

Taking a New Look at MaineCare

by Paul Saucier



Maine's Medicaid program, called MaineCare, provides health care coverage to one in five state residents. Paul Saucier gives an overview of MaineCare's services, eligibility categories, and financing. He discusses root causes of MaineCare's continued expansion in breadth and cost, which has prompted reform proposals to rein in what many believe is unsustainable growth. Examining reform efforts in other states, Saucier cautions that we need to learn from these experiments. Finally, he raises important questions for policymakers related to MaineCare's mission, its complexity, and the stability of its financing. Two commentaries provide additional viewpoints on these questions. Lisa Pohlmann and Christine Hastedt critique reform efforts in several states and emphasize the key role of MaineCare in the state's overall health care system. Dr. Erik Steele discusses MaineCare from the providers' perspective. He suggests that delays and problems in the state's reimbursement to providers have led to doubts about the state's credibility both as a payer and as a health care systems change leader. 



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Maine's Medicaid program, called MaineCare, is an important part of the state's health care system. It provides health care coverage to one out of every five Maine citizens. The largest group covered is poor children and their parents, though nearly two-thirds of the program's costs are attributed to the smaller group of people receiving long-term care and disability support services. Many MaineCare members would be uninsured or underinsured if MaineCare did not exist because they are unemployed, work for an employer that does not offer insurance, or have long-term care or disability support needs that neither employer-sponsored insurance nor Medicare cover.

In 2005, Medicaid provided health care coverage to 37.8 million people nationally, surpassing Medicare, which covered 34.6 million (Kaiser Family Foundation 2007). Adjusted for inflation, national (state and federal combined) Medicaid expenditures grew from \$40.9 billion in 1985 to \$311 billion in 2005 (U.S. Department of Health and Human Services 2007). The growth in Medicaid spending is caused in part by the same inflationary pressures affecting health care costs generally, but also reflects steady, intentional, incremental expansion of eligibility, much of which has been mandated federally and some of which has been optional to states. Over time (and particularly since the late 1980s), Medicaid has been the program of choice for incremental expansion of publicly financed health coverage, as employer-based insurance has waned and attempts at comprehensive universal coverage have failed repeatedly (Brown and Sparer 2003).

Maine has been no exception to the national trend, responding to federal mandates and incentives to expand coverage. As a result, the state's share of MaineCare costs has consumed an increasing portion of the state's General Fund, from 12.4 percent in SFY 1997, to 22.8 percent in SFY 2006 (Office of Fiscal and Program Review 2007a). With MaineCare now second only to General Purpose Aid for Local Schools in state expenditures, the program has become central to state budget deliberations and is subject to increasing policy scrutiny as its growth threatens to crowd out other state priorities. Is MaineCare a safety net program for certain categories of poor people, or is it a key component of a larger

universal coverage strategy? What are the federal requirements for state participation, and does the program really need to be so complex? Is it possible to increase the fiscal stability of the program? How can the program's value be maximized for beneficiaries and tax payers? But before we delve into these questions, an overview of the Medicaid program's basic features is in order.

MEDICAID BASICS

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.

The federal legislation creating Medicaid was enacted in 1965, largely as an afterthought to Medicare, which was the real focus of the debate at the time (Friedman 1995). It was a compromise, considered not very significant, that would provide basic health care to certain categories of people: poor children and their caretaker relatives receiving Aid to Families with Dependent Children (AFDC), and persons who were blind, elderly, or disabled. Unlike the universal nature of Medicare for older people, Medicaid was created as a means-tested, categorical program with a two-part eligibility requirement. First, a person needed to be in one of the population categories described above (AFDC, blind, elderly, disabled), and second, the person needed to be poor. In 1996, federal welfare reform replaced AFDC with Temporary Assistance for Needy Families (TANF), and severed the formal link between welfare and Medicaid, but the program fundamentally remained categorical and means-tested.

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TABLE 1: **New England Income Eligibility Levels for Major Medicaid Categorical Groups, 2006, by Percentage of Federal Poverty Level**

States	Pregnant Women	Infants	Children 1-19	Parents (non-working)	Elderly, Disabled
Connecticut	185%	185%	185%	150%	69%
Maine	200%	200%	150%	200%	100%
Massachusetts	200%	200%	150%	133%	100%
New Hampshire	185%	300%	185%	45%	76%
Rhode Island	250%	250%	250%	185%	100%
Vermont	200%	300%	300%	185%	74%

Source: Kaiser Family Foundation (2007)

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 and sets a minimum matching rate of 50 percent. 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 percent in SFY 2006. This means that for every \$100 of services purchased by MaineCare, the federal government paid about \$63 and the state paid about \$37. The federal government pays a flat 50 percent matching rate to all states for administrative costs. In SFY 2006, MaineCare benefit costs were around \$2.2 billion. Of this, the state paid approximately \$800 million, and the federal government about \$1.4 billion (Office of Fiscal and Program Review 2007a). The federal matching incentive has had the intended effect, prompting states to add services and population groups to the Medicaid program over time, especially services that were previously funded with 100 percent state dollars that could be “re-financed” to attract federal dollars. Services to persons with mental retardation, for example, were previously a state responsibility exclusively, but now most mental retardation services are financed by Medicaid.

Complex Eligibility Categories

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. The basic

federal categorical groups include older persons (65 and over), persons who meet Social Security disability criteria, children, parents with minor children living at home, and pregnant women. States have some flexibility to extend income eligibility above federally required floors, and the floor and ceiling levels vary by categorical group. Table 1 displays MaineCare income eligibility levels for basic categories of people, compared to the other New England states.

The complexity introduced by this approach to eligibility is obvious, even at this summary level, where only major categories are displayed. Maine and other states actually have dozens of eligibility categories, developed over many years in response to incremental federal policy changes focused on expanding eligibility. In addition to the eligibility choices that states may elect under explicit federal policy, they may propose to cover additional categories of people, or cover existing groups at higher income levels, by seeking federal approval of waivers to “normal” federal rules. For example, Maine, Massachusetts, Vermont, and several states outside New England have received waivers to extend coverage to low-income individuals who do not fit existing federal categories. These individuals are referred to variously as “non-categoricals” or “childless adults.”

Mandatory, Optional and Waiver Services

The benefits provided by MaineCare are also guided by federal requirements and options. States must provide certain services (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 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. In addition to mandatory and optional services, states may seek waivers to offer certain benefits associated primarily with community-based long-term

care and disability support services. MaineCare operates community-based services waiver programs for older persons, persons with mental retardation, persons with HIV-AIDS, and others.

Two traditional requirements of “regular” (non-waiver) services are that they be offered statewide, and be comparable across categorical groups. This has made it difficult for state Medicaid programs to target specific services to subsets of beneficiaries, because a service available to one person must be available to all. States may use pre-authorization processes to ensure that services go to those who need them, but doing so carries an additional administrative cost.

Service Delivery Options

MaineCare generally relies on the traditional, existing network of doctors, hospitals, home health agencies, rural health centers, and others. Despite paying less than commercial insurers for many services, the MaineCare program enjoys high rates of participation among most types of providers. In addition to traditional healthcare providers, MaineCare also funds a large array of long-term care and disability support service providers, reflecting 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 where commercial HMOs thrive. Maine’s managed care market has not been nearly as robust as those in larger states, and MaineCare remains predominantly a traditional fee-for-service program.

Disease management, also pioneered by managed care organizations, appears to be ushering in a new wave of care management efforts in which a state Medicaid program layers care management on top of the existing fee-for-service system. The disease management/care management approach is typically targeted to groups of beneficiaries based on condition (e.g., diabetes, asthma) or by cost of care (so-called

high users). MaineCare is pursuing a care management strategy, premised on the hypothesis that better primary care, patient education, and other low-intervention strategies decrease unnecessary use of emergency rooms, hospitals, and other high-cost services, thereby improving care while saving money. Because care management for Medicaid beneficiaries has just begun in Maine, there is as yet no substantive data about its impact on costs or quality of care.

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THE 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 (Pew Center on the States 2006). Nationally, Medicaid is expected to spend \$350 billion in 2007, and the Congressional Budget Office has estimated growth of 7.7 percent a year over the next decade (U.S. Department of Health and Human Services 2006). Concerns about Medicaid sustainability have increased as Medicaid costs consume an increasing portion of federal and state budgets, and health care costs overall increase as a percent of gross national and state products. This concern has been exacerbated as Medicaid has expanded to address the growing problem of uninsured Americans (and particularly children) in response to the steady erosion of employer-based coverage.

Kronick and Rousseau (2007) argue that the Medicaid sustainability question is overblown. Their future expenditure model estimates that Medicaid will stay roughly unchanged as a percentage of national health expenditures (16.6 percent) until 2025, then rise

TABLE 2: **State Plan Amendments Approved Under the Deficit Reduction Act (DRA), as of June 2007**

State Initiative	Features	Date Approved
Idaho Value Based Reform	Creates three voluntary benchmark plans: <i>Basic</i> for children and adults; <i>Enhanced</i> for persons with disabilities and special health needs; and <i>Coordinated</i> for beneficiaries with Medicare (“duals”).	May 2006
Kansas Working Healthy	Creates a voluntary benchmark plan for working disabled, to allow use of personal care services in the workplace.	January 2007
Kentucky KyHealth Choices	Creates four benchmark plans: <i>Family Choices</i> , modeled after the state employee plan, is mandatory for children; <i>Comprehensive Choices</i> is voluntary for elderly with long-term care needs; and <i>Optimum Choices</i> is voluntary for persons with mental retardation. The fourth plan, <i>Global Choices</i> , is the default plan for those who are not in one of the others. Kentucky is also using the DRA to offer premium assistance for those who have and elect a private coverage option.	May 2006
South Carolina State Employee High Deductible Health Plan, and Health Opportunity Account	Up to 1,000 beneficiaries in Richland County will be eligible to opt into the state employee high deductible plan. Availability of a self-managed health opportunity account will partially offset the value of the deductible.	June 2007
Virginia Healthy Returns	Voluntary benchmark plan to offer additional disease management benefits for persons with one of four conditions.	June 2007
West Virginia	Two benchmark plans, <i>Basic</i> and <i>Enhanced</i> , with <i>Enhanced</i> enrollment contingent on beneficiary adherence to care plan.	May 2006

to 19 percent through 2045. The model considers the long-term care needs of aging baby boomers and projects forward the downward trend in employer-based coverage. It does not assume any further expansion of Medicaid eligibility. Kronick’s and Rousseau’s analysis offers some comfort that Medicaid, in its current form, will not bankrupt the federal government.

Long-term projections aside, state policymakers face the need to balance their budgets on an annual or biennial basis, and with Medicaid growth generally outpacing the growth of state general revenues, the program is viewed by some as crowding out other public priorities. The issue is not only fiscal sustainability, but political sustainability as well.

The national flexibility debate is linked to the sustainability issue. 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, and if they are to reposition the program as a key component of the larger health care system. But calls for flexibility are rejoined by some national advo-

cacy groups, where there is concern that state flexibility is little more than a euphemism for cutting services.

HOW FAR CAN A STATE GO?

As described earlier, states have some flexibility within existing federal regulations to establish eligibility, benefits and provider payment rates. Until recently, that flexibility was largely limited to exercising explicit state options contained in federal law. Provisions contained in the Deficit Reduction Act of 2005 (DRA), however, gave states substantial new flexibility. Under DRA, states can replace or supplement traditional Medicaid services with one of several “benchmark” plans, which can be modeled after 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 without seeking waivers of the

**TABLE 3: Comprehensive Reform in Florida and Vermont:
Two Different Applications of State Flexibility Under Section 1115 Medicaid Waivers**

State Initiative	Major Program Features	Risk Dynamics
Florida's Medicaid Reform Waiver Approved Fall 2005 Pilot implementation began Fall 2006	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 the market to create choice and value. State accepts a per capita cap from the federal government and allows plans to define benefits and control use within available state contribution.	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 use. Beneficiaries are no longer guaranteed a standard benefit package and are responsible for choosing a plan that meets their needs.
Vermont's Global Commitment Waiver Approved and took effect Fall 2005	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.	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.

traditional requirements of comparability and statewide coverage. 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.

As of June 2007, the federal Centers for Medicare and Medicaid Services (CMS) had approved DRA State Plan Amendments in seven states. Consistent with the intent of the DRA, the amendments approved to date show tremendous variety and experimentation across states (Table 2). Variety aside, every state has used the benchmarking provision to alter services in one way or another, and with the exception of South Carolina (which has used a state employee plan as the benchmark), every other amendment so far has opted for a unique benchmark approved by the secretary of the federal DHHS. Of particular relevance to Maine are the DRA initiatives in Virginia and Washington, where a benchmark plan will supplement “regular” Medicaid with a disease management initiative.

States seeking more comprehensive reform than that available under the DRA can pursue a Section

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. Section 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. An additional disadvantage is that the federal government insists on hard caps to ensure cost neutrality, which means the federal share of cost is capped, whether or not actual expenses come in as projected. However, if a state wants to expand eligibility or reform its Medicaid program in some other way that exceeds the flexibility allowed in the DRA, the waiver process may be unavoidable.

Vermont and Florida are getting much attention because their Section 1115 waiver reform programs are far-reaching and currently being implemented (Table 3). But the two efforts are very different philosophically and conceptually, underscoring the degree of flexibility available to states and reflecting 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 health care 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 state efforts described in Tables 2 and 3 clearly demonstrate that states have a substantial amount of flexibility to reform their programs, and they are doing so in ways that respond to their unique political, social and market conditions. Maine can do the same, but before we rush to emulate another state's efforts, we need to step back, carefully reconsider the program in light of its evolution, and set a new vision for its future.

TAKING A NEW LOOK AT MAINECARE

After more than 40 years of incremental evolution, it's time to take a fresh look at MaineCare and really consider the overall role it plays in our state. Key questions include the following.

What is MaineCare's mission? Is it a fundamental part of a universal health care strategy, or a safety net program for certain categories of poor people?

Now covering 20 percent of Maine's population, MaineCare has become *de facto* a major part of the state's strategy to achieve health care coverage for all citizens, but one would be hard-pressed to find that role in Maine's authorizing law: "The department [of Health and Human Services] is authorized to administer programs of aid, medical or remedial care and services for medically indigent persons" (Maine Revised Statutes Title 22, Section 3173). Provisions have been added over the years, adding incrementally to eligibility, services, and cost sharing, with no overarching guidance that sets out a clear mission for the program.

The recent Blue Ribbon Commission on the Future of MaineCare found that "due to the lack of policy direction and in the absence of program goals and management focused on those goals, MaineCare has fallen into a pattern of policy-making that is driven by fluctuations in the state budget" (Office of Policy and Legal Analysis 2006: 24).

A contentious but key aspect of this question is whether, in an environment of few new resources, the program should be further expanded to reach more uninsured Mainers, perhaps with the tradeoff of offering less comprehensive benefits.

How can the program be simplified to more rationally advance its mission and enjoy broader social and political support?

MaineCare (and Medicaid generally) is a phenomenally complex program. Dozens of eligibility categories; mandatory, optional and waiver services that vary by population group; and vague, overarching standards (such as the "amount, duration and scope" standard of sufficiency) are only a few examples of the characteristics that make Medicaid a very difficult program to understand and administer. Because it takes so much effort just to come to a common understanding of the facts, policy debate is arduous and often marked by disagreements about what is or is not true, rather than what is or is not good policy. And the fact that some people qualify for the program while others with the same financial profile do not (because they do not fit into a qualifying category) undermines support for the program among a public that sees serious inequities.

The complex structure of the program is in large part a legacy of its incremental growth over 40 years. Any reform effort should seek to collapse eligibility criteria into only a very few, with the first being financial. If MaineCare is to be the health coverage program for people at the low end of the income scale who do not otherwise have access to coverage, it should strive to capture everyone in that category. To address charges that the benefit package is far more generous than those covered by commercial insurance, Maine could conduct a careful, side-by-side analysis comparing MaineCare to one or more benchmark packages, such as those enjoyed by state or university

system employees. Because the program is so important to people with long-term care or disability needs, a second criterion would need to be an assessment of functional need, which would qualify those persons for an additional tier of benefits related to disability.

How can program financing be stabilized?

As MaineCare lurches from one state budget to another, the options for cost containment in the traditional program are limited. Policymakers can reduce the number of eligible people, reduce benefits, or reduce rates, none of which are attractive from a policy or politics perspective. One approach that could raise additional revenue while also promoting greater equity would be to implement a premium structure not unlike that designed for the Dirigo Health Plan, in which people between 100 percent and 300 percent of the FPL would contribute to the cost of their coverage, but on a graduated basis. Policymakers could establish global budget targets for the program with growth rates tied to an agreed-upon benchmark, and the sliding scale could be adjusted as needed to address anticipated shortfalls. This approach would undoubtedly cause some beneficiaries to drop coverage, as occurred in the Oregon Health Plan when premiums were increased. Can we accept that as an expression of consumer choice in the interest of being able to offer the choice to greater numbers of people?

Another strategy that would yield much greater financial benefit to the state but is far more difficult to achieve is to work with other states to get a new deal with the federal government. Federalizing all care for dually eligible beneficiaries (those who have both Medicare and Medicaid) would save states an estimated \$47.7 billion per year and would have the added benefit of rationalizing a system of financing and services that has historically been fragmented and inefficient (Holahan and Weil 2007).

How can we maximize value for beneficiaries and taxpayers?

The old paradigm of MaineCare as a bill payer with limited involvement in the health care system fails to recognize and leverage the program's huge

potential as a force for better health management. The State Health Plan notes that Maine has high rates of several chronic conditions, which, because of their complexity, require management across providers, settings and time (Governor's Office of Health Policy and Finance 2006). Beneficiaries with chronic conditions present opportunities for higher quality care at a lower cost, if closer management of the conditions leads to lower rates of emergency room, nursing home and hospital use.

The MaineCare program is moving in this direction. It is expanding an initiative with a national care management organization that targets high-cost, chronically ill beneficiaries, and it is preparing to select an administrative services organization to oversee the management of MaineCare-funded behavioral health services. These efforts and others like them should be carefully monitored for efficacy and expanded if they are found to add value.

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A PROGRAM WORTH DEBATING

Medicaid has come a long way from its roots as a relatively small program created as an afterthought to Medicare. In terms of size and the needs of the people it covers, it is arguably the most important health care program in the country. Yet we continue to treat it as a marginal program, expanding it incrementally when possible, and retracting it incrementally when budgets demand. The current interest in health care reform at both the state and federal levels gives us an opportunity to acknowledge Medicaid's role and think seriously about how best to ensure the program's long-term contributions to a more rational and effective health care system. 🐉



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