Medicaid Cost Containment: Issues and Options

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by

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Executive Summary

Origin

In April, 1992, the Legislative Council of the 115th Maine Legislature authorized the Office of Policy and Legal Analysis to conduct research and issue a report on the topic of cost containment in the Medicaid program.

Background

Maine's Medicaid program, like many others nationwide, is growing much faster than the rate of inflation and faster than General Fund revenues. Because the program is growing faster than revenues, it is taking up a larger and larger share of the General Fund each year, forcing policy makers to decide whether they wish to increase revenue, decrease Medicaid spending, or decrease spending on other programs to fund Medicaid.

Growth in the Medicaid budget is attributable to several factors, some that the State can control and some that it can not. Major factors include the following.

- **Inflation.** The State can not effectively control general inflation, but it may be able to reduce the rate of excess medical inflation through the implementation of comprehensive health care reform.

- **A growing number of recipients.** Other than to opt out of the Medicaid program altogether, the State has no control over federal mandates that have expanded eligibility in recent years. The State also has little control over the condition of the economy, which has made more Maine citizens eligible for Medicaid and other government subsidized programs. Much of the recipient growth, however, has been the result of a deliberate State policy to "maximize" Medicaid; that is, to use Medicaid to the greatest extent possible to replace programs that the State otherwise provides without federal matching funds.

Issues

Many issues complicate the implementation of Medicaid cuts. They include the limitations imposed by federal law and rules, as well as by State law. Many Medicaid cuts also have serious negative effects on access to medical services. Cost shifting is also a significant concern, whether it be a shift to private payers, to other parts of the State budget or to local governments.

Options

Many options exist to reduce the rate of growth in the Medicaid program, but policy makers should be aware of the undesirable implications that accompany many of the strategies. Options range from the broad approach of cutting Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) to the more specific strategy of implementing copayments for services. A list of options considered by other states and a discussion of policy issues regarding those options is included in Chapter IV.

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Abbreviations and Key Words

AFDC	Aid to Families with Dependent Children, a joint federal-state cash assistance program for single parent-headed households with low income. AFDC recipients qualify automatically for Medicaid.
AMHI	The Augusta Mental Health Institute, a State-operated mental health facility which is currently being reduced in size as part of a court-approved consent decree, commonly referred to as the AMHI Consent Decree.
Boren Amendment	A 1980 amendment to the federal Social Security Act, Title XIX, that requires state Medicaid programs to reimburse health care facilities at rates that are "reasonable and adequate" to meet the costs of "efficiently and economically" operated facilities.
Capitated Rate	A negotiated rate that is paid per program enrollee, regardless of the actual cost of delivering services to any particular enrollee.
Categorical Recipients	People who receive Medicaid automatically because they receive AFDC or SSI.
CON	Certificate of need, a process through which a state controls the supply of new health services by requiring that new services receive approval from the state.
DRG	Diagnosis related group, a payment mechanism used to reimburse hospitals in the federal Medicare program, whereby the amount received depends on the classification of the services provided, rather than on the actual services provided to a patient.
FFP	Federal financial participation, the amount that the federal government contributes to a state Medicaid program.
FFY	Federal fiscal year, which runs from October 1 through September 30.
FPL	Federal poverty level, an income bench mark that is adjusted annually by the federal Office of Management and Budget. Income limits for Medicaid and other programs are often expressed as a percentage of the FPL.
GA	General Assistance, a program administered by municipalities to provide assistance to persons who do not qualify for State programs or whose basic needs surpass their resources. The State reimburses municipalities for 90% of GA costs, after an expenditure threshold has been met.

GAO	General Accounting Office, a non-partisan Congressional research agency.
Gap	The difference between the standard of need and the maximum payment in the AFDC program. Effectively, the gap represents the amount of outside income an AFDC family may receive without becoming ineligible for AFDC.
HCFA	Health Care Financing Administration, the division of the U.S. Department of Health and Human Services that administers the Medicaid program at the federal level.
HMO	Health Maintenance Organization, an integrated health care delivery system that provides health services to enrollees at a prepaid, capitated rate.
ICF/MR	Intermediate care facilities for persons with mental retardation, which are Medicaid-funded programs that provide residential and day services to people with mental retardation in institutional and community-based settings.
Maximum Payment	The maximum cash grant that a family can receive in the AFDC program. The maximum payment depends on family size, and on whether an adult is included as part of the grant.
Medicaid Maximization	An informal policy pursued in Maine that seeks to maximize the amount of FFP received in Maine by using Medicaid to provide services that would otherwise by provided as a General Fund or locally-funded program.
MHCFC	Maine Health Care Finance Commission, an independent State regulatory agency that establishes the aggregate amount of charges that any hospital may collect in a given payment year.
NF	Nursing facility, a category used in the Medicaid program to describe what are commonly known as nursing homes.
RBRVS	Resource-based relative value scale, used to set physician rates that are based on the resources required to provide a service, rather than on the charges for those services.
Seed	State and local funds that must be spent in the Medicaid program in order to generate a federal matching amount, or FFP.

SFY	State fiscal year, which runs from July 1 through June 30.
SSI	Supplemental Security Income, a federal cash assistance program for people with low income who are at least 65 years of age or disabled. SSI recipients qualify automatically for Medicaid.
Standard of Need	The maximum amount of countable income that a family may have to qualify for AFDC.
UR	Utilization review, a broad term referring to a range of oversight activities that attempt to reduce the inappropriate use of medical services.

Chapter I

Introduction

Origin of Report

In April, 1992, the Legislative Council of the 115th Maine Legislature authorized the Office of Policy and Legal Analysis to conduct research and issue a report on the topic of cost containment in the Medicaid program. During the summer and fall of 1992, a review of the literature was conducted, information was compiled regarding Maine's Medicaid program, and cost containment measures proposed in other states were gathered.

Basic Medicaid Structure

A Federal-state partnership

Medicaid was authorized by the federal government in 1965 as Title XIX of the Social Security Act. Federal legislation and rules provide minimum standards which participating states must follow. Each state administers its own program, exercising considerable discretion through the development and amendment of its State Medicaid Plan.

Categorical program roots

Medicaid was originally established to provide medical assistance to people with low income who were receiving cash payments in one of the following categories: single parent with dependent children, elderly (65 or older) or disabled. This categorical link remains today, with AFDC (Aid to Families with Dependent Children) and SSI (Supplemental Security Income) recipients automatically qualifying for Medicaid. Although the categorical groups still comprise the majority of Medicaid recipients, much of the recent growth of the Medicaid program is attributed to federal expansions to so-called categorically-related groups, people who do not qualify for categorical assistance but who would if certain eligibility rules were altered. Generally speaking, categorically-related groups include people whose income is higher than the ceiling for categorical assistance.

Federal financial participation (FFP)

The federal govemment offers a powerful incentive to states to increase their Medicaid expenditures in the form of Federal Financial Participation, or FFP, generally referred to as the federal match or share. The federal share varies from state to state, based on relative per capita income. Currently, the federal share ranges from 50% in "affluent" states such as Connecticut, New York and California, to 79.99% in Mississippi. Maine's rate falls in between at 62.4% for federal fiscal year 1992.

The match rate published by the federal government for Maine is always different from the match rate used by Maine officials. This is because the federal rate is in effect for the federal fiscal year (FFY). In order to determine the match rate for the State fiscal year (SFY), Maine must blend the rates from parts of 2 federal fiscal years. For example, the federal share for Maine in FFY 92 is 62.4%, but the blended rate for SFY 92 is 62.67%.

As the overall Medicaid budget has increased, the states' share has increased more rapidly than the federal share, because federal legislation has progressively increased the share that all states pay. In Maine, people still commonly refer to a rule-of-thumb of 1/3 state, 2/3 federal,

while in fact the State share has climbed to 38.04% for SFY 93, up from 30.52% in SFY 85. (See Appendix A) As was mentioned earlier, the ratio varies from state to state depending on per capita income, but because a 3-year rolling average is used to determine per capita income, the full effect of an economic downturn is not immediately reflected in a state's match rate.

Growth of Medicaid Spending

Growth outpaces revenue

Medicaid has been called the Pac Man of state budgets. Its growth consistently surpasses inflation and, in most state budgets, it is the fastest growing line. During the heady economic growth of the mid-1980s, rapid expansion of the Medicaid program was absorbed by most states and welcomed by many, including Maine. But when the recession took hold, it quickly became clear that Medicaid increases would be exacerbated, and that growth in Medicaid would outpace growth in revenue.

This can be demonstrated dramatically in Maine. General Fund expenditures required to seed Medicaid grew from $105 million in SFY 88 to $170 million in SFY 91, an increase of 62%. During the same period, total General Fund revenue grew only 10%, from $1.29 billion to $1.42 billion. (See Appendix A) The Maine experience is not unusual. Similar patterns can be observed at the federal level and in numerous other states. Most states now face a set of unattractive options: increase revenue, cut Medicaid, or cut other programs to fund Medicaid.

Scope of Study

A strategic choice

States that do decide to grapple with their Medicaid budgets face a strategic choice: manage direct Medicaid costs, manage total health system costs, or manage both simultaneously. In making this choice, a conceptual preference for treating a problem at its roots competes with a real and practical need to balance a budget in the short term. Many who assert that Medicaid growth can not be reined in without comprehensive reform of the health care system acknowledge that many states can not afford to wait for comprehensive system reform. Yet, cuts in Medicaid often shift to other payers, fueling the rising spiral of costs in the private sector, and returning to haunt the public sector in the future.

Focus of this report

This report focuses on reducing growth in the Medicaid budget. It offers a range of options and explores issues raised by those options. Cost shifting, impact on access, categorical eligibility and Boren amendment lawsuits are just a few intricacies that make Medicaid reductions highly technical and potentially harmful undertakings. Broad options available to states are outlined, and specific strategies employed or proposed in other states are described and analyzed from Maine's perspective. The report acknowledges that Medicaid is but one small area inside the expanding health care balloon, but does not attempt to address comprehensively the larger health care problems of cost and access. Cost shifting that is likely to occur as a result of a Medicaid cut is discussed, but the focus of the report is management of direct Medicaid costs.

Cost Containment Overview

This chapter addresses containment of health costs generally and reviews various conceptual questions discussed in the literature. Cost containment strategies unique to Medicaid are discussed in Chapter IV.

Causes of Cost Increases

Medicaid increases compared to general health care increases

Using data provided by the Health Care Financing Administration (HCFA), the Congressional Budget Office has calculated the degree to which each of the following factors contributed to increases in general health spending between 1980 and 1989: general inflation in the economy, excess medical inflation, increases in population, and all other factors, which include changes in use and intensity per capita. (Langwell, 1992)

Also using HCFA data, the Advisory Commission on Intergovernmental Relations has made the same calculations for Medicaid for the period 1985 to 1989. (Advisory Commission on Intergovernmental Relations, 1992, 36) Significant differences appear when the analysis of health spending overall is compared to the analysis of Medicaid, as illustrated in Chart II-1.

Chart II-1: Percentage of Growth Attributable to Certain Factors for Health Spending Overall and for Medicaid.

Factor	% of Growth Attributed	
	Overall, 1980-89	Medicaid, 1985-89
General Inflation	46%	35%
Medical Inflation	22%	25%
Population	10%	17%
All Other	22%	23%

The significant difference in the percentage attributed to general inflation is largely explained by the longer period represented in the "Overall" figures. While the Consumer Price Index increased by less than 5% a year in the 1985 to 1989 period, it increased annually by more than 10% in 1980 and 1981. (U.S. Bureau of the Census 1991, 474)

Growth in Medicaid outpacing population

The difference in the percentage attributed to population is more revealing. It shows that the number of Medicaid recipients nationally grew more rapidly than the population overall. The Government Accounting Office (GAO) found that, while the national population grew by 1% between 1984 and 1989, the number of Medicaid recipients grew by 2.1%. The GAO was not able to determine how much of the increase in the number of recipients was attributable to the downturn in the economy and how much was attributable to federal expansions of Medicaid during that period. Major expansion provisions were in the omnibus budget reconciliation acts of 1985, 1986, and 1987, as well as the Medicare Catastrophic Coverage Act of 1988 and the Family Support Act of 1988. (General Accounting Office 1991, 26, 31)

Maine trends similar to national trends

Descriptive data suggest that Maine's Medicaid program is growing for the same reasons that the national program is. Growth in the number of recipients in Maine has outpaced increases in the general population. This is due to federally-mandated expansions, State-initiated expansions and increased eligibility resulting from a decline in the economy.

Maine's cost per recipient has risen steadily in recent years. Major factors contributing to increased per recipient costs include inflation, changes in the composition of recipients, and enhanced benefits. These and other trends of the Maine Medicaid program are discussed in more detail in Chapter III.

Likely causes of future cost increases

Major factors expected to increase health care costs in the near future include the aging of the population (of particular relevance to the Maine Medicaid program, which currently pays for 75% of nursing home costs) and rapidly developing biotechnology and other medical advances. In the Medicaid program specifically, observers expect new federal mandates to continue to increase costs, particularly in the absence of other federal access initiatives. The role of Medicaid in a future federal universal health care system is unclear.

Basic Variables of Health Care Expenditures: Price and Quantity

E = P X Q

Thomas Rice has pointed out that the fundamental variables that comprise health care expenditures are the price per unit of health care (P) and the quantity of units provided (Q). P multiplied by Q results in total expenditures (E). (Rice 1992, 22) Reductions in expenditures must come from reducing P or Q, but Rice points out that reducing one without controlling the other can result in a shift that undermines the cost control measure. For example, reductions in physician fee scales are directed at P, but if Q is not controlled, a physician can make up lost revenue to the practice by increasing Q, resulting in no decrease of E. Rice points to the 1989 changes in Medicare physician payments as a rare example where both P and Q were considered: fees were realigned to favor primary care, and limits were placed on the amount physicians can charge above the Medicare-approved amounts. In addition, volume performance

standards were established which tie payments in part to how well volume is controlled, thereby eliminating the opportunity to make up losses in P by increasing Q.

Examples of cost containment strategies directed at P include diagnosis-related group (DRG) payment systems and competitive bidding of health care contracts. Strategies directed at Q include certificate-of-need programs, which are intended to limit Q by controlling supply, and various cost-sharing proposals, which are intended to make consumers more selective about health care purchases.

Adding quality to the formula

The P X Q formula has been criticized for not considering the quality of services provided. One can argue, however, that quality affects the price per unit, and that differences in quality are therefore reflected in P.

Administrative costs

Some would argue that administrative costs contribute so significantly to P that they should be treated as a distinct cost component. How administrative costs should be defined, how much they contribute to the price of health care, whether they can be reduced significantly, and whether savings can be redirected equitably are all questions being addressed in the national health care reform debate. To date, Kenneth Thorpe has offered the most comprehensive effort to classify and measure administrative costs. (Thorpe, 1992)

Administrative costs take on a different meaning when considering the Medicaid program alone. While a central issue of the general health care cost debate is whether a system with fewer payers would cost less to administer, the Medicaid program itself has only 1 payer. In the Medicaid program, important administrative issues include automation and coordination with other State-funded health programs. These issues are discussed in more detail in Chapters III and IV.

Alternative Cost Containment Models

In addition to the P and Q dichotomy, cost containment strategies have been conceptualized in various ways.

Demand v. supply

Strategies that are directed at reducing demand for services include copayments and managed care. Strategies aimed at reducing the supply of services include certificate-of-need (CON) programs and health planning.

Regulation v. competition

This paradigm divides cost containment strategies into those that seek to hold down costs through government regulation and those that attempt to introduce competition into the health care sector to enable the market to bring prices down. This model, which has fueled much of the health care debate for the past 20 years, has been criticized for being rhetorical and for cornering debate participants into overly rigid positions. Observers point out that neither regulation nor competition has halted spiraling costs, and that the approaches are not mutually exclusive and could perhaps be more effective if applied simultaneously. (Altman and Rodwin, 1988) For instance, global budgets (regulation) can coexist and even encourage the expansion of managed care (competition).

By targeted group

Because an important role of the Legislature is to determine the distribution of resources, the paradigm developed by Thomas Rice may be the most useful in considering cuts. Arguing that recent cost containment strategies such as diagnosis-related groups (DRGs) and resource-based relative value scales (RBRVS) do not fit well into the competition v. regulation model, Rice offers a categorization scheme based on the group that is targeted by a particular strategy. (Rice 1992, 24) While DRGs do not fit well into either competition or regulation, they are clearly aimed at providers. Rice uses three categories of strategies, as follows.

- **Strategies aimed at users.** These include benefit reductions, copayments, and caps on services.
- **Strategies aimed at providers.** These include cuts in rates and changes in reimbursement methods.
- **Strategies aimed at both users and providers.** These include managed care, utilization review and fraud detection.

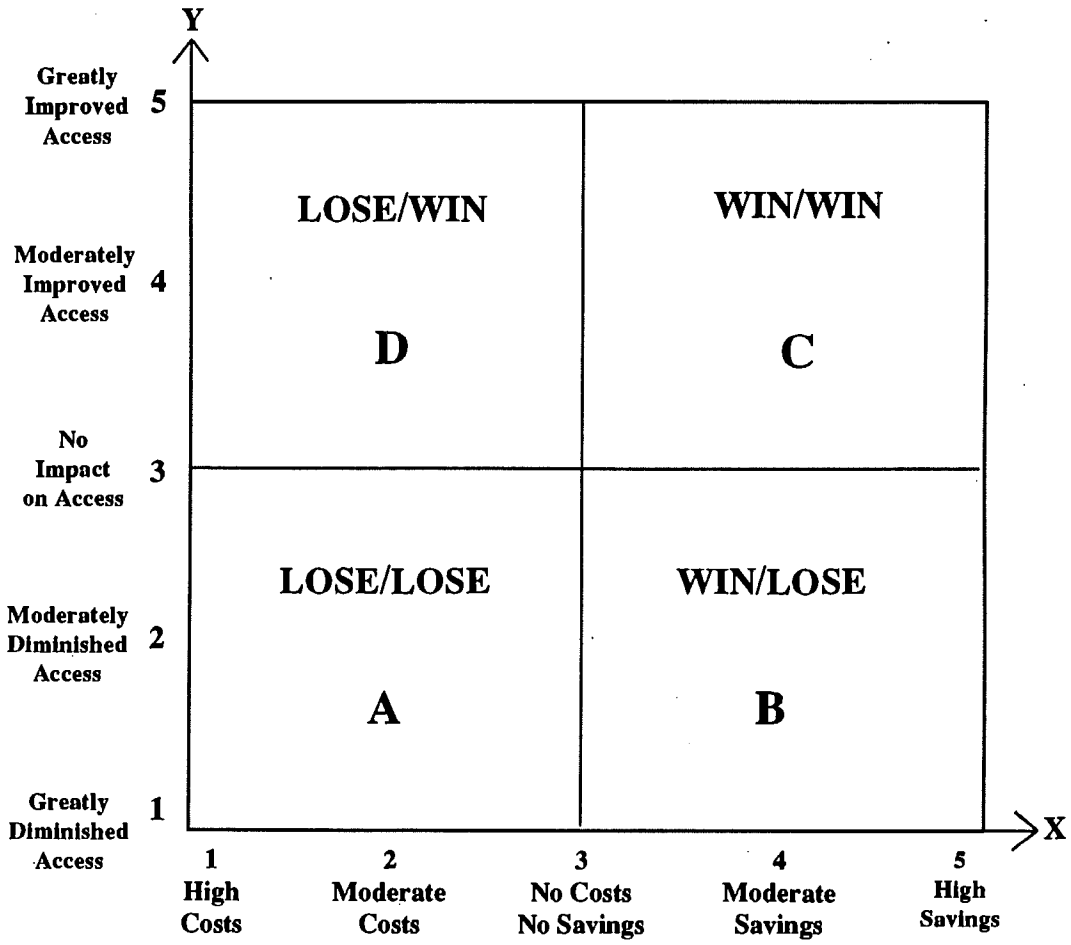
In Chapter IV, the Rice scheme is modified slightly and used to organize a list of Medicaid-specific cost containment strategies proposed in other states.

Cost and Access: Competing Goals

Although access to health care is not the focus of this report, policy makers must be able to gauge what impact their cost containment measures have on access. This question becomes especially important in the Medicaid program since, by definition, recipients have very few financial resources and are not likely to be able to afford alternatives. Louis P. Garrison, Jr. has observed that the objective of cost containment is not to reduce costs without regard to benefits, but to achieve a more affordable balance between the additional costs incurred and the benefits received. (Garrison, 1992, 13) Barrilleaux and Miller have pointed out that placing controls on Medicaid use seems counter to the legislative goal of using Medicaid to ensure access to health care. (Barrilleaux and Miller, 1992, 99)

Maine has taken many steps to improve access to health care in recent years. Medicaid coverage of elderly and disabled people up to 100% of the federal poverty level, establishment of the Maine Health Program, and creation of the MaineCare program in partnership with the private sector are only a few important examples. Clearly, improved access to health care has been a major policy goal. The programs described above, however, were initiated in good economic times, and they are now vulnerable to the State deficit. A key question for policy makers becomes: "Which cut has the least negative impact on access?" The 2 dimensions (cost and access) can be considered simultaneously by charting them on a grid, such as Chart II-2.

Chart II-2: COST - ACCESS MATRIX



Measuring cost

The x axis measures additional net costs or savings to the State. In a world of perfect information, this would include all costs, including indirect costs that are extremely difficult to measure. For instance, if Medicaid payments to hospitals were reduced, the cut would likely be shifted onto private third party payers. As an employer that provides private insurance to its employees, the State would absorb part of that shift in the form of higher premiums. As a practical matter, many indirect costs may not be readily measurable, but one can approximate the net cost of a given policy decision by adding up the answers to the following questions.

- What are the direct savings to the Medicaid program attributable to reducing this benefit?
- What costs are likely to be shifted to other parts of the Medicaid program? (Example: copayment on physician visit may lead to an increase in emergency room use.)
- What costs are likely to be shifted to other services funded by State government? (Example: reduction in categorical eligibility may lead to an increase in General Assistance expenditures.)

Measuring access

As with cost, access may be nebulous and difficult to measure. Unlike cost, which is easily measured in the standard unit of dollars, access measures are not uniform, making scoring of overall impact as much an art as a science. For instance, one unit of measurement might be number of persons denied access while another might be average reduction in frequency of procedure. The following questions may be used to gauge impact on access:

- How many recipients will be denied service?
- What will be the average reduction in frequency of service?
- Is an alternative source of care available?

Obviously, options that fall in quadrant C are the most desirable, since they expand access while reducing costs. Certain types of managed care fall into that category. Alternatively, quadrant A options offer the State less access at a higher cost and should be avoided. Falling into A are cuts that are immediately shifted to General Fund programs, where FFP is lost. Quadrants B and D are where most proposals fall, and they represent the most difficult decisions that policy makers face.

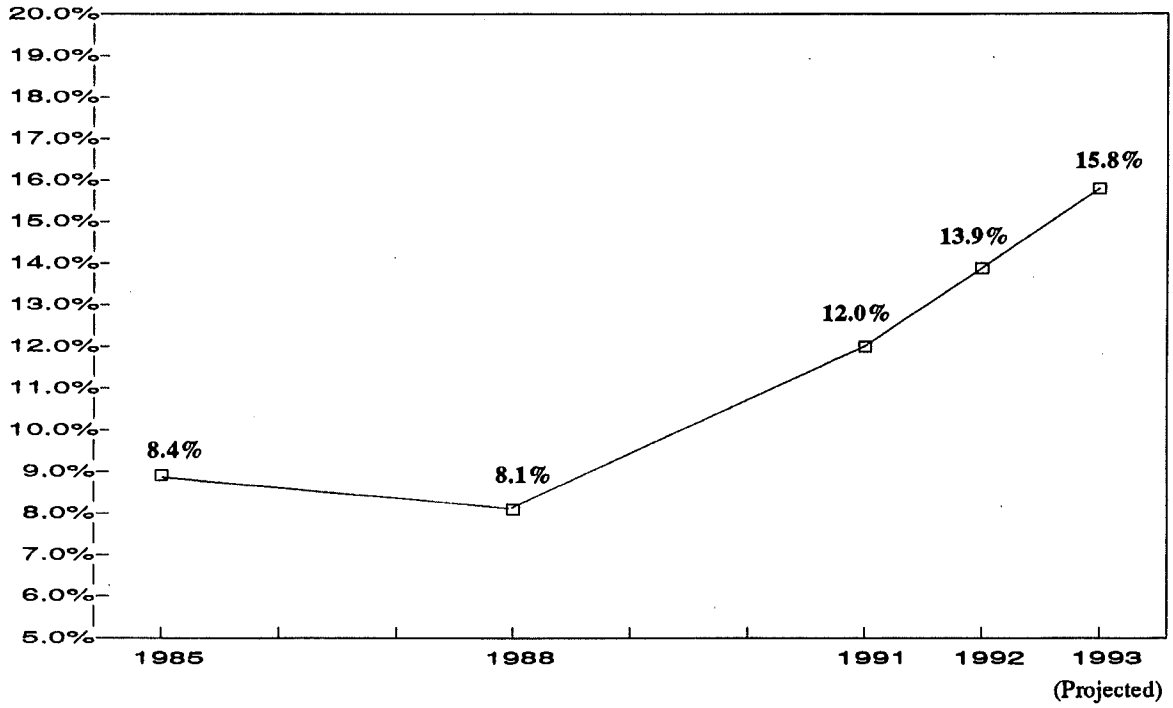
A Picture of Maine's Medicaid Program

Statistics

Medicaid seed an increasing portion of General Fund

The fundamental concern with the growth of Medicaid expenditures is that they are outpacing the growth of revenue. To the degree that the State is willing to sacrifice other General Fund programs to fund the Medicaid increase, this imbalance is not at issue. It becomes a problem only when the State no longer is able or willing to allocate an increasing share of the General Fund to seeding Medicaid. Chart III-1 illustrates the relationship between the State's share of Medicaid expenditures and General Fund revenue over time. As a percentage of General Fund revenue, State Medicaid seed will nearly double from SFY 88 (8.1%) to SFY 93 (15.8%). The percentage had actually declined from SFY 85 to SFY 88, despite the fact that the Medicaid budget grew by nearly 30%, because General Fund revenues increased by more than 50% in that period.

Chart III-1: State Share of Medicaid Expenditures as a Percentage of State General Fund Revenue



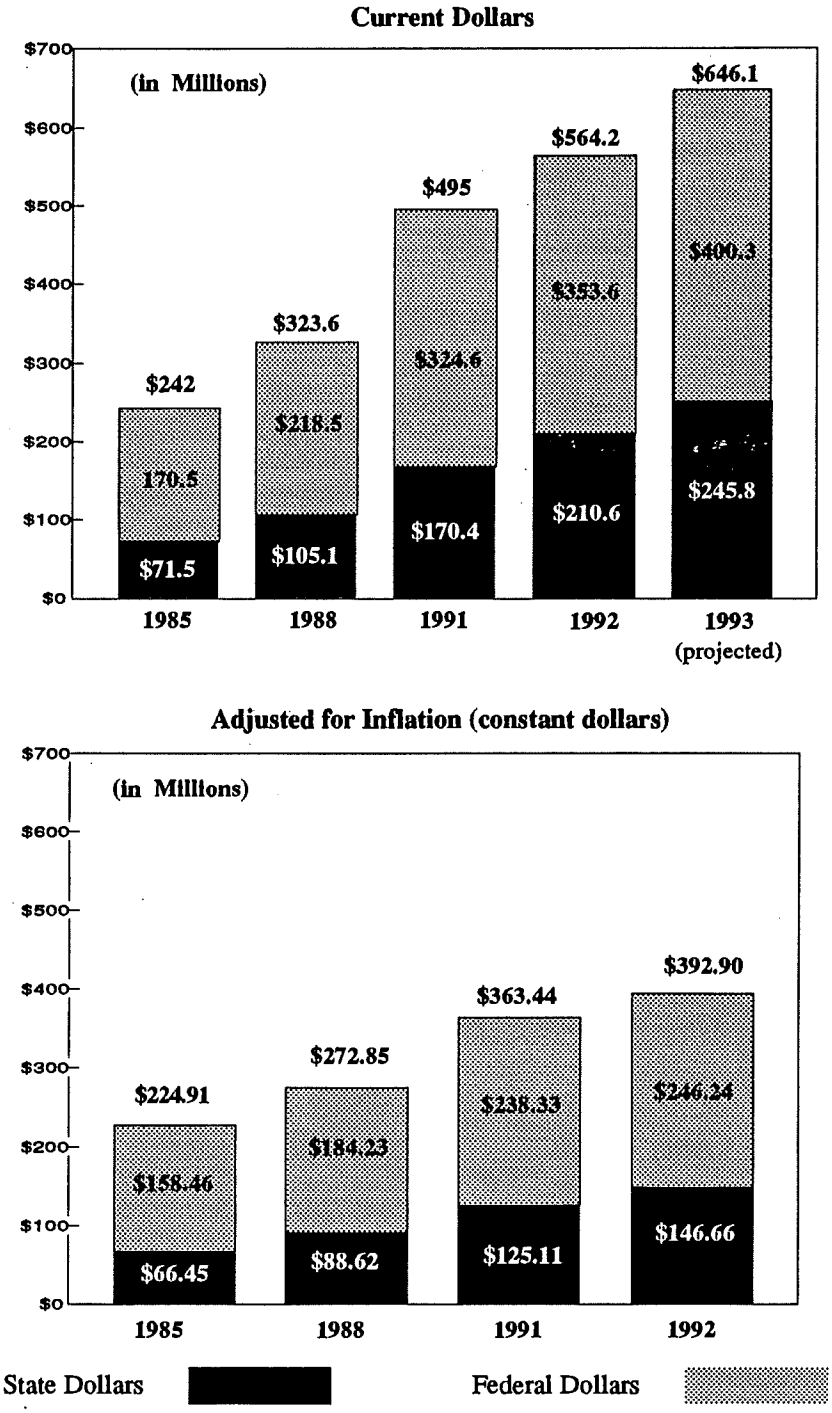
Data Sources: See Appendix A

Expenditures outpace inflation; enrollment grows

The increasing share of the General Fund that is devoted to Medicaid is at least partly explained by Maine's deliberate actions to "maximize" Medicaid expenditures, a policy which is discussed in detail below.

Chart III-2 shows that the Medicaid program is growing in real terms, after adjustments are made for inflation.

Chart III-2: Maine Medicaid Expenditures, Selected Fiscal Years



Data Source: Appendix A
Dollars adjusted for inflation using the Consumer Price Index (1982-1984 = 100)

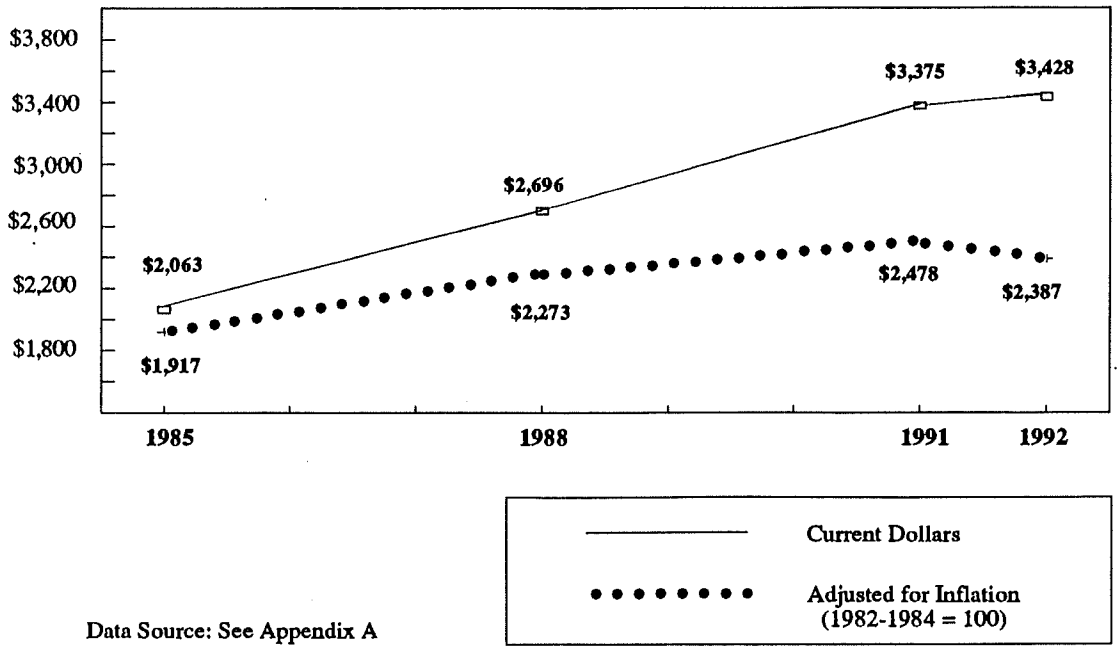
For the SFY 88 through SFY 92 period, the increase is at least partly explained by the increase in the number of recipients (from 121,907 in SFY 85 to 164,604 in SFY 92). The increase from 1985 to 1988 is more difficult to explain, since the number of recipients dropped in that period. It may be attributable to excess medical inflation, enhanced benefits and changes in composition of recipients. Until very recently, the cost per recipient was also rising in real terms, but that trend was reversed from SFY 91 to SFY 92, a year in which the number of recipients jumped dramatically from 11.9% of the population (146,669) to 13.3% of the population (164,604).

The relatively low marginal cost per new recipient suggests that the recent growth in enrollment is attributable more to economic conditions, which affect eligibility for AFDC, than to Medicaid maximization, which tends to focus on people with particular conditions or needs that are more expensive to treat than the routine medical needs of AFDC recipients. (See Charts III-3 and III-4)

Expenditures by category

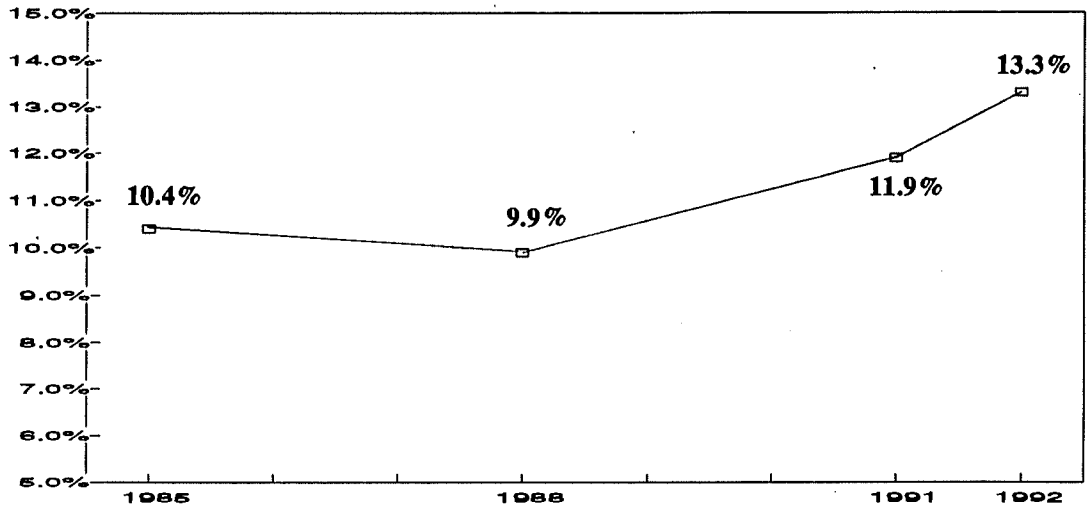
Chart III-5 shows the relative impact on the Medicaid budget of various categories of service. Nursing facilities have consistently taken the largest slice of the pie, a share that continues to increase. That trend may be mitigated somewhat by the adoption of new principals of reimbursement in October, 1992.

Chart III-3: Average Medicaid Expenditures per Recipient, Maine, Selected Fiscal Years



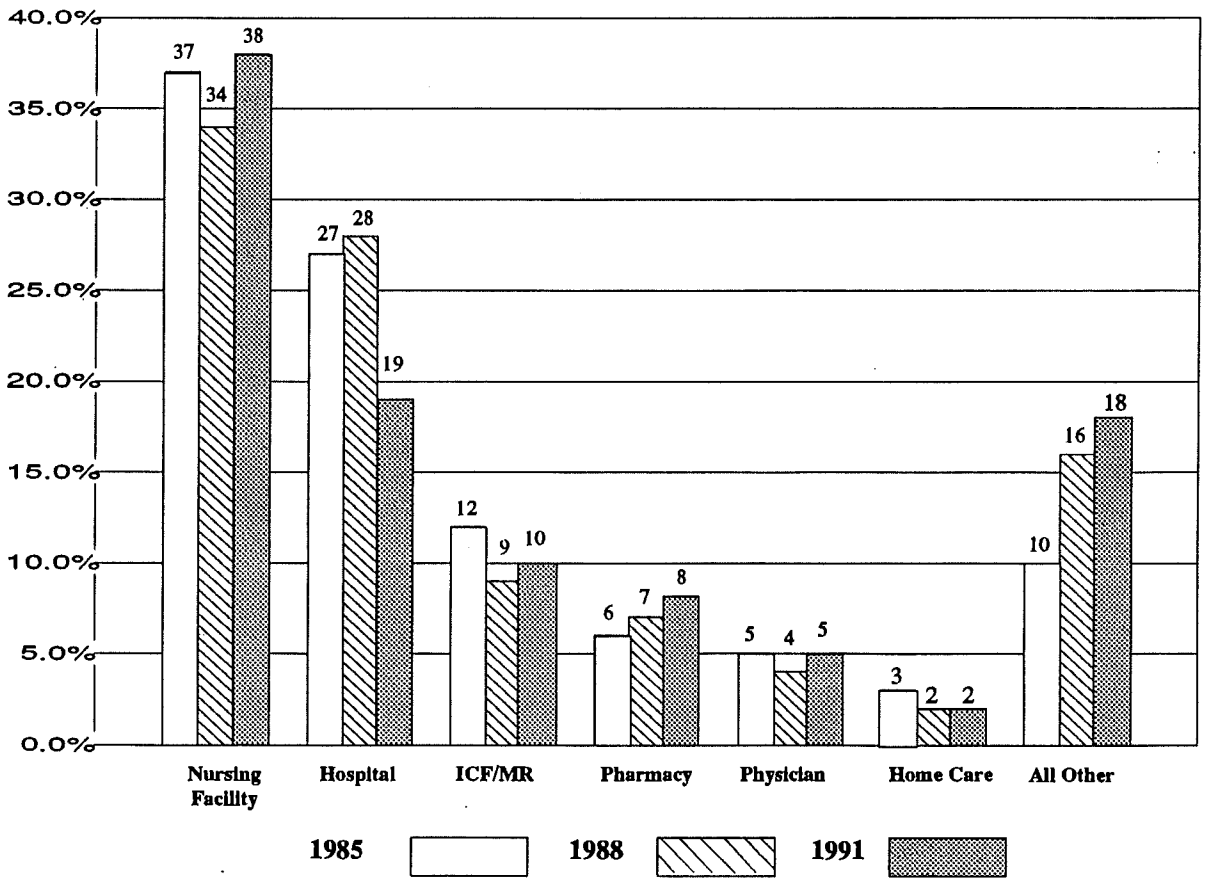
Data Source: See Appendix A

Chart III-4: Percentage of Maine Population Receiving Medicaid, Selected Fiscal Years



Data Source: See Appendix A

Chart III-5: Percentage of Maine Medicaid Services Expenditures by Category, Selected Fiscal Years



Data Source: Annual Medicaid Reports, Maine Department of Human Services
1985 figures were adjusted to remove administrative expenditures, to make them consistent with other years.

After nursing facilities, the next largest service area is hospitals, but as a percentage of the total Medicaid budget, hospital payments decreased more than any other category between SFY 88 and SFY 91. This is explained partly by declining utilization of hospital services in that period, and partly by the increasing importance of non-traditional services in the Medicaid budget.

Pharmacy has increased steadily, reflecting both the increasing number of recipients and the ever-increasing unit cost of prescription drugs. Growth in this area promises to continue at a significant pace, even when rebates from manufacturers are considered. The rebate program, started under federal law with great fanfare in SFY 1992, has proved to be a major disappointment. In addition to experiencing significant unit cost increases that more than offset rebates, Maine has had difficulty collecting its claims.

Highest per recipient category

The ICF/MR category (Intermediate Care Facilities for Persons with Mental Retardation) has the highest per recipient cost ($64,672 for SFY 91). The relative importance of this category should decline over the next several years as the Bureau of Mental Retardation continues to replace some ICF/MR services with community-based waiver services. Last year, the Bureau decertified 30 ICF/MR beds at Pineland Center and is currently seeking to decertify an additional 40 beds, bringing the Pineland ICF/MR capacity down from 295 beds in SFY 91 to 225 beds this year. The decertified beds have been vacated by former residents who have moved into the community. The community-based waiver (folded into "all other" on the chart) will grow as a percentage of the Medicaid budget; the per recipient costs of the waiver program ($28,857 for SFY 91) are likely to increase as participation is expanded to more people with greater needs.

All other grows

The sharp increases in the "all other" category reflect in part the rising importance of non-traditional services, such as those associated with the community-based waiver programs for older people and people with disabilities. The Bureau of Medical Services has begun reporting "waiver" as a separate category and may need to pull other items out of "all other" as they become more significant.

Administrative expenses

Program totals offered in this report do not include administrative expenses, but reflect service expenditures only. As a measure of administrative overhead, the Bureau of Medical Services uses its separate administrative services account. Totals reported by the Bureau for that account in the annual Medicaid report were $9.5 million in SFY 85, $12.4 million in SFY 88, and $15.4 million in SFY 91. These amounts are within 3 to 4% of the total services budget, but they are not an accurate measure of Medicaid administrative overhead. The figures include all administrative activities of the Bureau, some of which are not totally Medicaid related (licensing and certification, for instance). This makes the number larger than it should be. Far more significant, however, are the additional administrative costs of other agencies that are not captured in the administrative services account. These include activities of the Bureau of Income Maintenance, which is responsible for eligibility determination. A true accounting of Medicaid administrative expenses would include Medicaid eligibility workers and a pro-rated share of regional office expenses. Also, under an inter-agency agreement, significant Medicaid authority and administrative responsibility was transferred

recently to the Department of Mental Health and Mental Retardation. That department's costs would also be reflected in a true measure of Medicaid administrative costs.

Medicaid Maximization

An evolving policy

In Maine, the availability of federal financial participation (FFP) has led to an informal policy known as Medicaid maximization. Generally speaking, this policy attempts to use Medicaid to fund as many State programs as possible, on the theory that the State gets a better value for its dollar if that dollar in turn draws down $1.63 from the federal government. This policy has been applied in various ways over the years, leading to various possible interpretations of when the State ought to pursue a maximization approach. The major applications have been as follows.

- **Maximize Medicaid to expand access, even if additional State expenditures are required.**

  Examples of this application include the expansion of Medicaid in 1988 to cover pregnant women and infants up to 185% of the federal poverty level (FPL), and to cover older persons and persons with disabilities up to 100% of the FPL. These expansions were part of a deliberate strategy to expand access while keeping the costs of the soon-to-be-created Maine Health Program, a General Fund program, at a minimum.

  Another example is the Department of Mental Health and Mental Retardation's current effort to meet the terms of the AMHI Consent Decree by using Medicaid to develop a host of new community-based mental health services, including specialized boarding homes, intensive case management, and various outpatient services. By using Medicaid wherever possible, the Department stretches General Fund dollars appropriated for consent decree implementation.

- **Maximize Medicaid to expand access, but only if that can be done with no additional State expenditures.**

  This is perhaps the most popular form of maximization. It involves converting an existing General Fund program into a Medicaid program, using the existing appropriation as "seed" to leverage new federal funds, thereby expanding access without any additional State investment. An example of this is the State's move to use Medicaid to cover counseling services for children involved in child protection cases. By using existing State funds as Medicaid seed, counseling can be provided to many more children in a more timely way.

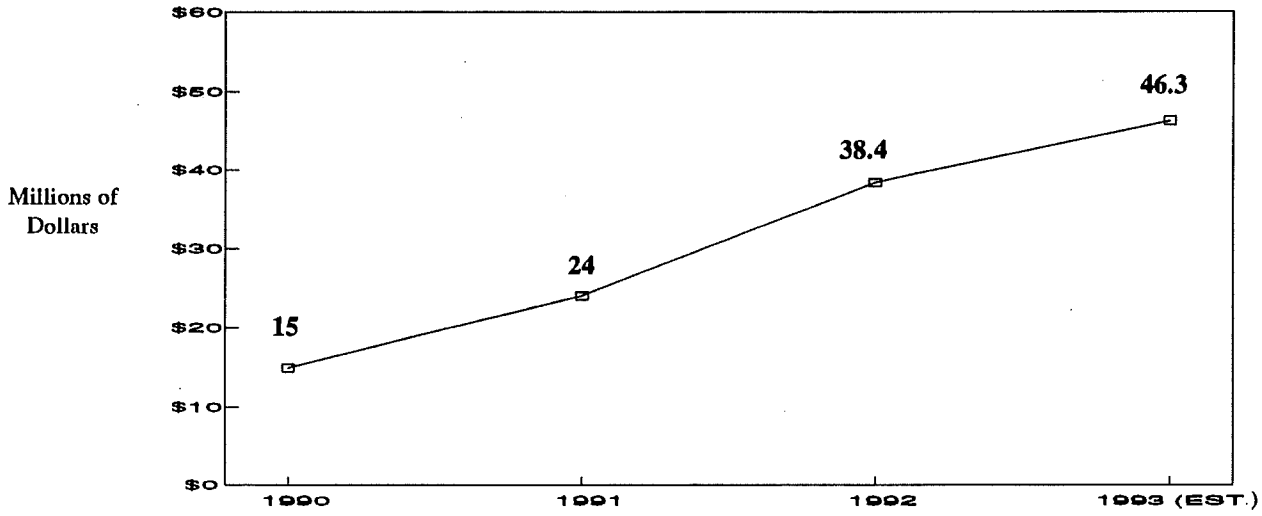
- **Maximize Medicaid, maintain current access, and reduce State expenditures.**

  This form of maximization has taken on a new urgency during Maine's current budget difficulties. The goal is to at least maintain current services, but to replace State expenditures with federal funds. One example of this is the Bureau of Mental Retardation's recent move to charge Medicaid for case management services that its case workers were already providing. This essentially resulted in new federal revenue going into the General Fund, since the caseworkers (State employees) were already being paid but are now generating undedicated revenue to the State through Medicaid billing.

Acceleration of maximization

The examples noted above are just a few of dozens of proposals generated throughout State government. Although Medicaid began as a health program, federal changes over the years have enabled states to use the program to offer an array of social services. As advocacy groups and State agencies have found new ways to tap into Medicaid, Medicaid maximization has accelerated. One measure of the extent to which Medicaid is being used in non-traditional ways is the amount of Medicaid seed being provided by agencies other than the Bureau of Medical Services. Chart III-6 illustrates the recent growth of outside seed in the "Medical Care— Payments to Providers" account. It has more than doubled from SFY 90 through SFY 92, and is expected to have tripled by the end of SFY 93.

Chart III-6: State Medicaid Seed Provided by Agencies other than the Bureau of Medical Services*, "Medical Care- Payments to Providers" Account



Data provided by the Maine Bureau of Medical Services
*Other agencies include Bureau of Health, Bureau of Child and Family Services, Department of Mental Health and Mental Retardation, Department of Education, Department of Corrections

Ongoing implementation of the Medicaid Plan for Children and Families and continuing compliance efforts in the AMHI Consent Decree case should continue to fuel this growth in the future. Other potentially large developments are planned in local school systems (tapping Medicaid to pay for school-based health and social services) and in the Department of Corrections (using Medicaid as a key element to "privatizing" the Maine Youth Center).

Retrospective review needed

From a cost point of view, acceleration of the maximization policy may be desirable. In fact, most of the expansions have been pursued to reduce or at least cap State expenditures in a particular service area. However, it would appear that no retrospective analysis of the maximization policy has been undertaken. In order to take on such a review, the goals of maximization would need clarification. Is the goal simply to save State funds? To improve access? Some difficult questions deserve asking. Is a program more likely to grow once it has obtained Medicaid's "entitlement" status? Is a program more difficult to cut or eliminate once it has been expanded to more people through Medicaid funding? Perhaps the central question is: Has Maine's Medicaid maximization policy resulted in fewer, the same, or more General Fund expenditures than would have resulted if programs had not been converted to Medicaid? The Department of Human Services does not list maximization growth as a distinct category in the Annual Medicaid Report, and there is no obvious way to assess whether the policy has been effective.

Chapter IV

State Options for Slowing the Growth of Medicaid

When a state makes the strategic decision to cut costs within the Medicaid program itself (either alone or in conjunction with broader health care reform), it finds that its options are limited by federal policy and by the negative impact that Medicaid cuts can have on other parts of the state budget. This chapter presents Medicaid cuts that recently have been adopted or considered across the country and places the proposals in a Maine context. Where available, research regarding the impact of a particular type of cut is summarized.

Cut Categorical Programs

Because Medicaid eligibility historically has been tied to eligibility for AFDC (Aid to Families with Dependent Children) and SSI (Supplemental Security Income), the broadest way to cut Medicaid is to make recipients ineligible by cutting categorical programs. On the surface, this may appear to be the easiest approach, but the State's options in this area are very limited, and they offer little by way of actual Medicaid savings.

SSI

SSI is a federal cash benefit program. In order to qualify, one must be either aged (65 or older) or disabled, and have income no greater than 76% of the federal poverty level (FPL). The State has no discretion regarding eligibility for SSI, and therefore can not affect Medicaid eligibility through cuts in the SSI program. Although SSI recipients are a much smaller group than AFDC recipients, their per recipient Medicaid costs ($5,606 for SFY 91) are much higher. This is to be expected, since by definition they are either disabled or older, and are likely to have greater than average medical needs.

AFDC

AFDC has evolved into a highly complex program with countless nuances, but at its core, it is a cash benefit program for low income single parent households with dependent children. While AFDC recipients are the single largest group of Medicaid users, their per recipient Medicaid costs of $996 in SFY 91 are virtually the lowest. (The lowest cost group is Qualified Medicare Beneficiaries, for whom the State pays only Medicare premiums.) In order to make significant Medicaid cuts through AFDC eligibility, then, a large number of recipients would need to be disqualified. This would be likely to result in cost shifts to other parts of the State and municipal budgets.

Federal constraint: May 1, 1988 payment minimum

AFDC is similar to Medicaid in that it is funded largely by the federal government (62.67% in SFY 92) but administered by the State. While the State does have considerable discretion in establishing AFDC policy, it must adhere to minimum standards established in federal legislation and rules. Although Maine may establish its standard of need (the income limit of recipients) and its maximum payment (the maximum amount of assistance that may be paid), it may not set either amount below the maximum payment amount that existed on May 1, 1988. (See Chart IV-1)

Chart IV-1: AFDC Standard of Need and Maximum Payments, Adult Included

Family Size	5/1/88 Maximum Payment	11/1/92 Maximum Payment	11/1/92 Standard of Need
		GAP	
1	197	214	337
3	416	453	628
5	629	685	912

Source: Maine Bureau of Income Maintenance

In order to reduce eligibility for AFDC, the standard of need must be reduced. Doing so would constitute further reduction or elimination of the so-called "gap," the difference between the standard of need and the maximum payment. Effectively, the gap is the amount of outside income that may be earned before a person loses eligibility for AFDC, so eliminating the gap has policy implications for the collection of child support and incentives for recipients to have part-time jobs.

It should be noted that Pine Tree Legal Assistance, representing AFDC recipients, contends that the May 1, 1988 minimum level must include gap payments allowed on that date. The State has prevailed in the first case, Stowell v. Maine Department of Human Services, First Circuit Court of Appeals, No. #92-1342, September 28, 1992; a second case, Stowell v. Sullivan, No. Civ. 92-125-P, is pending before the U.S. District Court for Maine.

State Constraints: §§3760-E and 3760-F

Sections of State law further limit the way in which Medicaid may be cut administratively through AFDC. 22 MRSA §3760-E expressly authorizes the Department of Human Services to cut the standard of need by 3.5% on or after January 1, 1992, an action which the Department took on March 1, 1992. The language could be interpreted to allow further cuts after January 1, 1992, but the intent appears to have been to limit total reductions to 3.5%.

Also in Title 22, §3760-F establishes a fully State-funded Medicaid category to provide Medicaid-like services to people made ineligible for Medicaid through AFDC cuts. On November 1, 1992, 287 people were receiving benefits through this special category. Obviously, if this or similar language were in force, the State would spend more rather than less money on Medicaid if it cut AFDC eligibility.

Sections 3760-E and 3760-F are scheduled to sunset on June 30,

1993, so they are not constraints in planning for the next biennium. If the State wishes to cut Medicaid expenditures by reducing the standard of need prior to June 30, 1993, both sections need to be amended.

AFDC-related categories minimize cuts

Chart IV-2 demonstrates why a cut in AFDC eligibility can not be expected to result in commensurate reductions in State health expenditures, even after §3760-F sunsets. The chart lists health programs that people can qualify for if they are not receiving AFDC.

Chart IV-2: AFDC - Related Medicaid Eligibility and Maine Health Program Eligibility

Category	Income Limit as a % of Federal Poverty Level
AFDC - Related	
Pregnant women and infants	185%
Children age 1 through 5	133%
Children age 6 through 9	100%
Maine Health Program	
Children through age 19	125%
Adults age 20+	100%

Recall that AFDC eligibility is determined by the standard of need. Returning to Chart IV-1, we see that the standard of need for a family of 3 is $628. That amount is 57% of the federal poverty level (FPL). Imagine a cut in the standard of need down to 50% of the FPL. Any children through the age of 19 who lose their AFDC as a result of that cut still qualify easily for AFDC-related Medicaid or for the Maine Health Program. Pregnant women still qualify for Medicaid, and other adults theoretically qualify for the Maine Health Program, although adult enrollment for that program is currently frozen. At most, then, some adults and no children would lose State-subsidized health coverage if the standard of need were reduced.

Likely cost shifts; reduced access

For those adults who do lose Medicaid as a result of an AFDC cut, some costs are likely to be shifted onto General Assistance (GA), particularly if Maine Health Program enrollment remains closed. The GA definition of "basic necessity" includes "nonelective medical services as recommended by a physician," making it a legitimate item for payment. (22 MRSA §4301, sub-§1) The financial drawback to the State of a shift to GA is that the medical costs will be paid with State and local dollars, with no federal match. People are also likely to

receive less care from GA than from Medicaid. In 1982, California eliminated MediCal eligibility for 250,000 adults and transferred responsibility for their health care to counties. A study of that event concluded that those who had been transferred to the counties received less care than those who retained MediCal eligibility. (Brown and Cousineau, 1991, 25)

Many people without health coverage will opt to obtain "free" care from emergency rooms and other providers rather than going to their municipal officials for help. The health costs of those people are likely to be passed on to other payers.

Cut Within the Medicaid Program

Short of cutting categorical programs, Medicaid costs can be reduced (perhaps more effectively) by making cuts within the program itself. Numerous proposals for doing so have been advanced in Maine and across the country. Those proposals are presented in Chart IV-3.

They have been collected from various sources and organized around the scheme offered by Thomas Rice (described in Chapter II), with cuts categorized according to targeted group: users, providers or both. A fourth category, internal administrative strategies, has been added to capture approaches such as electronic claims processing, which do not affect constituent groups directly but can reduce costs. The remainder of this chapter discusses the categories of cuts listed on Chart IV-3.

Strategies directed primarily at users (chart IV-3, lines 1 - 68)

These are approaches that reduce the Medicaid budget by reducing the number of recipients, reducing the benefits they receive, or requiring them to contribute more toward the cost of their care.

Eligibility reductions (lines 1 - 9)

Earlier in this chapter it was noted that most Medicaid recipients qualify through 1 of 2 categorical programs: AFDC or SSI. In SFY 91, more than 2/3 of Maine Medicaid recipients were so-called categorical recipients, and could not be made ineligible for Medicaid unless they became ineligible for categorical assistance.

Categorically-related groups. Most of the remaining 1/3 are AFDC-related, SSI-related, or medically needy. These are Medicaid recipients who do not receive categorical assistance, but who qualify for Medicaid when the eligibility standards for categorical assistance are modified. The most common modification is an increase of the income limit for a particular group. For example, a pregnant woman who does not qualify for AFDC because her income is too high qualifies for Medicaid if her income is no greater than 185% of the Federal Poverty Level (FPL). Chart IV-4 lists the major non-categorical groups and shows Maine's income standard and the minimum federal standard for each one.

Chart IV-3: Medicaid Cost Containment Measures Recently Approved or Proposed

		State	Status in Maine
I. STRATEGIES DIRECTED PRIMARILY AT USERS			
	A. ELIGIBILITY REDUCTIONS		
1	Reduce eligibility for pregnant women and infants from 185% to 133% of poverty	AR	Not possible
2	Eliminate or reduce eligibility for the medically needy option	FL, MA, NJ, OK, ME	Reduced in Commun.
3	Modify the treatment of income and resources of a married couple when one spouse is institutionalized	WI	
4	Limit use of trusts or other asset shelters by individuals seeking Medicaid eligibility for NF's	NY, OH, VA, CT	
5	Limit eligibility to citizens and legal aliens	CA	
6	Postpone schedule eligibility expansion	ID	
7	Reduce eligibility for orthodonture	ME	Authorized
8	Limit eligibility to categorical recipients only	UT	
9	Eliminate other misc. Medicaid eligibility categories	NJ, OK	
	B. BENEFIT REDUCTIONS		
	1. SERVICES ELIMINATED		
10	Audiology for adults	AR, NM	
11	Certain personal care services	NY, NM	
12	Optometrist or optical appliances	NJ, OK, UT	
13	Chiropractic services	WA, ME, AR, CA, NJ	Rejected
14	Dental for adults	AR, CA, OK, UT	
15	Out-of-state rehabilitation and therapies for adults	NM	
16	Podiatry	NY, CA, OK, NJ, WA	
17	Acupuncture	CA	
18	Psychology	AR, CA	
19	Elective inpatient hospital admissions and elective surgical procedures	NM	
20	Durable medical equipment for adults	AR	
21	Physical therapy for adults	NJ	
22	Outpatient prescription drugs for adults	OK, UT	
23	Orthotic shoes/accessories for adults	NJ	
24	Transplants for adults	NM	
25	Kidney dialysis	UT	
26	Lab and radiology	UT	

Chart IV-4: Categorically-Related Medicaid Eligibility and Medically Needy Eligibility

Category	Maine Income Limit	Federal Minimum for Maine
AFDC - Related		
Pregnant women and infants	185%	185%
Children age 1 through 5	133%	133%
Children age 6 through 9	100%	100%
Children age 10 through 20	57%	5/1/88*
SSI - Realted		
Disabled or 65 and Over	100%	76%
Nursing Homes	221%	75%
Medically Needy		
Nursing Homes	222%	Not required
Other		
Qualified Medicare Beneficiary	100%	100%
Low Income Medicare Beneficiary	100 to 110%	100 to 110%
Qualified Working Disabled	200%	200%

* Federal law requires this category be covered at the same level as the state's AFDC program. It could, therefore, be reduced to whatever extent categorical eligibility is reduced.

Source: Maine Bureau of Income Maintenance

A quick glance shows that the State has very few options for cutting the eligibility of these groups. Maine is at its federal minimum for all but one of the AFDC-related categories. Returning to Chart IV-3, line 1, we see that Arkansas has considered reducing eligibility for pregnant women and infants from 185% to 133% of the FPL. Maine does not have that option because it exercised the 185% option when it first became available in 1988. Federal policy locks states in at the level they used in December, 1989.

Medically needy. Line 2 shows that several states have considered eliminating or reducing eligibility for their medically needy programs. "Medically needy" is a state option that allows excess income to be offset by medical expenses. This is one area where Maine could reduce Medicaid eligibility. Because Maine currently covers SSI-related nursing home residents to nearly the same income level as medically-needy residents, it would have to reduce

Chart IV-3: Medicaid Cost Containment Measures Recently Approved or Proposed (continued from p.28)

		State	Status in Maine
	2. SERVICES LIMITED		
27	Limit enhanced prenatal services to women with high-risk pregnancies	IA	
28	Adult outpatient annual hospital visit limit	TN(9), NM(12), AR(12)	
29	Personal care for adults to 50 hours per month	AR	
30	Other limits on home health care, private duty nursing or personal care services	NR, AR, CT, PA	
31	Annual limit on clinic	WY(12), PA(18)	
32	Limit certain medical supplies	NM	
33	Limit lab and x-ray services to $500 per year per client	A	
34	Monthly limit on prescriptions	PA(3), NJ(1), NM(3), AR(4), CA(10)	
35	Outpatient surgery limits	NM	
36	Annual limit on physician visits	PA(18), AR(12), OK(12), WY(12)	
37	Annual limit on inpatient days	AR(20), OK(15), WY(20)	
38	Limit adult dental to emergencies	NM, PA	Current Policy
39	Limit drug and alcohol inpatient to 30 days/year	PA	
40	Reduce coverage for transportation	CT	
41	Limit ER and ambulance coverage to emergency treatment only	PA	
42	Limit incontinence supplies to $165 per month	CA	
43	Tighten NF admissions criteria	MA	
	3. COST SHARING		
44	Allow estate recovery	NJ, ME	Rejected
45	Co-payments for Lab	NJ	
46	Co-payments for prescription drugs	NJ, NY	Current Policy
47	Co-payments for home health services	WI, ME, NY	$2 Authorized
48	Co-payment for optometrist	NJ, ME	$2 Authorized
49	Co-payment for transportation	NJ	
50	Co-payment for prosthetics	NJ	
51	Co-payment for hospital in-patient or out-patient	NY, WY, ME	$3 Auth. Outpatient
52	Co-payment for x-ray	NJ	
53	Co-payment for orthotics	NJ	
54	Co-payment for podiatrist	NJ, ME	$2 Authorized
55	Co-payment for physician visits	WY	
56	Co-payment for optical appliances	NJ	
57	Co-payment for non-emergency ER visits	NY	
58	Co-payment for durable medical equipment	ME	$3 Authorized
59	Co-payment for ambulance	ME	$2 Authorized
60	Co-payment for private duty nursing, personal care	ME	$5 Authorized
61	Co-payment for physical therapy	ME	$2 Authorized
62	Co-payment for occupational therapy	ME	$3 Authorized
63	Co-payment for speech therapy	ME	$2 Authorized

both categories simultaneously to achieve actual savings and avoid a shift of recipients out of one category and into the other. Such a policy could, of course, have grave consequences, since many nursing home residents would lose their placements.

Asset shelters. Another area of considerable interest is asset sheltering. (See line 4) This is the practice whereby individuals shelter their assets in anticipation of future nursing home residency. Assets are generally transferred to family members or placed in "Medicaid proof" trusts, so that when an application is made for Medicaid, the applicant has become impoverished and meets income requirements. Of course, there are legal restrictions on how far a person can engage in sheltering. "How to" legal seminars are offered on the topic, and books are readily available for people who want to do such planning without an attorney. If asset sheltering could be further restricted, it would reduce Medicaid eligibility for short-term nursing home patients. Many longer-term patients would deplete their assets and eventually become eligible for Medicaid.

Benefit reductions (lines 10 - 68)

Services eliminated. States that participate in Medicaid must provide certain services, including hospital, nursing facility and physician services. In Maine, mandatory services comprise more than 60% of the Medicaid budget. The rest is made up of optional services which the State may choose to discontinue. The list of optional services offered in Maine in SFY 91 is included as Appendix B. (page 46) The most expensive option is pharmacy, followed by 3 options that serve people with mental retardation. As discussed earlier, many of the options were adopted as part of Maine's "Medicaid maximization" strategy and, if continued as General Fund services, would cost the State much more than they currently do. Also, care must be taken not to cut an optional service that is likely to be replaced with more expensive mandatory care. For example, discontinuing the option of ambulatory surgical services might be expected to result in Medicaid recipients being admitted to hospitals for surgery at a greater cost to the program. Nonetheless, this is one area where Maine could choose to make cuts, as several states have considered. Lines 10 through 26 describe eliminations ranging from acupuncture to kidney dialysis.

Services limited. Many states have considered limiting the amount of any particular service that is offered. The most popular method is placing caps on the frequency of visits (to doctor's offices or clinics), the number of days in the hospital, the number of hours of home care, or the number of prescriptions per month. The most frequent criticism of this approach is that it is an arbitrary rationing system that does not consider the individual needs of users. It is more arbitrary, for example, than the highly publicized Oregon proposal, which would base access to a service on the expected outcome of the procedure. Not much has been written about caps in Medicaid, but at least one study has found them to be a regressive strategy for reducing expenditures. When a 3-prescription-per-month cap was implemented in the New Hampshire Medicaid program, prescription use dropped suddenly by 46%. The drop was attributed to the poorest recipients, and they generally went without the additional prescriptions for inability to pay. (Soumerai and Ross-Degnan, 1990, 52)

Chart IV-3: Medicaid Cost Containment Measures Recently Approved or Proposed (continued from p. 30)

		State	Status in Maine
64	Co-payment for substance abuse services	ME	$3 Authorized
65	Co-payment for psychologist services	ME	$2 Authorized
66	Co-payment for chiropractic	ME	$2 Authorized
67	Double all existing copayments to a maximum of $180 per 6 months	PA	
68	Unspecified co-payments	CT, NM, UT	

II. STRATEGIES DIRECTED PRIMARILY AT PROVIDERS

A. REDUCTION IN RATES OR DEFERRED INCREASES

69	Reduce ICF/MR reimbursement by decreasing inflation factor	NM	
70	Reduce or freeze hospital payments	WI	
71	Reduce reimbursement rates for specialized medical vehicle transportation services by 10%	WI	
72	Lower case management reimbursement to a maximum of $37 per hour	NM	
73	Reduce disproportionate share payments	TN, PA, WA, CA	
74	Reduce by 48.3% NF reimbursement for Quality Incentive Program	IL	
75	Reduce adult day care rates from 75% to 50% of the NF rate	NY	
76	Cancel scheduled cost-of-living increase for non-hospital providers	WA	
77	Reduce or freeze physician fees	FL, ME, WI	10% Reduction Auth.
78	Reduce chiropractic fees	ME	10% Reduction Auth.
79	Reduce specialty hospital reimbursement by 5%	NM	
80	Eliminate the 2% increase in reimbursement rates for rehabilitation agencies scheduled for FY93	WI	
81	Reduce or eliminate NF reserved bed payments	NY, DC, MA	
82	Reduce or freeze rates for personal care and home health services	WI, NY	
83	Reduce reimbursement for anesthesiology, surgical & radiology by 9.5%	CA	
84	Other miscellaneous cuts in rates	CT	

B. CHANGES IN REIMBURSEMENT RULES OR METHODS

85	Raise outlier threshold for extra reimbursement to hospitals	WI	
86	Limit outpatient hospital reimbursement to Medicare rate less 3%	NM	
87	Modify outpatient hospital payment from cost reimbursement to a fee schedule for selected services	NJ	
88	Decrease by 12% Medicaid inpatient rates relative to BC/BS and Commercial payors.	NY	
89	Reduce reimbursement for hospital stays of less than 24 hours by redefining an admission	NM	
90	Cap hospital operating and capital to the median of peer groups	TN	
91	Base inpatient capital reimbursement on the difference between actual and budgeted	NY	
92	Tie NF reimbursement to the median for peer group	ME, TN	Effective 10/1/92
93	Enact NF case mix adjustment to control for excessive case mix increases	NY	
94	Require NFs participating in the Medicaid program to certify some Medicare beds.	NM, ME	Enacted

Cost sharing. Cost sharing has become a favored strategy for holding down health care costs generally, based on the theory that consumers overuse services because they are too insulated from costs. A key part of the theory, however, does not apply to Medicaid recipients. It assumes that people have disposable income and that they are able to make a choice whether to seek a particular service. By definition, Medicaid recipients have very few resources, and even a nominal copayment may force the choice of not seeking care. This conflicts directly with the overarching goal of Medicaid, which is to provide access to services to people who otherwise can not afford them. Co-payments diminish access more and more as people have fewer and fewer resources. Some copayments, such as those for physician office visits (line 55), may lead recipients to more expensive forms of care, such as emergency room visits.

In its famous Health Insurance Experiment, the RAND Corporation found a significant relationship between use of medical services and the amount paid out-of-pocket. The largest decreases in use were found between "free" plans and plans that required users to pay up to 25% of the cost. (Manning et al., 1988, 18) The authors of the New Hampshire Medicaid prescription drug cap study concluded, though, that "mild copayments are preferable to patient-level caps from the perspectives of cost, equity, and quality of life." (Soumerai and Ross-Degnan, 1990, 43)

When the Legislature enacted authorization for several copayments in the Maine program in 1992, it required the Department of Human Services to provide analysis of the copayments in its annual Medicaid report, due in January, so Maine should soon have better data from which to make further decisions regarding copayment policy.

Pine Tree Legal Assistance has brought two cases representing Medicaid recipients subjected to copayments. In Fulkerson v. Maine Department of Human Services, No. Civ. 92-238-P, the plaintiffs argued that Maine's copayments violate various provisions of federal law and rules. The State has prevailed on all but one issue in that case, which is still pending. In a case before the Maine Law Court, Fulkerson v. Commissioner, No. KEN-92-407, the plaintiffs argue that the copayments violate various provisions of State law. A decision in that case is not expected until spring of 1993.

Strategies directed primarily at providers (chart IV-3, lines 69 - 106)

Lines 69 through 84 describe various ways in which states have proposed cutting provider rates or deferred scheduled increases. Lines 85 through 106 describe proposed changes to reimbursement rules or methods that have the effect of reducing reimbursement.

The Boren Amendment

For either approach, the major legal obstacle is the Boren Amendment to the Social Security Act, passed in 1980. It requires that Medicaid reimbursement be "reasonable and adequate" to meet the costs of "efficiently and economically" operated facilities. Since the 1990 U.S. Supreme Court ruling in Wilder v. Virginia Hospital Association, 110 S. Ct. 2510 (1990), which held that the Boren language created enforceable rights for health care facilities, a spate of law suits has been filed against states. An analysis of those cases suggests that, in order to successfully defend itself against a Boren Amendment suit, a State must articulate findings regarding:

Chart IV-3: Medicaid Cost Containment Measures Recently Approved or Proposed (continued from p. 32)

		State	Status in Maine
95	Other miscellaneous changes in NF reimbursement	IL, NY, CO, PA, ME	Effective 10/1/92
96	Limit home health reimbursement to Medicare rate	WI	
97	RBRVS physician schedule, to strengthen primary care	TX	Current policy
98	Allow no exceptions to the rule that providers must submit claims within 12 months of service	WI	
99	Tie reimbursement of hospitals located out-of-state to reimbursement of in-state	WI, CA	
100	Reimburse for over-the-counter drugs, except insulin, at the generic drug equivalent price	WI	
101	Limit reimbursement of non-emergency transportation provided by taxis and handivans	NM	
102	Change billing practices for methadone furnished to outpatients	WI	
103	Limit administrative component of reimbursement for personal care and home health care providers	NY	
104	Pay the lower of Medicare or Medicaid for Medicare Part B services	CO, CA	
105	Prohibit referrals to laboratories if financial relationship exists between the lab and the physician	CO, FL	
106	Limit retail mark-up on assistance devices to 25% of sales price	CA	

III. STRATEGIES DIRECTED AT BOTH USERS AND PROVIDERS

A. MANAGED CARE

107	Fee-for-service primary care gatekeeping	ME, KY	Authorized
108	Other Primary care gatekeeing	MT, DC	
109	Increase the use of managed care (type unspecified)	NC, CO, NY, CA, NV	
110	Managed care demonstration	TX	
111	Managed care for mental health services	AR, MT, CO, FL, MA, SC, UT	
112	Aggressive case management of elective hospital admissions	CA	
113	Eliminate cap on percentage of Medicaid recipients in any one managed care program	CA	

B. OTHER CONTROLS ON UTILIZATION

1. UTILIZATION REVIEW

114	Automate and expand concurrent hospital review processes	PA	
115	Establish Medicaid Utilization Program	AR	
116	UR with fee reduction if lab and radiology do not conform with guidelines	CO	

2. PRIOR AUTHORIZATION

117	Expand prior authorization program to include selected chiropractic and home health service	PA	
118	Controls on purchases of durable medical equipment	CT	
119	Impose restrictions, including prior authorization, for the drug Persantine	WI	

- Efficiently and economically operated facilities within the State;
- The costs incurred by such facilities; and
- Payment rates that are reasonable and adequate to meet those facilities' reasonable costs. (Barr, 1992, 2)

In Maine, the Department of Human Services recently went through this exercise to revise its method for reimbursing nursing facilities. It engaged Peat Marwick Management Consultants to make the findings and help it devise rules of reimbursement that are defensible. The new rules took effect October 1, 1992. If the State decided to reduce rates paid to hospitals, it would be subject to potential legal problems.

Cost shifting

The question of whether to cut Medicaid rates to providers raises again the strategic question of whether a State should pursue Medicaid cuts without undertaking broader health care reform. While annual Medicaid expenditures of $600 million are certainly significant, they are only 20% of the estimated $3 billion in health care expenditures from all sources. (Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program, 1992) To the extent the market will bear it, Medicaid cuts will be shifted to other payers, and overall health care costs will not decrease. As a policy matter, the question becomes what share Medicaid should contribute to overall health care costs in the State.

Hospital rates

Many of the hospital rate strategies included in lines 69 through 106 are not immediately applicable to Maine because of the hospital payment system that Maine has implemented through the Maine Health Care Finance Commission (MHCFC). With exceptions for particular services, the Maine Medicaid program does not actually set rates for hospital payments. Rather, Medicaid's share of hospital payments is calculated by MHCFC as follows.

- MHCFC establishes the aggregate amount of charges a hospital needs in order to operate.
- Based on historical data, MHCFC estimates the amount of those charges that should be allocated to Medicare, Medicaid, and other payers. The Medicaid amount estimated by MHCFC is paid to the hospital by the State in regular installments.
- At the end of the payment year, MHCFC's Medicaid estimate is reconciled with actual Medicaid utilization for that year and year-end adjustments are made. Medicaid utilization is calculated using actual charges. Unit charges are uniform across payers, except that Medicaid charges may not be higher than allowed under federal law.

Through the MHCFC system, then, Medicaid pays its fair share up to the federal ceiling. In order for Medicaid to actually set rates for the services it uses, the MHCFC statutes would need to be amended to recognize State-established rates in MHCFC's year-end reconciliation. The State could then establish its own rates in order to pay less, but it is not at all clear that it could justify paying less and defend itself against a Boren lawsuit. Such a policy shift would implicitly endorse a cost shift

Chart IV-3: Medicaid Cost Containment Measures Recently Approved or Proposed (continued from p.34)

	C. FRAUD AND ABUSE DETECTION	State	Status in Maine
120	Increase auditing of pharmacists to increase compliance with drug program rules	WI	
121	Hire eight additional reviewers to expand capability to deter fraud, abuse, and poor qualiity	PA	
122	Create offenses regarding:	NY	
123	transfer of Medicaid cards, unauthorized sale or purchase of prescription drugs, referral fees or kickbacks		
124	Increase recoveries through establishment of real-estate data base	NJ	
125	Use computer analysis to identify charges that have been "unbundled" inappropriately	PA	
	IV. INTERNAL ADMINISTRATIVE STRATEGIES		
126	Eliminate $10 payment per applicant made to counties for eligibility determinations	NJ	
127	Competitive bidding for certain services (i.e. oxygen, inpatient)	CO	
128	Contract out for recoveries of potential trauma related recoveries from third party payers	NJ	
129	Volume purchase for durable medical equipment and wheelchairs	MT	
130	Lag 53rd payment cycle	NY	
131	Contract out for preadmission screening reviews for LTC candidates	NJ	
132	$100 fee for NF preadmission screenings for non-Medicaid patients	NJ	
133	Contract for multi-source pharmaceuticals	CA	
134	Pay for insurance coverage for recipients when cost-effective	CA	Being Implemented

Abbreviations:

BC/BS = Blue Cross / Blue Shield
NF = Nursing Facility
ER = Emergency Room
LTC = Long Term Care
ICF/MR = Intermediate Care Facility for Persons with Mental Retardation
UR = Utilization Review
RBRVS = Resource-based relative value scale

Sources:

American Public Welfare Association: Medicaid Cost Containment Survey, February 1992.
State Policy Research, Inc: State Policy Reports, V. 10, n. 14, pp. 6-9
Intergovernmental Health Policy Project: State Strategies for Containing Health Care Costs: A Review of Selected State Programs, December, 1991
Intergovernmental Health Policy Project: State Health Notes V. 13, nos. 122, 129, 139, 140, 141,143
Maine Budget Documents for FY 92 and 93
California State Senate Analysis of FY 93 Medical Budget
American Health Line for week of 6/29/92
Health Policy News, October, 1992

from Medicaid to other payers, since the aggregate amount of charges required by any hospital would not change.

Practitioner reimbursement

The level of physician reimbursement is thought to have an impact on access for Medicaid recipients. In a study of over 2000 recipients in 36 states, higher physician reimbursement was the only state policy variable found to increase significantly the likelihood that recipients would have a regular source of health care. (Barrilleaux and Miller, 1992, 106)

In an effort to improve access to primary care physicians, Maine's Medicaid program has adopted a resource-based relative value scale payment system (RBRVS). This shifted the basis of payment from charges to relative values (rankings) that reflect the resource costs of actually providing the service. This has had the effect of increasing reimbursement to primary care physicians relative to specialists, but the positive effect of the new reimbursement system may have been somewhat offset by the 10% decrease in physician reimbursement that was enacted by the Legislature in December, 1991.

Ashby and Lisk have suggested that effort should go into designing physician reimbursement methods that create incentives for physicians to use hospital resources efficiently, since virtually all patient care in hospitals is provided at the direction of a physician. (Ashby and Lisk, 1992, 145)

State as a provider

A perverse incentive exists to set rates as high as possible when Medicaid services are provided directly by the State. For example, the State appropriates a certain amount of money each biennium to operate Pineland Center. As an Intermediate Care Facility for People with Mental Retardation (ICF/MR), Pineland is eligible for Medicaid reimbursement. The federal match generated by the operation of Pineland is not dedicated, so it goes to the General Fund.

The daily rate the State receives is calculated by dividing allowable costs by the number of certified beds. The lower the denominator (certified beds), the higher the rate, so it is in the State's financial interest to keep the number of certified beds as close as possible to the actual census of Pineland, avoiding the lower rate that comes with excess capacity. This, of course, drives up the Medicaid budget but provides a net advantage to the State.

Strategies directed at both users and providers (chart IV-3, lines 107 - 125)

Managed care (lines 107 - 113)

Defined. Managed care is a broad term that refers to any service delivery arrangement that promotes the coordination of services and a reduction in the delivery of unneeded or unnecessarily expensive services. The following are the major types of managed care that have evolved in Medicaid.

- **Fee-for-service primary care gate-keeping.** This refers to a system in which recipients must choose or be assigned a primary care physician, who then controls access to other services. The primary care physician receives regular fees for services rendered, plus a small

per-recipient fee for case management services. The physician assumes no financial liability. Savings are generated from a decline in the unnecessary use of emergency rooms and specialists, and from an emphasis on prevention.

- **At-risk primary care gate-keeping.** This system is similar to the previous one, with one key difference: the physician assumes some financial risk through incentives that are built into the reimbursement mechanism. The incentives may be triggered by retrospective utilization reviews that determine whether a physician's practice patterns are within the norm.

- **HMO/prepaid health plan.** In this system, the recipient is enrolled in an integrated health care delivery system at a capitated rate. The HMO assumes financial responsibility for costs that surpass the capitated rate, though many Medicaid programs have negotiated capitated rates with stop-loss features to limit the liability of providers.

AFDC recipients targeted. Most Medicaid managed care experience has been with AFDC recipients. Although they make up 75% of Medicaid recipients nationally, they are responsible for only 25% of expenditures. SSI recipients, who are a smaller group but have much higher per recipient costs, are more difficult to enroll in managed care plans because of their chronic conditions.

A win-win option. Managed care has generated much excitement in Medicaid programs because it is considered one of very few options that exist to reduce costs and improve access simultaneously. Medicaid recipients who otherwise are not able to find providers who accept Medicaid are guaranteed access in a managed care program. Critics point out, however, that quality has been inconsistent in managed care programs around the country; therefore, quality must be monitored carefully.

Obstacles. Savings in Medicaid managed care programs have been in the range of 5 to 10% per recipient. (Hurley, 1992) HMO/prepaid health programs offer the best guarantee of savings and predictability, but they have also been the most controversial in terms of inconsistent quality. In their review of the Medicaid competition demonstrations, Freund et al. identified quality issues throughout the demonstration sites, but found no evidence that quality was worse than in services to Medicaid recipients generally. They also found that utilization of emergency rooms and specialists decreased, but that costs were not decreased, suggesting that initial capitation rates had been set too high. (Freund et al., 1989, 89 and 94) Other authors see Medicaid recipient turnover as a significant barrier to HMO enrollment. (Buchanan et al., 1992, 93) Start up costs for HMO enrollment can present a significant obstacle to a state in tight budget times. In addition to the administrative costs involved in starting a program, the prepaid aspect of HMOs means a state has to accelerate payments it otherwise would have made on a reimbursement basis.

In the Maine Medicaid program. Maine began work on a fee-for-service primary care gate-keeping system in 1991, as reflected on line 107. It is expected to be operating in 1993. The Department of Human Services has not indicated that it plans to pursue HMO enrollment. Although some question the viability of HMOs in rural states, Maine does have two well-established HMOs operating statewide that the Department could consider: Healthsource Maine, based in Freeport, and HMO Maine, operated by Blue Cross/Blue Shield.

Managed mental health. Line 111 suggests that managed care of mental health services is of current interest in many states. Most of these programs are in planning or early implementation stages with no results to report. Typically, SSI and AFDC recipients are eligible for enrollment in a prepaid mental health services program, though other arrangements are emerging as well. Generally, HMO enrollees and residents of institutions are not eligible. Establishment of such a program in Maine would require close cooperation between the Department of Human Services and the Department of Mental Health and Mental Retardation.

Other controls on utilization (lines 114 - 119)

Utilization review, the practice of evaluating whether use of services is appropriate, has become somewhat controversial, particularly among practitioners who find the practice intrusive and time consuming. Utilization review appears to be moving away from the haphazard patient-by-patient approach that has been inconsistently applied in the United States, to a system of uniform monitoring of providers through regular practice-based utilization reports.

Maine's Medicaid program does require prior authorization for various services, and has attempted to develop better utilization review capacity. Enhancement of the program's computer system would allow utilization reports to be compiled and submitted to practitioners on a regular basis.

Fraud and abuse detection (lines 120 - 125)

Several states are attempting to reduce fraud and abuse on the part of both recipients and providers through automation, addition of audit staff, and creation of criminal penalties.

Internal Administrative Strategies (Chart IV-3, Lines 126 - 134)

As was mentioned in Chapter III, we do not really know what it costs to administer the Medicaid program in Maine. There are at least two areas, however, in which administrative savings could be realized, though probably not in the short run.

Automation

The Medicaid program's current computer capacity is a significant barrier to moving beyond the present electronic claims rate of 25%. If the program could increase the number of claims it receives electronically, it would reduce the amount of staff needed for claims processing in the future, and would provide the program with an instantaneous data base for the purposes of planning, report generation, and regular utilization review of providers.

Links to other programs

The State as a whole might enjoy savings if the Medicaid program were somehow tied to other State health programs, such as the State employee program, worker's compensation, and health services provided by the Department of Corrections and the Department of Mental Health and Mental Retardation. The State's purchasing power could be consolidated and, in some areas, administrative duplication might be identified and reduced. The Department of Human Services sought funding from the Robert Wood Johnson Foundation earlier this year to study the feasibility of establishing such links, but the proposal was not funded.

Summary: Range of Options

Chapter IV discussed several specific options for reducing expenditures in the Medicaid program. Not all of them are good or even possible choices for Maine, but many of them are feasible, if not palatable. The options selected in any state will depend on how much of a cut must be made and how quickly it must be implemented. The degree to which cost shifting, access and future costs are considered will also depend on the severity of the situation. In short, the State faces the strategic decision outlined in Chapter I: manage direct Medicaid costs, manage total health system costs, or do both simultaneously.

The broad range of options available to policy makers includes the following.

- **Implement drastic stop-gap measures.** All rule-making that results in increased costs could be frozen, stopping any program development in progress. Of course, this would not affect new federal mandates, and consideration should be given to exempting certain areas where the State expects a net gain to the General Fund (through maximization) or where program development meets some mandate (such as the AMHI Consent Decree). This freeze in program development would be combined with a selection of cuts in eligibility, benefits, rates, or all three. In order to limit cost shifts to the General Fund, other programs, such as General Assistance, would need to be restricted.

  Obviously, there are many disadvantages to this approach. If program development is frozen, it may not be possible to anticipate all of the worthy exemptions ahead of time. Also, many cuts would get shifted onto private payers in the form of uncompensated care, and would come back to haunt public programs in the future as medical costs continued to rise. Access would be severely curtailed, particularly if other programs were also restricted.

- **Combine immediate measures with measures that will produce savings beyond this biennium.** This would entail combining some of the immediate cuts described in Chapter IV with development of options that require a longer lead time, such as expansion of managed care, enhancement of automation, and expansion of practice-based utilization review. Maximization proposals that are in development could be prioritized and phased in gradually.

  The greatest disadvantage to this approach is the time required to implement parts of it, and the investment of additional resources needed to develop infrastructure.

- **Implement comprehensive, long-term reform.** This strategy focuses on reducing health costs generally, thereby enjoying a slower rate of growth in the Medicaid program. Broad reform is being studied in Maine by the Joint Select Committee to Study the Feasibility of a Statewide Health Insurance Program, and is expected to be addressed at the national level by the next Congress.

  This strategy obviously does not address deficits in the short-term, but it avoids cost shifting and offers the best hope for long-term gain.

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Appendix A

Raw Data Used to Derive Statistics Presented in Report

State Fiscal Year	Total Expenditures	Blended State Share	State Share	Total Recipients	Expenditures/per recipient (state and federal)	State Census	Total General Fund Revenues
1985	$241,960,185 [1]	30.52% [3]	$71,488,204 [1]	121,907 [2]	$1,985	1,175,869 [4]	$848,218,341 [3]
1988	$323,610,339 [1]	32.48% [3]	$105,108,638 [1]	120,046 [2]	$2,696	1,208,034 [4]	$1,291,702,852 [3]
1991	$495,032,434 [1]	36.08% [3]	$170,400,005 [5]	146,669 [2]	$3,375	1,235,000 [4]	$1,424,084,700 [3]
1992	$564,236,050 [2]	37.33% [2]	$210,629,317 [2]	164,604 [2]	$3,428	1,235,000 (est)	$1,512,438,114 [3]
1993 (projected)	$646,085,292 [2]	38.04% [2]	$245,763,237 [2]				$1,556,343,884 [3]

Sources:

1 Annual Medicaid Reports, Maine Department of Human Services
2 Department of Human Services Staff
3 Legislative Office of Fiscal and Program Review
4 Maine Department of Labor, Census Data Center
5 Estimate provided by the Office of Fiscal and Program Review

-Figures supplied by Department of Human Services staff were supplied in October 1992.
-FY 92 and 93 figures adjusted by Department of Human Services to exclude revenues and expenditures from the Medicaid Health Care Assessment
-All figures are for services only and do not include administrative expenses.

Appendix B

Maine Optional Medicaid Services

Service	FY91 Expenditures
Pharmacy	$37,704,451
ICF/MR Nursing	$35,332,307
BMR Waiver	$14,890,449
ICF/MR Group	$14,141,900
Acute Psychiatric Hospital	$ 6,371,381
Mental Health Clinic	$ 6,097,344
Private Non-Medical	$ 5,820,971
Day Habilatation	$ 5,789,990
Dental	$ 5,636,925
BME Waiver	$ 4,989,519
DME and Supplies	$ 3,886,453
Case Management	$ 3,342,030
Personal Care Services	$ 2,714,089
Psychological Services	$ 2,085,283
Substance Abuse	$ 1,200,990
Physical Disabled Services	$ 1,137,020
Optometric	$ 866,676
Private Duty Nursing	$ 745,045
Prosthetic / Orthotics	$ 543,654
Speech Pathology	$ 453,793
Boarding Home Waiver	$ 301,975
Chiropractor	$ 292,525
Speech and Hearing	$ 291,821
Podiatry	$ 226,391
Physical Therapy	$ 195,919
Rehabilatative Services	$ 168,974
Optical Services	$ 151,504
Hospice	$ 114,583
Home Based Mental Health	$ 99,514
Occupational Therapy	$ 57,504
Hearing Aid Dealers	$ 44,781
Amb. Care Clinic	$ 22,372
Ambul. Surgery Services	$ 15,964
Audiology	$ 14,414
VD Screening	$ 7,571
Total Optional Services	**$155,756,081**
Total Medicaid Expenditures	**$495,032,434**

Source: 1991 Annual Medicaid Report