond to becoming behavior monitors, or whether any savings will accrue.

Does MaineCare attract people from out of state? Some legislators have expressed concern, as reported to them by constituents, that MaineCare is attracting people from other states. While this does occur to some extent, data provided by the Maine Department of Health and Human Services suggest that Maine is a net exporter of public assistance cases. Between April, 2004 and April, 2005,

695 new public assistance cases (including MaineCare) were coded as having recently moved into the state, but during the same period, 3,373 cases were closed due to persons moving out of the state.¹¹

A Debate with Impact

MaineCare policy decisions affect the number of uninsured persons, revenue to healthcare and related providers, the cost of private health insurance, the level of bad debt and charity care in the system, the amount of federal revenue coming into the state and the amount of state General Fund dollars allocated to healthcare. For all these reasons, with or without a reform agenda, MaineCare is certain to be at the center of Maine's healthcare debate.

For More Information

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Endnotes

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