

Issue Brief

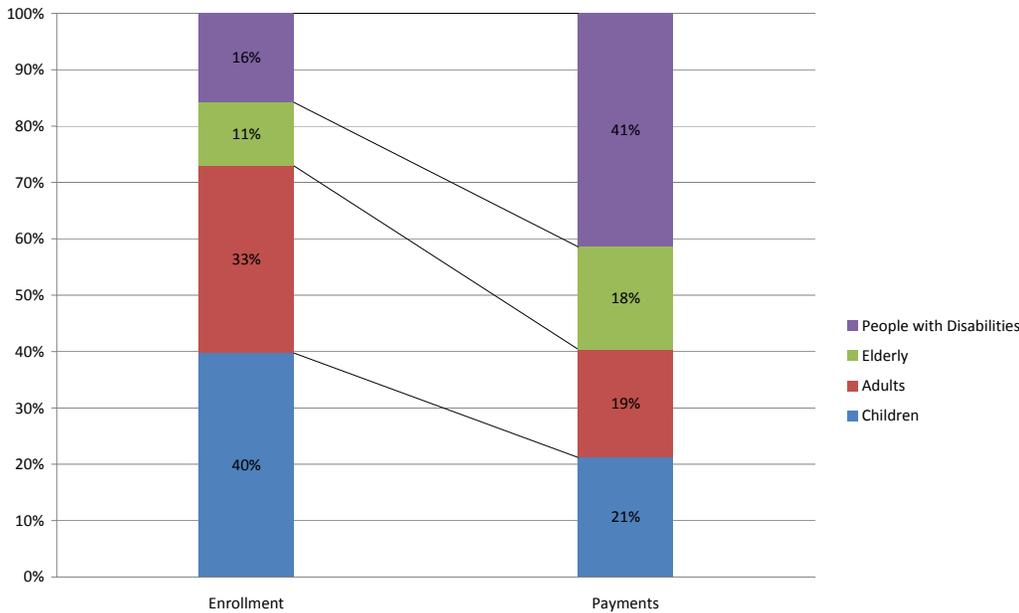
National and State Medicaid Issues in 2009

Maine’s Medicaid program, called MaineCare, is an important part of the state’s health care system. It provides coverage to 1 out of 5 Maine citizens. The largest group covered is poor children and their parents, though nearly two-thirds of the program’s costs are attributed to a smaller number of people receiving

represents the state’s second largest General Fund expenditure, after General Purpose Aid to Local Schools.

The current economic outlook has increased pressure on Medicaid programs and states across the country. The unemployment rate na-

Figure 1: MaineCare Enrollment and Payments by Enrollment Group, FY 2004



Source: Kaiser State Health Facts based on data from the Centers for Medicare and Medicaid Services.

long-term care and disability support services. In fact, Medicaid is the largest public payer of long term care and disability services, making it distinct from Medicare or other health care insurers.

Nationally and in Maine, the Medicaid program is a perennial issue for policy makers because it consumes such a large portion of the budget. In Maine, the state’s share of MaineCare costs

tionally is at its highest level in 15 years.¹ As unemployment rises and access to employer-sponsored health insurance and incomes decline, Medicaid enrollment increases. Medicaid officials across the country projected an average 3.6 percent increase in enrollment for FY 2009 due to the worsening economy.² At the same time, increases in unemployment and loss of income reduce state tax revenues, making it more difficult for states to pay for Medicaid

Fast Facts

- MaineCare is the name of Maine’s Medicaid program, which provides health care coverage to 1 out of every 5 Maine citizens.
- The State’s share of MaineCare funding is the second largest General Fund expense, after support for local education.
- In 2008, the federal government paid just over 63% of MaineCare’s \$2.3 billion cost, or about \$1.7 billion.
- Medicaid is the largest public payer of long term care and disability support services in the state and nationally.
- Nearly two-thirds of MaineCare’s costs are attributed to long-term care and disability support services.

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spending increases. As of November 2008, at least 43 states have faced or are facing budget deficits for fiscal years 2009 and/or 2010. Maine's estimated shortfall for FY 2009 is \$140 million.³ The Governor's proposed supplemental budget closes Maine's budget gap with minimal changes to the MaineCare program,⁴ but it is still likely to be a large part of upcoming legislative debates.

Medicaid Overview

Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a means-tested federal entitlement program. 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 Medicaid coverage. The federal medical assistance percentage (FMAP) is the share of total Medicaid expenditures that the federal government pays and varies by state based on relative income. Because Maine's median income is below the national average, the federal government provides a relatively high matching rate for MaineCare services -- 64.4% for federal fiscal year 2009 (Oct 2008- Sept 2009).⁵ This means that for every \$100 of services purchased by MaineCare, the federal government pays about \$64 and the state pays about \$36. The federal government pays a flat 50% matching rate to all states for administrative costs. In SFY 2008, total MaineCare costs were around \$2.3 billion. Of this, the state paid \$607 million, and the federal government paid over \$1.7 billion.⁶

Many eligibility categories

In order to qualify for Medicaid, a person must have low income, expressed as a percentage of the Federal Poverty Level (FPL), and must fall into one of the groups that are "categorically eligible" as defined by the federal government. Federal law requires states to cover certain "mandatory" groups in order to receive any federal matching funds. These groups include low-income pregnant women and children, parents below state welfare eligibility levels, and most elderly and persons with disabilities with low incomes who receive Supplemental Security Income (SSI). States have some flexibility in extending eligibility for each categorical group beyond the required minimum income level as an "optional" group. As a result, Medicaid eligibility limits differ from state to state.

Because of the strong federal financial incentive, Maine and most other states have added services and population groups to the Medicaid program over time, especially those that were previously funded with 100% state dollars. Similarly, many state efforts to expand insurance coverage, including the large efforts currently underway in Massachusetts and Vermont,

maximize Medicaid eligibility to bring as much federal funding to the effort as possible.

Adults without dependent children, no matter how poor they are, are categorically excluded from Medicaid unless they are disabled or pregnant. However, some states, including Maine, Massachusetts and Vermont, have received special federal permission to extend coverage to these individuals who are referred to variously as "non-categoricals" or "childless adults."⁷ States are able to cap enrollment for these groups and due to pressures on the Maine state budget, enrollment in this program is currently closed.

Mandatory and optional benefits

The benefits provided by Medicaid are also guided by federal minimum requirements and options. States must provide services in certain categories (called "mandatory"), and have the option to provide several additional benefits (called "optional") by including them in their State Medicaid Plans. Maine and every other state cover many optional services to maximize federal matching funds and to stay current with evolving health care delivery trends including prescription drugs and home health services, which are critical services for many MaineCare recipients today.⁸ Generally, if a state offers a benefit, it has to offer the same set of services to all individuals covered in the state.

Service delivery options

For 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. Despite paying less than commercial rates for many services, the MaineCare program enjoys high participation among most types of providers. Medicaid also funds a large array of long term care and disability support service providers that are generally not covered by commercial health plans or Medicare, including long term nursing home stays, home care services, and personal assistance services.

Medicaid was originally modeled on the fee-for-service delivery system. Paralleling the trend in employer-based coverage, many state Medicaid programs have moved to various forms of managed care, particularly those with urban centers.

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

For greater flexibility from minimum Medicaid requirements, states can seek an §1115 waiver. This mechanism can be used to waive most provisions of federal Medicaid law, but the overall proposal must be cost neutral to the federal government costing no more than it would have cost under the regular program. In other words, the state assumes the risk if actual expenses are higher than estimated. If the waiver program covers a small sub-population of beneficiaries, the state takes on a relatively small risk. But if all or most beneficiaries are included, as in some of the comprehensive reform proposals, a state needs to be confident it can really deliver the innovative approach within the available budget. §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.

Several waivers approved by the Bush administration – including those in Vermont, Florida and most recently Rhode Island - significantly expand state flexibility under Medicaid and have drawn national attention. Florida’s program relies on a market-based approach paying private managed care plans risk-adjusted premiums to serve Medicaid beneficiaries and allowing them some discretion in setting benefit packages. Beneficiaries are responsible for choosing plans that meet their needs. The program has been implemented in five counties and serves around 9 percent of Florida Medicaid enrollees. While too early to determine the program’s impact on access and program costs, early findings suggest that it has not resulted in a large influx of commercial insurers to Medicaid or significant differences in benefit packages. Beneficiary enrollment has also been concentrated in a small number of plans and awareness of an enhanced plan designed to encourage healthy behaviors has been limited. Pending further study, the state has delayed expanding the program statewide.⁹

Vermont -- which like Maine has low population density and few health plans in their market -- established its Medicaid agency as a managed care organization, directly taking on the risks and potential rewards of managing beneficiary care within a capped global budget. Vermont’s waiver has not yet been evaluated, but the state expects to stay within its negotiated cap even while expanding insurance coverage up to 200% FPL¹⁰ through reduced administrative costs resulting from combining multiple waivers into one, a statewide health information exchange, improved purchasing, and chronic care management. Thus far, it has not proposed to modify benefits or eligibility even though the waiver gives them that option.

A highly controversial waiver recently approved in Rhode Island modifies the federal Medicaid matching structure to a fixed annual amount, while limiting the state’s Medicaid contribution to a constant share of the state budget. Unlike typical 1115 waivers that operate under a per capita or per person cap that allows federal funding to grow with enrollment increases, Rhode Island’s unprecedented program would move its Medicaid program under a block grant. The state also has the authority to establish waiting lists, eliminate optional services, or increase cost-sharing for certain eligibility groups.¹¹

The future of these waivers under the new Obama administration is unknown. Both the General Accounting Office and Democratic members of Congress have raised concerns about these waivers regarding the extent of public input and whether the scope exceeds statutory authority.¹²

In 2005, new rules under the Deficit Reduction Act (DRA) also allowed states to vary benefits, premiums and cost-sharing requirements across beneficiary groups or geographical areas and to replace the traditional Medicaid benefit with new “benchmark” plans offered in the state.¹³ DRA flexibility can

be gained by amending the State Medicaid Plan, a process that requires formal review by the federal government but is considered much less cumbersome than seeking waivers of existing law. However, few states have taken advantage of the new rules. In 2009, only 8 states were using the DRA authority related to benefit changes.¹⁴

Current Issues in Maine

As in all the other states, the immediate challenge for Maine in 2009 will be how to maintain or retool MaineCare in the current fiscal environment. The options for cost containment in the traditional Medicaid 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, reduce rates or manage utilization of services. 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 payers. The last option, managing use of services, has potential to control costs and improve quality and coordination of services. The following are some MaineCare issues likely to be discussed:

Federal fiscal and administrative rule relief under new administration

As states confront large budget deficits, many state policymakers are looking to the new Obama administration for federal relief. Several Congressional proposals would temporarily increase the Medicaid FMAP to help states avoid having to cut critical health services as was done during the last economic downturn.¹⁵ President-elect Obama has indicated some federal Medicaid assistance would be made available and his stimulus package may include as much as \$100 billion to subsidize the state Medicaid programs.¹⁶ With an FMAP temporary increase, Maine could see as much as additional \$228 million in federal support for Medicaid over the next two years.¹⁷

In addition to fiscal relief, states are seeking relief from regulatory rules and directives promulgated by the Bush administration. In 2007, unable to get Congressional support for Medicaid budget cuts, DHHS issued a series of regulations designed to limit federal Medicaid spending through administrative action. The rules limit the amount of Medicaid reimbursements for rehabilitative services, intergovernmental transfers, graduate medical education, targeted case management services, school based administrative and transportation services, as well as payment to public safety-net institutions and coverage of hospital clinical services. Together these rule changes could shift \$15 to \$50 billion in federal Medicaid spending over to the states in the next five years.¹⁸ While Congress passed a moratorium on most of these regulations until April 1, 2009, it is unclear which of these rules will remain in place under the new administration.

A related issue that could impact Medicaid (and discussed in more detail in a separate brief on Children’s Health) is federal action on the reauthorization of the State Children’s Health Insurance Program (SCHIP). SCHIP is a block grant program designed to provide health insurance to low-income children and their families who are above the income limits in state

Medicaid programs. Medicaid and SCHIP are closely linked. In implementing SCHIP, states were allowed to either expand Medicaid and/or create a new state SCHIP program.¹⁹ Maine did both, creating what is known as a “combined” SCHIP program – with some children covered under a Medicaid expansion and others covered under a separate SCHIP program called CubCare. The federal match rate for services funded through SCHIP is higher than in Medicaid. In FY 2009 Maine received an enhanced SCHIP match of 75% for every dollar spent on services, compared to the regular Medicaid federal match of 64.4%.²⁰ Children in both CubCare and Maine’s Medicaid expansion are eligible for this enhanced rate.

In 2007, SCHIP was up for renewal, but attempts to reauthorize the program by Congress were vetoed by the President. A compromise measure temporarily funded the program through February 2009. Without legislative action before March 2009, Maine along with all states would lose the states’ FY 2008 and FY 2009 federal allotments and funds for eliminating FY 2009 shortfalls of approximately \$1.8 billion in 28 states- including Maine. The impact could be mitigated by the ability to access Medicaid funding, but it would be at a reduced matching rate compared with SCHIP.²¹

Other federal actions that could assist states include increasing rebates that pharmaceutical companies are required to offer state Medicaid programs and greater support to build and enhance Health Information Technology (HIT) infrastructure.

Could more savings be achieved through greater managed care?

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.

MaineCare has also contracted with APS Healthcare to pilot a model for managing behavioral health care services for MaineCare members with mental health or substance abuse diagnoses. This intervention is still being evaluated to assess cost savings.

Should MaineCare providers be paid more and how can provider payment be tied to quality?

Whether MaineCare pays providers sufficiently is a perennial debate, and the answer depends in part on what one considers the appropriate base of comparison. MaineCare rates are generally lower than those paid by commercial insurers and Medicare. However, MaineCare rates are similar to those paid by Medicaid programs in the other New England States, with the exception of physician fees which are lower.²³ Maine has attempted to address this issue by raising provider reimburse-

ment in the last two years.²⁴ In addition, as part of the state’s PCCM program, MaineCare does offer a payment enhancement to providers that offer care management (\$3.50 per member per month they are managed) and Maine’s Physician Incentive Program ties 30 percent of a performance bonus to emergency department utilization measures. Following Medicare’s lead, other states are also using negative payment incentives (i.e. not paying for medical errors or ‘never events’) to address quality. The degree to which MaineCare should pay rates even closer to those paid by commercial payors is likely to continue to be debated. 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.

How can MaineCare improve the quality of care for persons with chronic health conditions?

To better manage the chronic care needs of the program’s highest cost beneficiaries, which includes 10% of adults and 5% of children, MaineCare has contracted with Shaller Anderson, a national care management company. An initial pilot of 300 members demonstrated some positive results in reducing inpatient and emergency room use. The program is currently serving approximately 10,816 of the estimated 17,000 highest cost users.²⁵ Continued evaluation of this intervention is needed to determine its efficacy.

Another approach for managing chronic care through enhancing primary care delivery that may hold promise is the patient-centered medical home model (PCMH). The PCMH is a model for delivering comprehensive primary care through coordinated, care which is supported by an alternative payment model that recognizes the additional investment required by practices. Studies have shown that practices modeled on the principles of a medical home in other states are associated with better patient outcomes, reduced costs and reduced disparities. The MaineCare program in collaboration with the Maine Quality Forum, Quality Counts, the Maine Health Management Coalition, and Anthem Blue Cross Blue Shield have begun designing a PCMH pilot in 10-20 primary care practices in Maine over a 3 year period. In addition to including key components of a medical home defined by national provider associations,²⁶ the pilot adds Maine-specific principles of using a team-based approach and promoting physical-behavioral health integration.²⁷

What can Maine do to address long term care and disability costs?

Maine has also recognized the need to reform its long term care system. The final report of the Blue Ribbon Commission to Study the Future of Home-based and Community-based Care recommends that the State adopt a vision of long-term care services and supports in settings that optimize health and independence, and reverses the spending trend from residential and nursing facility care toward home and community-based care. It also recommends a uniform budget for institutional and home and community-based services to facilitate coordinated planning. If implemented, these changes, combined with new opportunities available to expand home and community-based services and to offer evidence-based programs in the community, may help to improve quality of care and reduce costs in the future.

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