kaiser commission on medicaid and the uninsured

MaineCare and Its Role in Maine's Healthcare System

Prepared for
The Kaiser Commission on Medicaid and the Uninsured
by
Paul Saucier
Director of the Chronic Illness, Disability and Aging Program
Muskie School of Public Service, University of Southern Maine.

January 2005

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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Executive Summary

As state policymakers and others across the country seek strategies for responding to rapidly rising health care costs and the increase in the number of uninsured, they often are encouraged to look to Maine's reform efforts. Through a statewide effort known as "Dirigo Health," Maine recently has made a commitment to expand access to care, contain costs, and improve quality. Although it is not always as widely recognized, a key part of Maine's health care system on which Dirigo Health builds is "MaineCare," the state's Medicaid program. As a companion piece to descriptions of Dirigo Health, the Kaiser Commission on Medicaid and the Uninsured has commissioned this paper to explore the role of MaineCare in the state's health care system; the challenges confronting MaineCare and strategies under consideration for addressing them; and the relationship between MaineCare and the Dirigo Health plan.

MaineCare is a critical part of Maine's healthcare system, covering one in five Maine citizens.

MaineCare, Maine's Medicaid program, has evolved into one of the most important parts of Maine's healthcare system. With expenditures of $2 billion in State Fiscal Year (SFY) 2004, MaineCare contributes more than a quarter of the state's overall health spending. About 20% of Maine citizens rely on MaineCare for their health insurance. Not quite 20% of the State General Fund is allocated to paying the state's share of MaineCare, placing the program second behind General Purpose Aid to local education in terms of General Fund expenditures.

MaineCare is a State-Federal partnership: The federal government reimburses the state for close to two-thirds of MaineCare expenditures.

MaineCare, like all Medicaid programs across the country, operates as a partnership between the state and federal governments. Maine has some flexibility to establish eligibility, benefits and provider payment rates within federal regulations. The federal government provides matching funds as an incentive to states. The matching funds formula 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 to Maine, not quite 65% in SFY 2005. This means that for every $100 of healthcare purchased by MaineCare, the federal government pays about $65 and the state pays about $35.

Most MaineCare members are children and parents, but most of the budget is needed for older persons and persons with disabilities.

MaineCare provides health insurance to certain categories of people who have very low income. Usually, assets are also considered. Most MaineCare members are children, their parents and other groups of adults, but most of the budget goes to meet the needs of older persons and persons with disabilities. This is because long term care and disability support services are very expensive, and other insurance (Medicare, commercial) generally do not cover those services. MaineCare is Maine's high risk pool for disability.

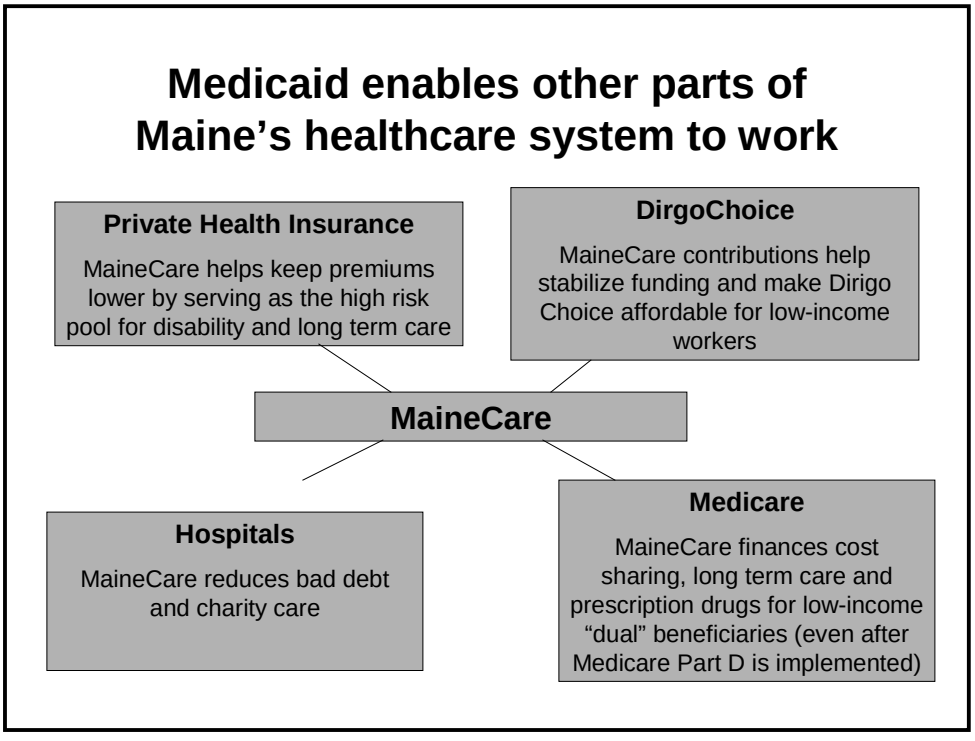
MaineCare is a key component of Maine's healthcare system.

MaineCare supports Maine's healthcare system in a number of ways.

- **Supporting private health insurance**. MaineCare works with employer-based coverage to keep the rate of uninsured persons down. It provides coverage to several categories of people who do not have access to employer-based coverage, or have access but cannot afford the cost. As Maine's high risk pool for disability, it keeps the high cost of disability out of private insurance costs.
- **Complimenting Dirigo Health.** Maine is currently in the midst of implementing Dirigo Health, a statewide health reform effort aimed at reducing health care costs, improving health care quality, and providing access to all Maine residents by 2009. A key feature of Dirigo Health is DirigoChoice, a health insurance product available to small businesses, the self-employed, and individuals. Discounts on DirigoChoice are available to those who are above MaineCare income limits yet are not able to afford regular commercial insurance. MaineCare also provides a base on which to partner with other large purchasers to support Dirigo

Health's joint purchasing initiatives. Finally, MaineCare will contribute some federal Medicaid matching funds on behalf of Medicaid-eligible people who enroll in DirigoChoice, contributing to the stability of Dirigo financing and its ability to make DirigoChoice affordable to low-income workers.

- **Reducing bad debt and charity care**. MaineCare also supports Maine's healthcare system by reducing the level of bad debt and charity care in the state. When hospitals and other providers give free care to uninsured persons, they must recoup their losses by charging more to commercial payers, resulting in higher prices for employer-based insurance. Covering more people through MaineCare provides insurance to those most likely to be uninsured.
- **Supplementing Medicare**. Finally, MaineCare supplements Medicare for low-income beneficiaries. It covers Medicare's cost sharing requirements and pays for services that Medicare does not cover, most notably long-term care and prescription drugs. Even after Medicare's Part D prescription drug benefit goes into effect, MaineCare will be responsible for reimbursing Medicare for most of the prescription drug costs of low-income beneficiaries.



MaineCare faces challenges and is working on solutions.

MaineCare faces challenges in the upcoming biennium that are spurring the program to find new approaches that should result in more cost effective services in the future. Challenges include a diminishing federal matching rate, a federal spending cap that may affect services to non-categorical adults, a new Medicare prescription drug program that could leave some older persons and persons with disabilities with less coverage than they have had in the past, a population that is aging more rapidly than the national average and is likely to result in greater demand for long term care, and the possibility that federal policymakers may reduce the federal government's contribution to Medicaid expenditures in response to budget pressures.

To respond to these and other challenges, MaineCare is working on initiatives for managing better the chronic care needs of members, expanding consumer directed options and participating in joint purchasing discussions with other large groups in the state. MaineCare is also studying the possibilities offered by select networking and pay-for-performance approaches to quality improvement. It is also looking at veterans benefits to ensure that members get the full benefit of other programs.

MaineCare is vital to Maine's health.

MaineCare is a critical program and an important component of Maine's health reform efforts generally and Maine's goal to achieve universal access specifically. Because the program is important to so many members, small businesses, providers and policy makers, any change is controversial. Yet in order to keep pace with a rapidly changing health and economic environment, MaineCare must continue to innovate and contribute to the health of Mainers.

Other states looking to Maine will want to consider the ways in which MaineCare and Dirigo Health work together.

For policymakers outside of Maine who are looking to the state for ideas about ways to manage rising costs, the growth in the uninsured population, and quality issues, it will be important to look at the ways in which MaineCare and DirigoHealth work together. While they each play distinct roles, the two

programs are complimentary and together contribute to the state's efforts to develop a system where high quality, affordable coverage is available to all residents.

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Introduction

Maine often is cited as a state that is actively pursuing strategies for addressing rising health care costs and the increasing number of people without health insurance.[1] As a state that is less affluent than some of its Northeast neighbors and dominated by small employers, its experiences with its Medicaid program and its new efforts to control costs and expand access through its "Dirigo Health" reform initiative are of interest to state policymakers across that country. As a companion piece to other papers that review the Dirigo Health plan, the Kaiser Commission on Medicaid and the Uninsured has commissioned this paper to explore the role of MaineCare, the state's Medicaid program, in Maine's health care system; the challenges confronting MaineCare, and the relationship between MaineCare and the state's Dirigo Health plan.

As described in detail in the paper, MaineCare has evolved into one of the most important parts of Maine's healthcare system. In Maine and most other states, Medicaid is now the second largest item in the state's General Fund budget, after General Purpose Aid to Local Education (GPA). Two out of every ten Maine citizens (20%) rely on MaineCare for health or long-term supports. MaineCare is one of the largest sources of federal funds coming into the state, drawing about $1.4 billion from the federal government in SFY 2004.

MaineCare provides or subsidizes health coverage for people who do not have access to or cannot afford employer-based coverage. In Maine's current effort to achieve universal coverage, MaineCare and the Dirigo Health plan work together to develop a system where healthcare is affordable for all. MaineCare is also the state's high risk pool for disability support and long-term care services. It ensures that people receive long-term supports while keeping the very high costs of disability out of the private healthcare cost pool, thus keeping a lid on private insurance premiums. Unlike most private insurance plans, MaineCare does not disallow costs related to pre-existing conditions. Just the opposite is usually the case—the program provides coverage *because* pre-existing conditions have made people uninsurable in the private market. This role is an expensive one,

and managing MaineCare's growth has become an annual challenge to Maine policy makers.

The paper, which explores these issues in more detail, begins in Part One with the basics of the MaineCare program and key statistics about its size and trends. It provides an introduction for new policymakers and a refresher for those who already understand how it works. Part Two describes how MaineCare fits in the state's overall healthcare system, including its role relative to Dirigo Health. Part Three discusses challenges in the program and some promising policy and program directions.

Part One. An Introduction to the MaineCare Program

MaineCare is Maine's Medicaid Program. It provides health coverage to poor children, their parents, older persons, persons with disabilities and others who in most cases would be uninsured were it not for the MaineCare Program. The federal government authorized the Medicaid program in 1965 in Title XIX of the Social Security Act. Nationally, it is the largest source of federal funding to states, providing $158 billion to cover 51 million Americans.[2] Initially, the program served primarily individuals and families receiving means-tested cash benefits and individuals receiving care in nursing homes. Today's program has a much broader focus, including coverage to low-income working persons and a broad array of community-based disability support and long-term care services.

MaineCare operates as a partnership between the state and federal governments. State participation is voluntary, but since 1982 every state has chosen to participate. The federal government sets broad national guidelines for the program and provides a share of the funding based on a formula that considers the relative wealth of states. States administer the program within these guidelines, but have flexibility regarding eligibility, benefits and payments to providers. The choices made by state policy makers 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. Because of this state flexibility, no two Medicaid programs are exactly alike.

MaineCare Financing

MaineCare is financed jointly by the state and the federal government. The federal share provided to a state for most Medicaid services is based on a formula known as the Federal Medical Assistance Percentage (FMAP). The formula takes into account Maine's income per person relative to the national average. It is designed to give states with higher per person income a lower federal assistance rate than those with lower incomes. The FMAP rate ranges from a minimum of 50% to as high as 83%. States at the average per capita

personal income receive a federal share of 55%. Because Maine's per person income is lower than the national average, it receives a relatively higher FMAP. In FFY 2004 Maine's FMAP was 68.38%. Maine's share of the cost of services for that year was 31.62%. Put another way, for every $100 of MaineCare service costs, the federal government paid just over $68 and the state paid under $32.

The FMAP is published by the U.S. Department of Health and Human Services for each federal fiscal year. One of the current challenges facing MaineCare is that Maine's FMAP rate has fallen to 64.89 in the current federal fiscal year (FFY 2005) and is estimated to fall further to 62.90 in FFY 2006, creating a need to generate additional state matching funds to achieve the same overall level of program spending.[3] In MaineCare's current $2 billion budget, an FMAP variation of 1 percent is worth $20 million. This is discussed further as one of MaineCare's challenges in Part Three.

MaineCare Stretches State Dollars

To maximize access to healthcare with limited state dollars, Maine and many other states have pursued a policy sometimes referred to as Medicaid refinancing. The policy has many variations, but in general, it involves identifying a service financed with state dollars that is a legitimate Medicaid service and switching the source of financing to Medicaid. With the new federal revenue, the state can expand services at no additional state cost, or maintain the previous level of service and apply the resulting state savings to other healthcare needs. This is a legal practice that allows states to receive federal matching funds for services that the federal government has deemed appropriate for Medicaid reimbursement. A few examples illustrate how Maine has legitimately pursued Medicaid refinancing in the past:

- Targeted case management. Maine has used Medicaid's targeted case management service to pay for state and private agency employees who provide case management for persons with disabilities. Previously, the state bore the full cost of state employees who provide child and adult protective services and case management to persons with mental retardation and mental illness. Now it bears about one-third of the cost.

- Private Non-Medical Institution (PNMI). Maine offers several types of residential care to children, older persons and persons with disabilities, including adult family care homes, assisted living and group homes. Residents contribute most of their income and the state pays the balance of the cost. The PNMI option enables MaineCare to pay for certain residential services previously financed with state-only dollars and expand residential alternatives to nursing homes and psychiatric hospitals.
- School-based Services. Schools now provide an array of MaineCare funded services that were previously paid out of General Purpose Aid to Local Education (GPA) and local school funds. These include health services to students from poor families and disability-related services that would otherwise contribute to special education needs. This particular application of refinancing may be highlighted in the current property tax relief debate. The Maine Municipal Association has proposed that the state pay for 100% of local school districts' special education obligations, and some will undoubtedly look to MaineCare as a way of using federal dollars to ease pressure on both property taxes and the state General Fund.

Refinancing shifts certain expenditures from the General Fund to the MaineCare program, adding to MaineCare's budget growth, but the state's unit cost for a refinanced service falls from 100% to about 35%.

Most of Maine's refinancing approaches have been used by many states and clearly fallen within federal law. The federal government has expressed concern, however, that some states have pushed the limits of refinancing. This concern and increasing attention to the federal budget deficit led the federal Centers for Medicare and Medicaid Services (CMS) to deploy auditors to every state capital across the country to ensure appropriate Medicaid practices.[4]

MaineCare Eligibility

MaineCare 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). Usually assets are also considered. How a person's income and assets are

considered is determined by what category the person is in. The basic Medicaid 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.[5] 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." Coverage is also available to a number of smaller groups, described in Appendix A.

Federal regulations give states the option of extending eligibility for each categorical group beyond a required minimum level. As a result, Medicaid eligibility limits vary from state to state. Figure 1 shows the income levels that Maine and the other New England states have adopted for the major categorical groups. Maine is lower than some New England states in some categories and higher in others, but is not an outlier in any category.

Figure 1
New England Income Eligibility Levels for Major Medicaid Groups, 2003.
(By Percent of Federal Poverty Level)

	Pregnant Women	Infants	Children*	Working Parents	Aged, Blind, Disabled
Conn.	185%	185%	300%	107%	69%
Maine	200%	200%	200%	157%	100%
Mass.	200%	200%	200%	133%	100%
New Hampshire	185%	300%	300%	61%	76%
Rhode Island	250%	250%	250%	192%	100%
Vermont	200%	300%	300%	192%	74%

Source: Kaiser Family Foundation[6]
*Eligibility level reported for children is the higher of a state's Medicaid or State Children's Health Insurance Program (SCHIP).

MaineCare Services

The services provided through MaineCare are also guided by federal requirements and options. States are *required* to provide services in certain healthcare categories (called "mandatory"), and they *may* provide several

additional services (called “optional”) by including them in their state Medicaid Plans.

Figure 2
Major MaineCare State Plan Services

Mandatory	Optional
Services that MaineCare *must* offer under federal law in order to receive federal matching funds.	Services that Maine opted to include in its state Medicaid Plan. No special federal permission was required.
• Inpatient hospital; • Outpatient hospital; • Prenatal care; • Early and periodic screening, diagnostic and treatment services for children under age 21; • Physician services; • Medical and surgical dental services; • Nursing facility (NF) services for individuals aged 21 or older; • Home healthcare for persons eligible for nursing facility services; • Family planning services and supplies; • Laboratory and x-ray services; • Pediatric and family nurse practitioner services; • Rural health clinic services and any other ambulatory services offered by a rural health clinic that are otherwise cover under the state plan; • Federally-qualified health center services and any other ambulatory services offered by a federally-qualified health center that are otherwise covered under the state plan; • Nurse-midwife services; • Certified nurse practitioner services (States must also ensure that transportation is available to get people to and from medical appointments.)	• Prescribed drugs; • Medical supplies, durable medical equipment, prosthetic and orthotic devices; • Intermediate care facilities for persons with mental retardation (ICF/MR); • Personal Care Services; • Home healthcare services; • Private duty nursing; • Hospice • Rehabilitative services; • Speech therapy; • Physical therapy; • Occupational therapy; • Case management; • Podiatry; • Optometrist services and eyeglasses; • Diagnostic services; • Behavioral services; • Chiropractic; • Hearing aid services; • Emergency dental services for adults; • Inpatient psychiatric services for individuals under age 21.

Maine and every other state cover several optional services because doing so allows them to receive federal matching funds. In addition, despite the name, many optional services are critical to health or represent relatively new treatment

approaches that were not broadly included in commercial plans when Medicaid was first authorized in 1965. The provision of prescription drugs is an example of a very important and expensive optional service covered by every state. Figure 2 lists the major services included in the MaineCare State Plan.

MaineCare Waivers

States that want to extend eligibility or covered services outside the limits of regular federal law may request special permission (called "waivers") from the federal Centers for Medicare and Medicaid Services (CMS). Home- and Community-based Services waivers are very common and easy to obtain. Every state uses them to provide community-based alternatives to nursing homes and institutions. Other waivers, notably Section 1115 waivers, are more difficult to obtain. Section 1115 waivers may be used to waive most provisions of the federal Medicaid law, but must be cost neutral, which means they must not result in greater costs to the federal government than otherwise would have been spent without the waiver.

A common use of Section 1115 waivers is to expand eligibility to non-categorical groups (persons who do not fit into regular Medicaid categories). Maine was granted a Section 1115 waiver to provide coverage to its non-categorical group. To make its proposal cost neutral, Maine used Disproportionate Share Hospital (DSH) payments that had been allocated but not expended. (DSH payments are available under Medicaid for hospitals that serve a "disproportionate share" of poor people.) The result is a reduction in bad debt and charity care for hospitals, since previously uninsured persons now have MaineCare coverage. This is discussed further in Part 2.

Figure 3 describes the waivers available from the federal government and whether MaineCare has received them.

Figure 3: Medicaid Waivers

Type of Federal Waiver	MaineCare Experience
Home and Community-Based Services (HCBS) Waivers (Section 1915(c)) • Used to offer flexible alternatives to persons who would otherwise need nursing home, ICF/MR or other institutional care • Very common and relatively easy to obtain • The people who use HCBS services must have high needs that would qualify them for the institutional services they are avoiding • HCBS services must not cost more than the institutional and related services they are replacing	MaineCare has 3 separate HCBS waivers for: • Elderly persons • Persons with physical disabilities • Persons with mental retardation or autism
Section 1115 Demonstration Waivers • May be used to waive nearly any provision of Medicaid law • Usually difficult to design and obtain • Most common use is to expand eligibility to persons who do not fit into regular Medicaid categories • May not result in greater federal Medicaid spending than would have occurred without the waiver	MaineCare has two Section 1115 waivers for: • Persons living with HIV/AIDS, to help with the high cost of prescribed drugs and other treatment. Participant cost sharing is required. • Non-Categoricals, to provide coverage to childless adults who do not qualify in any regular MaineCare category.
Health Insurance Flexibility and Accountability (HIFA) Waivers (A Type of 1115 Waiver) • A streamlined Section 1115 waiver process that the federal government has used to promote comprehensive state approaches that increase the number of persons with health insurance coverage • Like all Section 1115 waivers, HIFA waivers must not result in greater federal Medicaid spending overall.	MaineCare's Non-categorical Waiver (above) is a HIFA/1115 waiver.
1915(b) Waivers • Used to waive specific portions of Medicaid law, including freedom of choice, statewide coverage and comparability of services • Most commonly used to create Medicaid managed care plans or other selective contracting approaches	None currently.
Independence Plus Waivers • A 1915(c) HCBS waiver or Section 1115 waiver that has the additional program feature of allowing consumers to direct their own care • A relatively new type of waiver being considered in several states	None currently, though one under development for adults with mental retardation. (MaineCare does have 3 consumer-directed programs that operate under other authority.)

Goldie from Augusta, ME

I am 66 years old and I live in an assisted living apartment in Augusta. I am mentally retarded and epileptic.

My family gave me up when I was 3. I lived in Pineland until I was adopted by my foster mother when I was 26. She took care of me. She taught me how to cook and take medicine. When she died, I was on my own. Now, a case manager comes to see me every Wednesday. She takes me grocery shopping and checks in on me.

Because I live in assisted living, my doctor says that I can live alone. I like to live alone. I love to keep my apartment clean.

I like MaineCare and I hope they don't cut back any more.

MaineCare Provider Participation

Participation of providers in MaineCare is voluntary. Despite paying below market rates for certain health services, MaineCare has enjoyed reasonably good participation among Maine's traditional healthcare providers, including physicians, hospitals, nursing homes and home health agencies. These providers receive a relatively diverse funding array that also includes commercial insurance and Medicare. Because MaineCare pays less for an office visit than most other payers, some physicians limit the number of MaineCare patients in their practices. Dentists have historically had a very low participation rate, but recent data suggest some improvement in access to dental services.

MaineCare participation is nearly universal among providers that specialize in long-term care or supportive services for persons with disabilities, such as home care agencies, nursing homes, mental health agencies and agencies providing community-based support to persons with disabilities. For

these providers, MaineCare is the largest and sometimes the only source of funding. In some instances, in order to provide incentives to develop capacity, the state agreed to pay for these services on a cost basis, in which provider-specific rates are negotiated to reflect each provider's actual costs. This policy was successful in developing a provider capacity to deliver community-based supports, but has resulted in substantial inequalities across providers and MaineCare population groups. Now that Maine has developed a supply of community-based supports for most population groups, MaineCare program officials are working to develop standardized rates wherever possible.

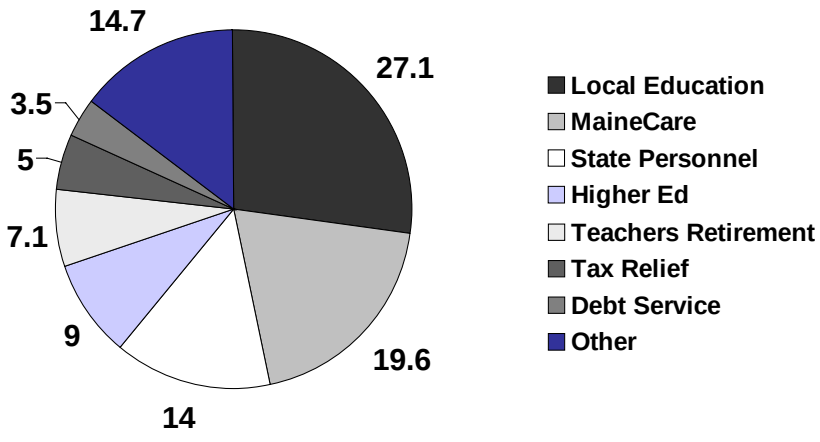
MaineCare By the Numbers

Expenditures

This year, for the first time, MaineCare's total state and federal spending surpassed the $2 billion mark and, as in all states, its size makes it important to state budget deliberations. The lion's share of this is federal money, but the state's share is nonetheless significant, the second largest General Fund expenditure after local education. Maine now commits 19.6% of its General Fund to MaineCare. (Figure 4)

Figure 4

Percent of General Fund Expenditures by Category, SFY 2004



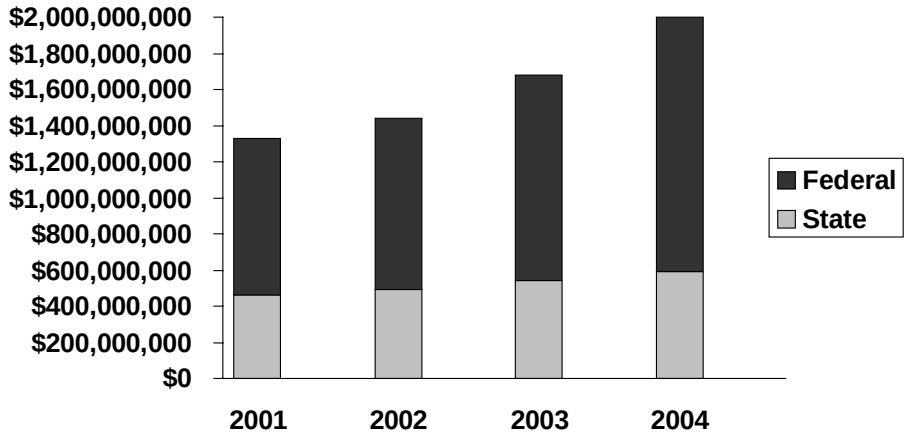
SOURCE: Maine Legislature, Office of Fiscal and Program Review[7]

Note that Figure 4 includes state funds only. This allows state policy makers to see the portion of state funds dedicated to "seeding," or attracting federal match for MaineCare. At 19.6%, it remains second to the portion of state funds spent on education (27.1%). In contrast, the National Association of State Budget Officers (NASBO) and the National Governors Association (NGA) have recently reported that Medicaid has overtaken Primary and Secondary Education as the largest area in state budgets.[8] The NASBO/NGA statistic includes all state and federal funds. Because federal Medicaid funding is much greater than federal education funding, including federal funds in the statistic makes Medicaid larger than education.

MaineCare's overall expenditures (state and federal funds combined) has grown significantly since 2001, from about $1.3 billion to about $2 billion, as shown in Figure 5. Much of the growth has been deliberate, as the state has sought to convert state-only funded programs into MaineCare programs and expanded eligibility to reduce the number of uninsured persons.

Figure 5

SFY MaineCare Budget Over Time, by Source of Funds

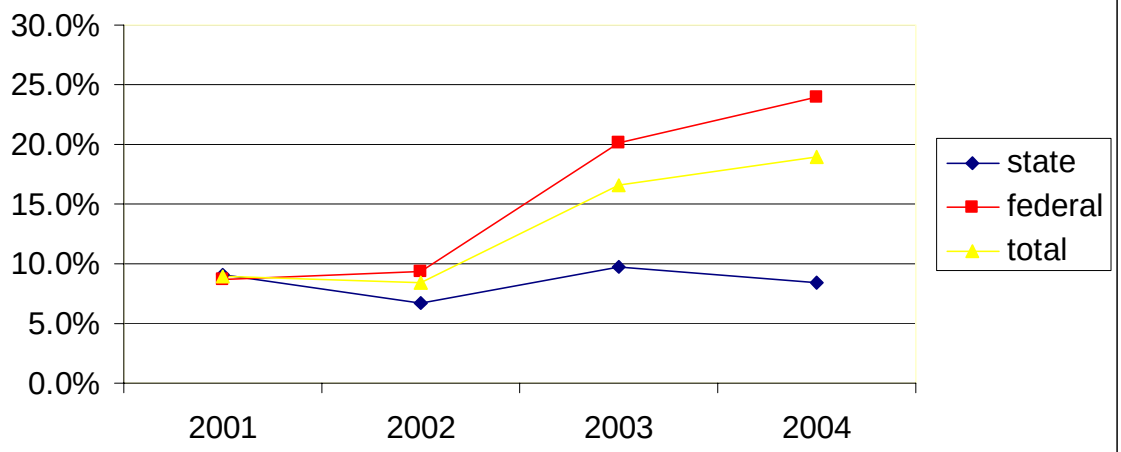


SOURCE: Maine Legislature, Office of Fiscal and Program Review[9]

The rate of growth has been higher on the federal side of the equation, in part because federal fiscal relief was given to states in the form of a temporary 2.95%

increase in the Federal Medical Assistance Percentage (FMAP) rate between April, 2003 and June, 2004. Figure 6 shows that the overall (state and federal) rate of growth in SFY 2004 was 19%, but the state's share grew by only 8.4% while the federal share grew by 24%. Because Maine's FMAP rate (the amount of match provided by the federal government) is scheduled to decline over the next two years, this ratio of federal-to-state growth will not continue.

Figure 6. SFY Percentage Increase in MaineCare Expenditures by Source of Funds

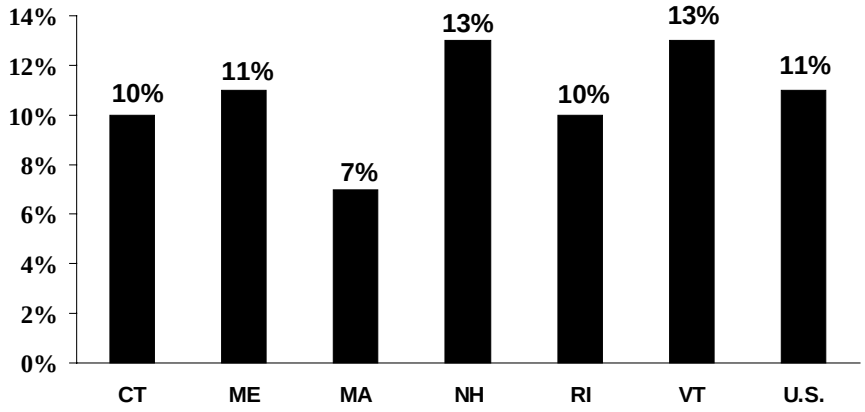


Source: Maine Legislature, Office of Fiscal and Program Review[10]

The average growth rate from 1991 to 2001 was significant, though not unusual compared to the rest of New England and the national average. (Figure 7)

Figure 7

Average Annual Increase in Total Medicaid Expenditures, New England and U.S., FFY 1991-2001

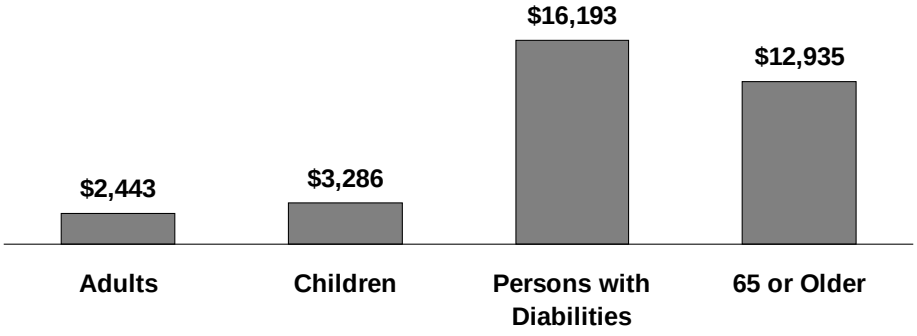


SOURCE: Kaiser Family Foundation[11]

Many think of MaineCare as a program primarily for poor parents and children, but most MaineCare (and national) expenditures are for older persons and persons with disabilities, whose per-person expenditures are much higher than those of children and adults. (Figure 8)

Figure 8

Average MaineCare Expenditure by Group, SFY 2003



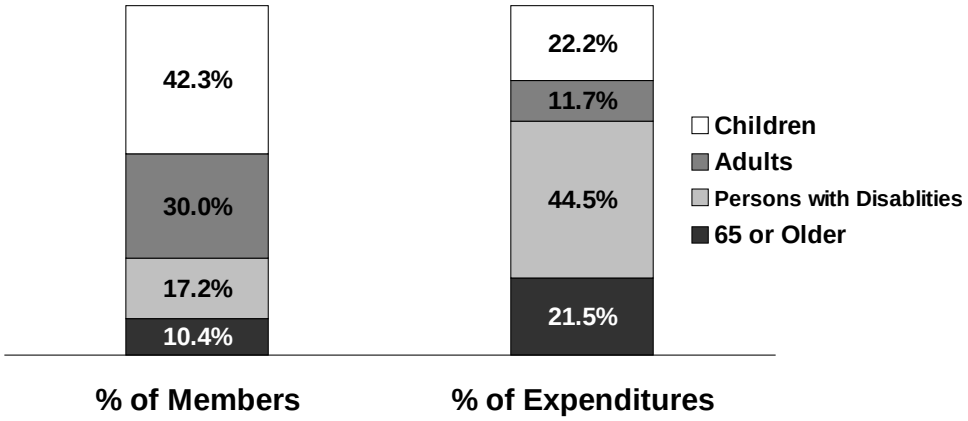
SOURCE: Maine Department of Health and Human Services[12]

Note that the per person expenditures for all groups may be inflated relative to other states, to the extent that Maine has successfully refinanced state services into MaineCare services. The expenditures for children, for example, include services delivered through schools, often to children with special needs whose costs are higher than average.

Older persons and persons with disabilities comprise only 27.6% of MaineCare members but account for 66% of the program's expenditures. (Figure 9)

Figure 9

Older Persons with Disabilities Comprise Just Over 1/4 of MaineCare Members and Account for 2/3 of MaineCare Expenditures (SFY 2003)

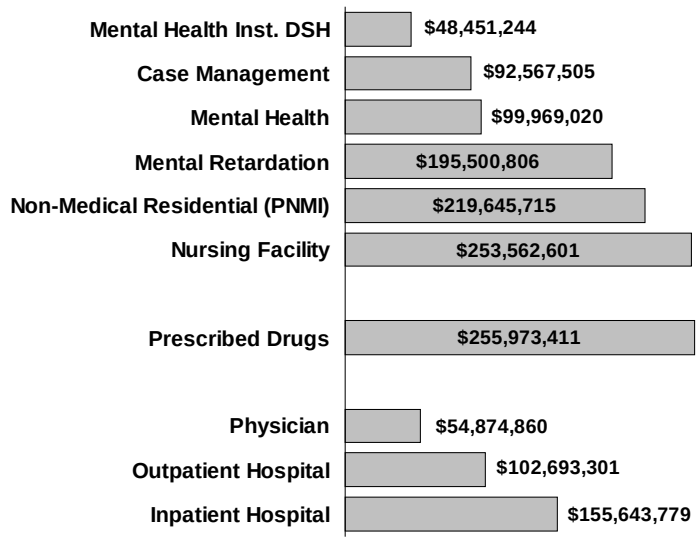


SOURCE: Maine Department of Health and Human Services[13]

This is because many persons in these categories have complex and ongoing support needs that result in greater use of long-term care and disability support services. Six of the top 10 service expenditure areas are associated directly with long-term care and disability support. (Upper six services in Figure 10.) A seventh service, prescribed drugs, is also very important to older persons and persons with disabilities but is also accessed by all other MaineCare groups.

Figure 10

Top 10 MaineCare Service Expenditures, SFY 2004

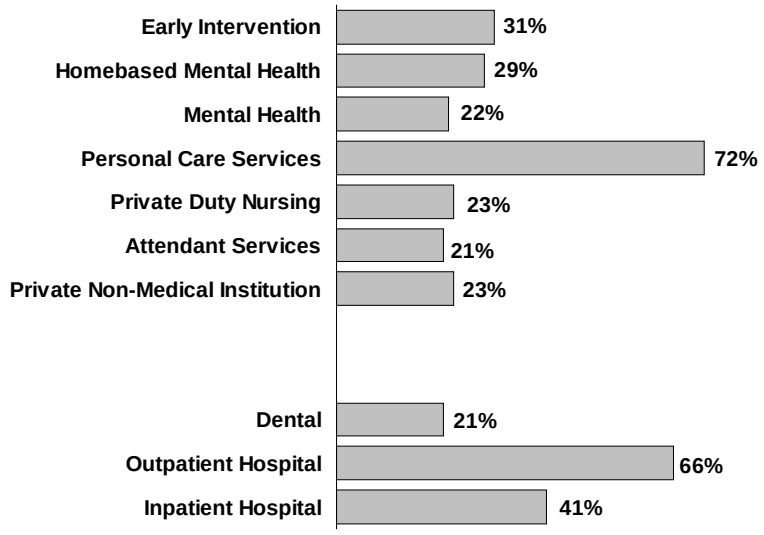


SOURCE: Maine Department of Health and Human Services[14]

Some services are growing faster than others. Among services that had SFY 2004 expenditures of at least $5 million, ten experienced growth rates of 20% or more from 2003 to 2004. (Figure 11)

Figure 11

Growth Rate of Services of 5$ Million or More with Growth of 20% or More, 2003-2004



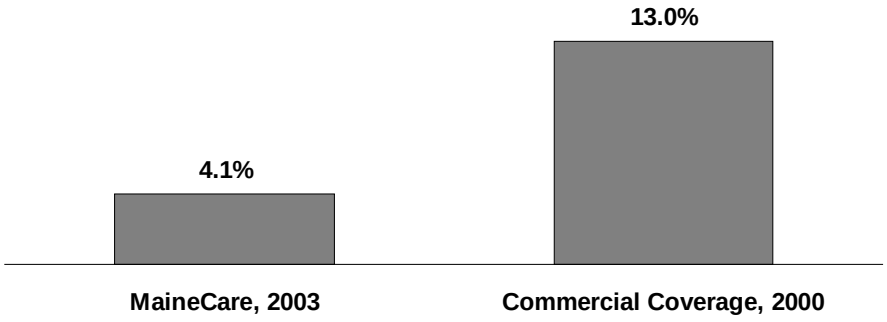
SOURCE: Maine Department of Health and Human Services[15]

The upper seven services shown in Figure 11 are associated with older persons, persons with disabilities and children with special needs. Most of these areas have been part of ongoing efforts to refinance state-funded services to MaineCare, so some portion of the growth has been intentional and resulted in off-setting state savings elsewhere. Maine has long had concerns about low access to dentists and recently raised rates, explaining the growth in that area. Given that the non-categorical waiver group is reported as a separate expenditure area, it is difficult to explain the high growth of hospital services. The outpatient increases may be attributable to hospital acquisition of physician practices, which results in certain physician expenditures moving to the outpatient services category.

The MaineCare program's reported administrative costs are low relative to commercial insurance, as shown in Figure 12. However, the extent to which MaineCare and commercial insurance companies report similar types of expenditures in the "administration" category is not clear.

Figure 12

MaineCare's Administrative Costs Are Relative to Commercial Coverage



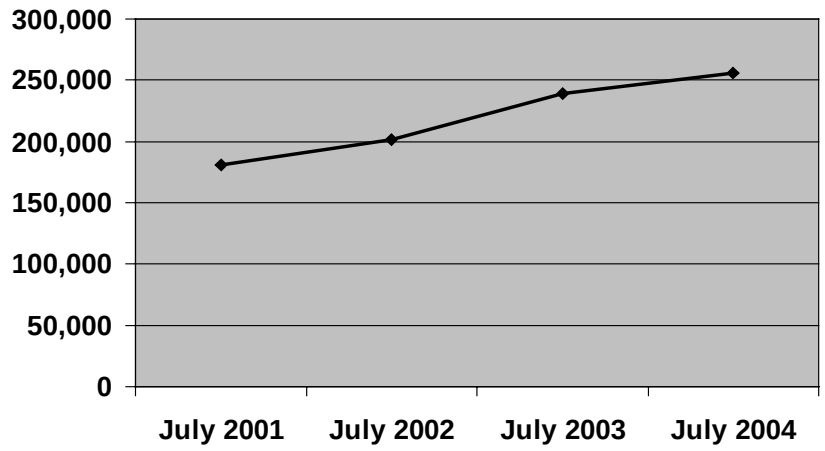
SOURCE: Maine Department of Health and Human Services and Maine Bureau of Insurance[16]

Members

In July 2004, MaineCare provided coverage to 254,472 people, or 20% of Maine's population. Enrollment growth continued in 2004, but at a slower pace than in previous years. (Figures 13 and 14)

Figure 13

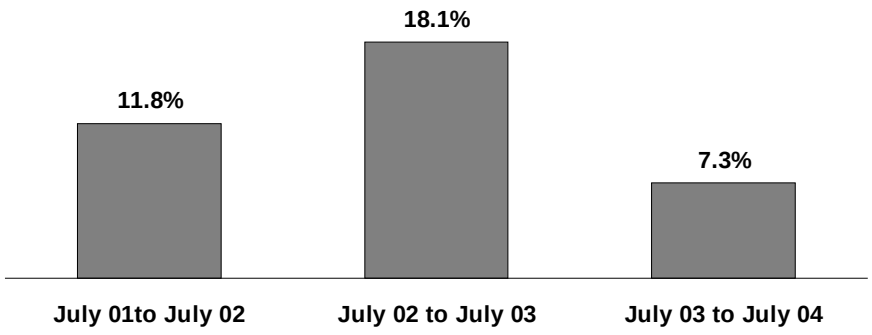
July MaineCare Enrollment*, 2001-2004



SOURCE:Maine Legislature, Office of Fiscal and Program Review[17]
*Enrollment in drug-only programs (Drugs for the Elderly, Maine Rx, Healthy Maine Prescriptions) not included.

Figure 14

MaineCare Enrollment Growth Rate*



SOURCE:Maine Legislature, Office of Fiscal and Program Review[18]
*Enrollment in drug-only programs (Drugs for the Elderly, Maine Rx, Healthy Maine Prescriptions) not included.

State Fiscal Year 2004 was the first full year of experience with the non-categorical adult waiver, resulting in about 26,000 new members receiving assistance at some point during the year. (As of November 2004, 23,072 such individuals were enrolled.)

Given that MaineCare is a countercyclical program (demand increases when the economy worsens and vice versa), one would also expect the data to begin showing decreases in enrollment related to the improving economy. However, Maine has continued to lose traditional manufacturing jobs that included health coverage while the economic recovery produced largely service sector jobs without health benefits, which may mean that the MaineCare program will not see the same enrollment declines it has experienced in past periods of economic growth. This issue is discussed further in Part Two, next.

Part Two. How MaineCare Fits Into the State's Healthcare System

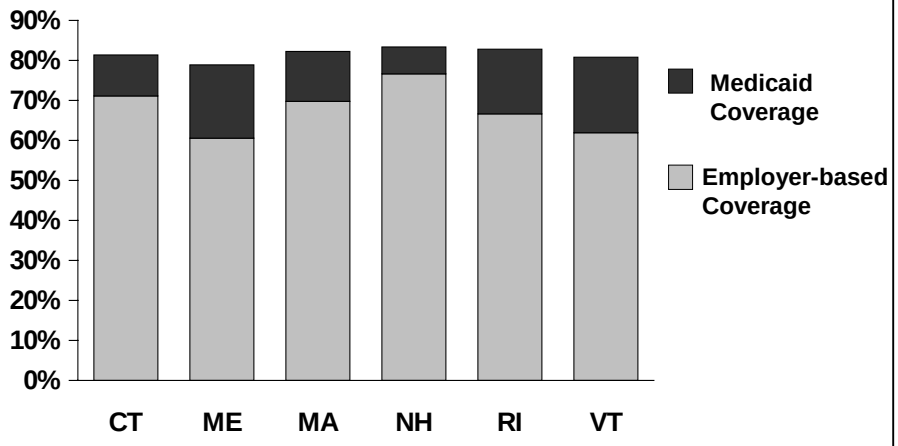
MaineCare plays an important role in Maine's healthcare system. The State Health Plan estimates that $7.695 billion was spent on healthcare in Maine in 2004.[19] Of that, $2 billion, or 26% of the total, came from MaineCare. And as previously described, $1.4 billion of the $2 billion were federal dollars contributing to Maine's economy.

MaineCare Compliments Employer-Based Coverage

MaineCare works with employer-based coverage to keep the rate of uninsured persons down. Figure 15 shows that all of the New England states rely on a combination of employers and Medicaid to cover approximately 80% of non-elderly persons.

Figure 15

Percent of Non-Elderly Covered by Employers and by Medicaid, 2002-03



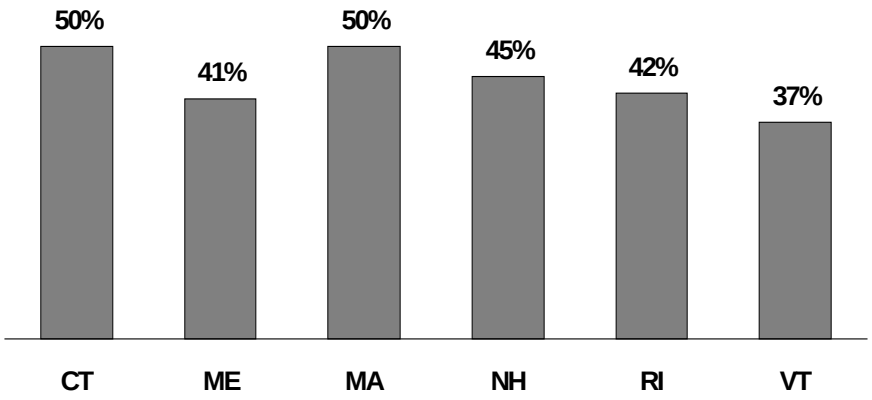
SOURCE: Kaiser Commission on Medicaid and the Uninsured[20]

Note that the three New England states with the highest rates of employer coverage are able to rely less on Medicaid. Those states, Massachusetts, New Hampshire and Connecticut, have a greater percentage of employees in large

firms than Maine and Vermont, which must rely more on small businesses and self-employment. (Figure 16)

Figure 16

Percent of Employees in Firms with 500 or More Employees, 2001

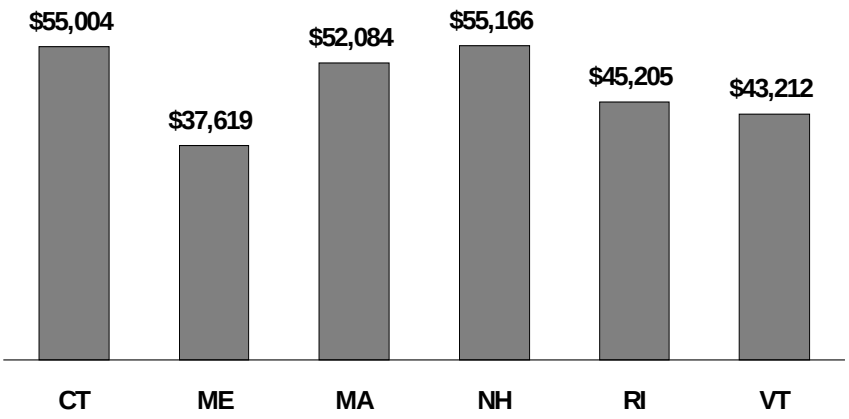


SOURCE:U.S Small Business Administration[21]

But employer size is not the only distinction among these states. Maine and Vermont have the lowest household income levels in the region, while Massachusetts, New Hampshire and Connecticut have the highest. (Figure 17)

Figure 17

Median Household Income, 2001-03



SOURCE: Kaiser Family Foundation[22]

Maine's economy has been in transition for some time. The 1990s saw a sharp reduction in the state's traditional manufacturing jobs that often included health benefits. The decline in Maine manufacturing has been far greater than the national average. Maine now has about 65% of the manufacturing employment it had in 1960, while the U.S. as a whole retains 95%.[23] Maine lost 2,000 manufacturing jobs between December 2003 and August 2004 alone.[24] Lost manufacturing jobs have been replaced largely with service sector jobs that are less likely to include affordable health benefits. Nationally in 2003 the percent of uninsured persons employed in the manufacturing sector was 16.6% compared to an uninsured rate of 35.7% in the service sector.[25]

These Maine characteristics—heavy reliance on small businesses, increasing reliance on service jobs and low median income—have conspired to keep the rate of employer-based coverage low and the rate of Medicaid coverage high relative to most other New England states and the national average.

MaineCare Provides Key Enhancements to Dirigo Health

In 2003 the Legislature enacted a major health reform effort generally known as the Dirigo Health Program. Dirigo Health's goals are to increase

Laura and Ted from Orono

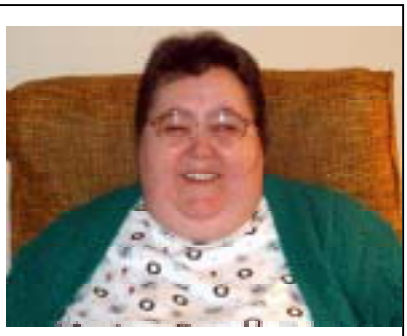
Ted, my husband, works full time as a cook and I do odd jobs. Most recently I have been doing some babysitting. We could never afford to pay for health insurance on our tight budget. We have four children and MaineCare Has truly saved our children's lives.

Our oldest daughter recently had a gastric bypass which we believe was a lifesaving operation for her. She was morbidly obese before the operation. Now she is healthy and she has stopped gaining weight.

Our two younger sons who are both 16 years old have been helped by MaineCare. They both were diagnosed with Attention Deficit-Hypertension Disorder and Oppositional Defiant Disorder. One also has a learning disorder. The boys saw behavior specialists who taught them good coping skills and anger management. These skills have been critical for helping them to function and to be able to focus on and complete their school work. The therapy received by our boys prevented them from heading down the wrong road.

access to health coverage, reduce unnecessary costs, and assure better quality of care.[26] Among other things, it is designed to give small businesses, the self-employed, and individuals the chance to purchase affordable, high quality health insurance coverage. Anthem Blue Cross Blue Shield of Maine is providing the Dirigo Health coverage through a product known as "DirigoChoice." Based on their family size and income, enrollees with household income up to 300 percent of the federal poverty level can receive discounts on monthly payments and reductions in deductibles and out-of-pocket expenses. The discounts are designed to make coverage more affordable and to increase the rate at which employees elect to participate in DirigoChoice. Dirigo Health helps bridge MaineCare to the private healthcare system, and also relies on MaineCare for its success in several ways.

Dorothy from Farmington, ME



I am disabled and I live on $594 per month in Social Security benefits. I am a college graduate and a former kindergarten teacher and librarian. I also spent a number of years providing care to the elderly.

I have serious lung problems caused by pulmonary fibrosis and I have insulin dependent diabetes. Without my medications, I wouldn't be able to breathe and I would go into insulin shock and die. I have also been diagnosed with Post Traumatic Stress Disorder from things that happened to me while I was a child. All of my relatives are gone so my counselor is often my only lifeline. It is clear to me that a person's mental health is extremely important. If you don't have help, it will affect the rest of your life and your physical health.

I am 51 years old and I find it so frustrating that I can't work and I do hope to work again. But my disability makes it impossible right now. I am thankful for the services I receive through MaineCare.

- *Providing some federal matching funds.* Some of the small employers who elect to purchase DirigoChoice will have employees who are eligible for MaineCare. These MaineCare-eligible employees will be able to enroll in DirigoChoice. Their employers' contributions to the plan will mix with other

dollars in the Dirigo Health Agency, contributing to the financial stability of DirigoChoice. MaineCare, contributing its federal matching dollars, will purchase the DirigoChoice plan for the employee. This aspect of the program has been scrutinized by the federal government, but program planners believe the design meets all applicable federal Medicaid regulations. The federal Centers for Medicare and Medicaid Services (CMS) recently approved the contract between MaineCare and Anthem with respect to the DirigoChoice product.

- *Serving as a base for Dirigo Health's joint purchasing initiative.* MaineCare also provides a base on which to partner with other large purchasers to support Dirigo Health's joint purchasing initiatives, one of the strategies the state is using to contain health care costs.
- *Enhancing provider rates for MaineCare members who join Dirigo Choice.* A longstanding concern of physicians, hospitals and other health providers is that MaineCare pays below market rates for their services, causing them to shift losses onto commercial payers. MaineCare members who join DirigoChoice because they work for a business that participates in Dirigo Health will have an insurance card that brings with it the rates paid to providers by Anthem.

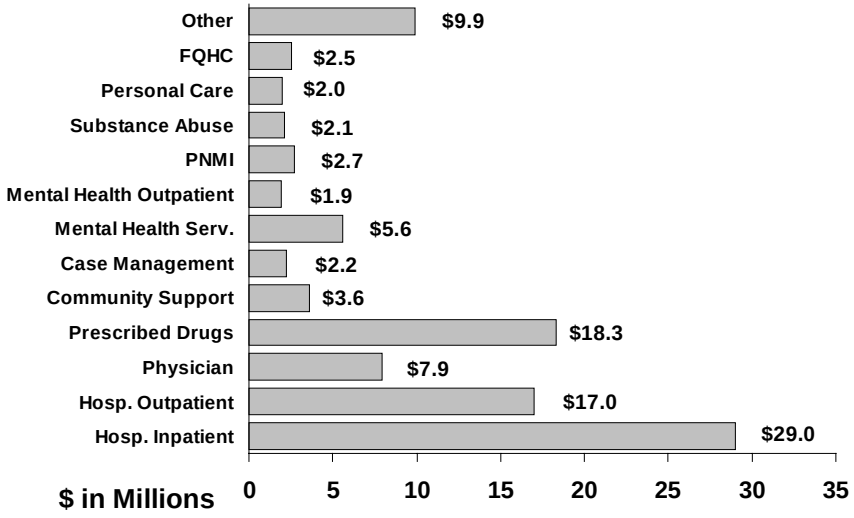
MaineCare Reduces Bad Debt and Charity Care

An important goal of the Dirigo Health Reform effort is to reduce uncompensated care. In 2002, Maine hospitals experienced over $190 million in bad debt and charity care costs that arose from providing care to uninsured and underinsured persons. [27] Physicians and other healthcare providers also experience losses, but they are more difficult to calculate. The cost of providing uncompensated care is passed on to insurance companies and premium payers, driving up the cost of private insurance. MaineCare has long been recognized as a cost-effective strategy to reduce uncompensated care. By providing MaineCare coverage, the rate of uninsured goes down, and the payments made to providers on behalf of MaineCare members include federal matching funds. For example, in SFY 2004, MaineCare paid more than $100 million to providers

for care to people enrolled in the non-categorical adult waiver program, of which more than $66 million were federal dollars.[28] Figure 18 shows the major service categories used by the non-categorical group. Almost half of the total ($46 million) went to hospital inpatient and outpatient services. Without MaineCare coverage, this group would likely have been uninsured, and their hospital use would have contributed to bad debt and charity care.

Figure 18

SFY 2004 Expenditures (preliminary*) for Non-Categorical Group ($ millions)



SOURCE: Maine Department of Health and Human Services[29]
*Based on preliminary analysis by Muskie School of Public Service, 12/15/04

The Dirigo Health reform initiative extends this strategy. In addition to covering more people with commercial insurance through DirigoChoice, the state also plans to extend MaineCare eligibility on April 1, 2005. Coverage for parents is authorized to expand from the current 150% to 200% of the federal poverty level (FPL). The income limit for non-categorical (childless) adults and persons with disabilities is authorized to expand from 100% of the FPL to 125%.[30]

MaineCare is Maine's High-Risk Pool for Disability

Because neither Medicare nor commercial health insurance cover long-term care and disability supports, MaineCare is the high risk pool for low-income older and younger people with disabilities, including persons with mental retardation, autism, physical disability, mental illness, HIV/AIDS and other long-term chronic and often disabling conditions. In Part One, we saw that older persons and persons with disabilities account for two-thirds of MaineCare costs, approximately $1.32 billion in SFY 2004. If these costs were reflected in commercial insurance products or uncompensated care, premium prices would be substantially higher than they are now.

Sharon from Falmouth, ME

I am 43 years old and I live in Falmouth in a long term care facility. In 1983, I was diagnosed with primary progressive multiple sclerosis, which is one of the more severe forms of MS. Since then my physical condition has gone down hill. I was able to work as a receptionist in Portland until 1995.

In 1999 a Grand Mal Seizure put me in the hospital. My husband was told at that point that I would have to go into a long-term care facility. At first I resented the fact that I had to relinquish my autonomy even though I clearly need other people to take care of me. I cannot walk and I am not capable of preparing my own food. The nurses also need to stretch my muscles at least twice a day so that my muscles don't contract completely.

Over time, I have become close friends with all of the staff at the facility. They are now my community. I have interactions with people here that I would never be able to have if I were at home alone. The staff not only helps me physically but also on an emotional level. I am happy here.

MaineCare and Maine Health Reform

In summary, MaineCare is a vital piece of Maine's health reform efforts. It keeps the rate of uninsured persons down, reduces uncompensated care, acts as a high-risk pool for disability and helps key aspects of Dirigo Health function. But MaineCare faces big challenges in the immediate future. These, along with some promising program directions, are discussed next.

Part Three. MaineCare Challenges and Promising Developments

MaineCare's size and importance make it an item for debate in every legislative session, but the debate is likely to be particularly strenuous in 2005 and 2006. The economy is improving and state revenue projections have been revised upward, but property tax reform and a host of other needs compete for very scarce resources. This Part describes briefly some of the major MaineCare challenges that will affect deliberations, as well as some promising developments likely to improve the program's effectiveness.

Major MaineCare Challenges

Responding to a Diminishing Federal Match Rate

Maine (and most other states) will need to come up with an increasing state share of Medicaid costs in the immediate future. As discussed earlier, the federal government publishes the Federal Medical Assistance Percentage (FMAP) annually, based on average income per person in each state and in the nation as a whole. Maine's current share of 35.11% in FFY 2005 increases to 37.10% in FFY 2006. The change has been estimated to require an additional $76 million state dollars in the 2006-07 biennium just to maintain existing services.[31] This rate change is more severe than it would normally have been because states were enjoying a temporary increase of 2.95% from April 2003 through June 2004, passed by Congress to provide states with fiscal relief during that period.

The methodology on which the federal FMAP formula is based has been criticized for being unresponsive to short-term economic downturns (and upswings) because of the time lag inherent in the collection and calculation of personal income data. The existing FMAP uses an average of per capita personal income for the three most recent calendar years for which data are available from the U.S. Department of Commerce. So, for example, the FMAP for federal fiscal year 2006, published in the fall of calendar year 2004, was based on personal income data for 2001, 2002, and 2003.[32]

Maintaining Eligibility Expansions

Capped Population Group. As noted in Part One, Maine was granted a federal waiver to provide coverage to non-categoricals, or childless adults, on the condition that the state would not exceed the amount of federal funds allocated to the state under the federal Disproportionate Share Hospital (DSH) program. The DSH cap for federal fiscal year 2004 is just over $100 million dollars (state and federal combined).[33] Expenditures appear to be reaching the cap. Per person expenditures for the group have been higher than expected, and certain service use patterns, such as high utilization of behavioral health services, suggests that some persons may have been eligible for MaineCare in the disability category. Work is currently underway to determine the extent to which misclassification has occurred and, if necessary, to reclassify persons with disabilities into a more appropriate group.

Tia from Augusta, ME

My husband, two sons and I all receive MaineCare. My youngest son is 11 years old and has been diagnosed with multiple disabilities. MaineCare has been a life saver for my son. He receives help through his medications and his weekly therapy visits. Both of these things keep us from being in crisis mode all the time!

MaineCare has also been important for me. Last spring, I had to leave my job because I was hospitalized with a brain aneurysm. In the past, I personally had only used MaineCare for regular check ups, but when I had my brain aneurysm, I would have lost everything if it wasn't for MaineCare.

As noted in Part Two, eligibility for the non-categorical group is scheduled to increase from 100% to 125% of the federal poverty level ($11,638 for a single individual) on April 1, 2005 as authorized in the law creating Dirigo Health. If the

current group reaches the federal cap, there will not be resources to further expand eligibility absent an increase in the DSH cap.

Uncapped Groups. Two other groups, parents and persons with disabilities, are also scheduled for eligibility expansions on April 1, 2005. These groups fall into "regular" categories in federal Medicaid law, and because Maine's planned expansion does not exceed federal eligibility criteria, no federal waivers are needed, and the populations are not subject to federal expenditure caps. Under the Dirigo Health law, the state's share of cost for these expansions rely on the Dirigo financing mechanism rather than the General Fund.

Implementing Medicare's New Part D Prescription Drug Benefit

Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Medicare beneficiaries will have access to a prescription drug benefit beginning in January 2006. This Act also has broad implications for the Medicaid program. When Medicare begins providing a prescription drug benefit, the federal government will no longer provide matching funds for prescription drugs in the Medicaid Program to dually eligible beneficiaries (those receiving both Medicare and Medicaid). Most of MaineCare's older members and about half of MaineCare's non-elderly members with disabilities are dually eligible. In 2002, Maine had 42,000 dually eligible persons with full MaineCare benefits.[34] In what has been labeled the "claw-back" provision, states will be required initially to reimburse the federal government for 90% of what they would have spent on prescription drugs under Medicaid on dually eligible members. The claw-back formula is based upon the number of dually eligible persons in a state, and the per-capita cost of providing drugs to those individuals. Under this formula Maine loses out relative to other states in two ways:

- Because Maine has been a national leader in extending prescription drug coverage to older persons and persons with disabilities, the percentage of individuals who were eligible for prescription drugs under MaineCare will be higher than the percentage eligible for Medicaid in most other states.
- Although work has been ongoing for the last several years to reduce the cost of prescription drugs in Maine, the most significant cost reductions have been

in 2004, yet those savings will not be reflected in the formula since they occurred *after* 2003, the baseline year for the clawback formula. Additionally, per-capita expenditures under the formula will be trended forward annually based on the average annual percent increase in per capita prescription drug spending nationally, an amount that will almost certainly exceed the actual percentage cost increases in Maine given the cost savings strategies currently in place.

In addition to these Maine-specific challenges, all states face two additional challenges:

- Once Part D is implemented, the drug costs for dually eligible persons will no longer be managed by states. Nationally, this represents approximately 48.5% of total Medicaid spending on drugs. This means that states like Maine that have achieved savings by leveraging the volume of services used by beneficiaries in both Medicaid and state-funded pharmaceutical programs will lose some of their purchasing power.[35] States will not benefit indirectly from the federal government's larger volume purchases, because the federal government is explicitly prohibited from negotiating discounts under the new legislation; and
- Part D coverage will only pay for prescription drugs that are on the formularies of the Medicare drug vendors. Coverage will vary from plan to plan, and is not likely to be as comprehensive as MaineCare coverage. Maine and all other states will have to decide whether to maintain the level of coverage that members currently receive, or allow coverage to be reduced.

Facing Demographic Challenges

The baby boom demographics facing Maine and most of the nation are well known. Older MaineCare members tend to come to MaineCare when they develop long-term care needs, not covered by Medicare. Because they use long-term care disproportionately, the average cost of older MaineCare members is more than three times as much as the cost of a child's care.

.As the program serves more older persons relative to other groups, the average MaineCare cost per person will rise. Policymakers must expect increases of this type for 2-3 decades, absent a major change in how long-term care is financed. Though still at its very early stages, the demographic shift is already being felt. Maine already has a higher percentage of older people than the national average.[36] The State Planning Office has suggested that the aging of Maine's population was a major driver of the 1,900 new health and education sector jobs that were created in Maine in 2003.[37]

MaineCare also has the 6th highest percentage in the nation of members with disabilities. 21% of MaineCare members qualify based on their disability, compared with the national average of 15%. In the general population Maine has the highest rate of cancer deaths per 100,000 in the Northeast and the twelfth highest rate in the country. The state also has the highest rate in the nation of persons diagnosed with asthma. [38]

Robert from Portland, ME

I was born and raised in Brunswick, ME. I am now 72 years old and live in a long term care facility in Portland. I started working at the age of 14 and I was a bartender for almost 35 years. In 1986 the doctors told me I could no longer work because of the serious symptoms caused by my diabetes. I retired from bartending and was able to live on my own in an apartment in Brunswick for a number of years. Unfortunately, my health continued to decline.

I came to the long term care facility when I started having serious back problems. I have now had 3 operations to get rid of an infection in my back. I have been dependent on insulin since 1982 and the lack of circulation, which has caused so many of my problems, finally led to my legs having to be amputated.

They take good care of people here. They make sure that I take my medications. They make sure that I get to all of my doctor's appointments.

Possibility of Changes in Federal Medicaid Policy

Federal policymakers currently are discussing the federal government's role in Medicaid, including proposals to reduce federal spending on the program and to expand state control over Medicaid rules. Driven both by concerns about the federal budget deficit and questions about the appropriate role of the federal government in Medicaid, the federal debate over the program is expected to be intense over the next several months. Depending on the outcome of the debate, MaineCare could face a reduction in federal support for its Medicaid program and/or a change in the federal rules governing how it uses Medicaid funds.

Promising Future Directions

A number of promising developments can help MaineCare meet the substantial challenges it faces.

Chronic Care/Disease Management

Given the demographic factors just discussed and the fact that most MaineCare costs are related to chronic care and disability, MaineCare will need to give increasing attention to people with chronic conditions. MaineCare needs to develop additional capacity in this area and is looking at models used by Medicaid programs in other states. While private sector disease management may be a bit too narrow for the MaineCare population (managing only diabetes or only asthma, for example), the concept of deliberately targeting members with certain characteristics and ensuring that their conditions are well managed to avoid acute flare up is likely to result in better care and reduced costs. MaineCare and other state agencies are participating in a National Governors Association Policy Academy on chronic disease prevention and management.

Joint Purchasing

Maine's health reform efforts include renewed attention to joint purchasing across large organizations. MaineCare provides a huge base on which to build effective purchasing coalitions. Discussions are being held among officials from the Governor's Office of Health Policy and Finance, MaineCare, state employees, the City of Portland, the state University System and the Teachers

Association to explore the feasibility of joint purchasing. In the past, it has been difficult for these large purchasers to get past their immediate organizational needs, but the impetus may be great enough now to make some progress with this strategy.

Consumer-Directed Supports

Nationally, consumer-directed care is one of the most important innovations in service delivery for long-term care and disability support services. In consumer-directed care, funds are no longer tied to a particular provider. Instead, the consumer decides how supports will be delivered. A rigorous evaluation of the national Cash and Counseling program found it to be cost effective with high consumer satisfaction levels.[49] When consumers have greater control and responsibility over their budgets, they use resources more effectively. MaineCare has just introduced a “Family Provider” option in the Private Duty Nursing program and a new Independent Service Option program for young adults with mental retardation or autism is under development. Maine has had a self-directed program for persons with physical disabilities for several years. It is important to note that consumer directed programs are not for everyone and should always be an option, rather than a requirement for consumers, and that consumers should always be able to return to agency-based supports.

Select Networking

Among private insurance plans, there is growing interest in the identification of select or tiered provider networks. While selection criteria typically includes quality and efficiency measures, emphasis is placed on non-financial measures to avoid consumer skepticism as to the motivations behind the network's construction. While similar in concept to tertiary care "centers of excellence", select networks may include primary care physicians, routine hospital services and high volume specialists. Incentives, typically in the form of reduced cost sharing provisions, encourage enrolled members to access these providers. These initiatives are likely to be more effective when coupled with strong consumer education about options.

Payment Practices

Pay for performance. Medicare has moved strongly in the direction of tying enhanced payments to desired performance among providers. Rather than considering across-the-board rate increases for categories of providers, MaineCare can build on its experience with Physician Incentive Payments and grant targeted rate increases to providers who meet specified quality objectives. This approach can be coupled with the select networking discussed above.

Standardized Rates. MaineCare has standardized rates for most services but continues to use individually negotiated, cost-based rates with certain behavioral health providers. This not only creates equity problems across providers and population groups, but it also institutionalizes high rates for providers with historically high costs, providing no incentive for efficiency.

Maximizing Veterans' Benefits

Some states are beginning to realize significant Medicaid savings by helping qualified veterans access medical and financial services through the Veteran's Administration (VA). Because Medicaid pays last, after all other payers, states can avoid substantial costs if veterans take advantage of other programs to which they are entitled. Many veterans, particularly those with disabilities, are not aware of the full amount of medical and financial resources available to them through the VA. Washington State, one of the first states to aggressively pursue this strategy, recently estimated potential savings at more than $22 million. [40] California recently estimated potential savings to their Medicaid program to be as much as $250 million[41]. Maine could not expect to realize the level of savings estimated by these larger states, but the approach is worth pursuing.

Conclusion

MaineCare is a critical program and an important component of Maine's health reform efforts generally and Maine's goal to achieve universal access specifically. Because the program is so important to so many members, small businesses, providers and policy makers, any change is controversial. Yet in

order to keep pace with a rapidly changing health and economic environment, MaineCare must continue to innovate and contribute to the health of Mainers.

For policymakers outside of Maine who are looking to the state for ideas about ways to manage rising costs, the growth in the uninsured population, and quality issues through an initiative such as Dirigo Health, it will be important to look at the ways in which MaineCare and DirigoHealth work together. While they each play distinct roles in Maine's health care system, the two programs are complimentary and together contribute to the state's efforts to develop a system where high quality, affordable coverage is available to all residents.

Appendix A: Major MaineCare Eligibility Groups

Group	*Benefit Level*	*Income Limit*	*Asset Limit*	*Notes*
Children 0 - 18	MaineCare Full Benefits	200% of FPL (federal poverty level)	None	Children with income up to 150% of FPL and infants under 1 with income up to 185% of FPL pay not premium. Children between 150% and 200% of FPL are eligible for MaineCare through the SCHIP program, paying between $8 and $64 per month per family, depending on income. Children who have a serious medical condition are served under the Katie Beckett option. For the Katie Beckett option, only the income of the child who has the disabling condition (not the parents' income) is counted. There is an asset limit of $2,000. Full cost purchase option allows families who lose coverage due to increased income to buy into MaineCare at cost for 18 months.
Young adults age 19 - 20	MaineCare Full Benefits	150% of FPL	$2000 (Many assets are excluded)	Income of parents in the household is counted in some circumstances.
Parents with children under 19 at home	MaineCare Full Benefits	150% of FPL (To expand to 200% of FPL on 4/1/05)	$2,000[2] (Many assets are excluded)	Transitional coverage: If family income increases to over 150% of FPL due to earnings, an additional year of coverage is available. Their income must remain below 185% of FPL in months 7 through 12. The family must pay a small premium in months 7 through 12.
Pregnant Women	MaineCare Full Benefits	200% of FPL	None	For the mother, coverage continues 2 months beyond pregnancy. Coverage will continue longer, if the mother meets criteria above for parents. If the mother had full benefit MaineCare when the baby was born, MaineCare covers the baby for one year.
Disabled Adults and Persons 65 and Over	MaineCare Full Benefits	100% of FPL (For disabled only, this will expand to 125% of FPL on 4/1/05)	$2,000 ($3,000 for a couple)[2] For working disabled – $8,000 ($12,000 for a couple) (Many assets are excluded)	Full benefit MaineCare 'wraps around' Medicare. It covers Medicare deductibles and co-payments. Medicare beneficiaries who are not eligible for MaineCare full benefits may be eligible for the MaineCare Medicare Buy In benefit which may pay for Medicare Part B premium, co-pays and deductibles. The Working Disabled Benefit: People with disabilities who work may be eligible for full benefit MaineCare if their unearned income is under 100% FPL and their total income, including earnings, is under 250% FPL. Some people may have to pay small monthly premiums
HIV Positive Adults	MaineCare Prescriptions and other limited coverage	250% of FPL	None	Individual must be HIV-positive (with or without diagnosis of AIDS); coverage includes prescriptions, physician and hospital services, there are some limitations on services; co-pays are higher ($10 per prescription and office visit) than for full benefit MaineCare; there is a limit on the number of individuals who can participate in the program
Women who have Breast or Cervical Cancer (or pre-cancerous condition)	MaineCare Full Benefits	250% of FPL	None	Women must be without insurance; age 40 to 64 (or over 64 if they only get Part A Medicare, not Part B); and have a positive screening by the Bureau of Health Program
Adults medically eligible for nursing care	MaineCare Full Benefits	$1,692/mo	$2,000 ($3,000 for couple)[2] (Many assets are excluded)	Condition must be so severe that they would be nursing home eligible, but they are living in the community. Adults are served under the home-based care waiver program.
"Non-categoricals"	MaineCare Full Benefits	100% of FPL (To expand to 125% of FPL on 4/1/05)	$2,000 ($3,000 for couple)[2] (Many assets are excluded)	Adults who do not fit in another MaineCare category are eligible for MaineCare if their income is below 100% of poverty and are under the asset limit.

Source: Maine Equal Justice Partners[42]

[1] For example, see Brendan Kraus, *Doing More With Less: Recent State Coverage Expansions*, Center for Best Practices, National Governors Association, November 2003.

[2] Miller, Vic and Andy Schneider. *The Medicaid Matching Formula: Policy Considerations and Options for Modification*. Washington, D.C.: AARP, September 2004.

[3] The federally published FMAP rates are accessible on the web at http://aspe.hhsgov/health/fmap.htm

[4] Pear, Robert. "Administration Looks to Curb Growth of Medicaid Spending." New York Times, 12/20/04. http://www.nytimes.com/2004/12/20/politics/20medicaid.html?ex=1104557334&ei=1&en=2517fcdb2f91b43a (accessed 12/20/04)

[5] This eligibility discussion summarizes a very complex program area. For more detailed information, see the Kaiser Family Foundation's Medicaid Resource Book on-line at http://www.kff.org/medicaid/2236-index.cfm

[6] Henry J. Kaiser Family Foundation, statehealthfacts.org (accessed 11/12/04)

[7] Maine Legislature, Office of Fiscal and Program Review. "General Fund Expenditures by Major Categories." http://www.state.me.us/legis/ofpr/gfexpmajor.htm (accessed 11/27/04)

[8] National Governors Association. "Spending Pressures Continue Despite Revenue Growth." http://www.nga.org/nga/newsRoom/1,1169,C_PRESS_RELEASE^D_7688,00.html (accessed 1/7/05)

[9] Maine Legislature, Office of Fiscal and Program Review. "MaineCare\Medicaid Funding History, Update 10/19/04."

[10] Maine Legislature, Office of Fiscal and Program Review. "MaineCare\Medicaid Funding History, Update 10/19/04"

[11] Henry J. Kaiser Family Foundation. www.statehealthfacts.org (accessed 11/12/04)

[12] Maine DHHS. "MaineCare Expenditures by Kaiser Groupings, SFY 2003, Tables 2B and 3B", prepared for the Department by the Muskie School of Public Service, University of Southern Maine. Draft Report, 11/03.

[13] Maine DHHS. "MaineCare Expenditures by Kaiser Groupings, SFY 2003, Tables 2B and 3B", prepared for the Department by the Muskie School of Public Service, University of Southern Maine. Draft Report, 11/03.

[14] Maine DHHS. MaineCare Annual Report, SFY 2004 (forthcoming).

[15] Maine DHHS. MaineCare Annual Report, SFY 2004 (forthcoming).

[16] MaineCare administrative costs source: Maine DHHS. MaineCare Annual Report, SFY 2003. Commercial insurance administrative costs source: Maine Bureau of Insurance at http://www.state.me.us/pfr/ins/health_market_14.htm (accessed 12/19/04)

[17] Maine Legislature, Office of Fiscal and Program Review. "MaineCare Caseload", Updated 10/9/04. The "Subtotal" column was used, in order to exclude persons in drug-only programs.

[18] Derived from: Maine Legislature, Office of Fiscal and Program Review. "MaineCare Caseload", Updated 10/9/04. The "Subtotal" column was used, in order to exclude persons in drug-only programs.

[19] Maine Governor's Office of Health Policy and Finance. "Maine's State Health Plan." July, 2004. Figure 7.

[20] Hoffman, Catherine, A. Curbaugh, and A. Cook. "Health Insurance Coverage in America: 2003 Data Update." Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured (November 2004). Table 13.

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[22] Henry J. Kaiser Family Foundation. www.statehealthfacts.org (accessed 11/12/04)

[23] Index of Maine and U.S. Manufacturing Employment, as reported by Laurie G. Lachance, Maine State Economist, at The Maine Heritage Policy Center's "Emergency Tax Summit," March 24, 2004.

[24] Maine State Planning Office. "Highlights, October 4, 2004." http://www.state.me.us/spo/economics/economics/pdf/comment.pdf (accessed 11/10/04)

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[28] Maine DHHS. MaineCare Annual Report, SFY 2004 (forthcoming).

[29] Maine DHHS. "SFY 2004 Adjusted Claims for Recipient Aid Program 5C- Childless Adult Waiver." Prepared for the Department by the Muskie School of Public Service, University of Southern Maine. Draft Report, 12/15/04.

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