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MAINECARE COSTS: THE *REAL* STORY BEHIND THE NUMBERS

By Christine Hastedt, Ana Hicks, and Kurt Wise

Currently, large and growing revenue shortfalls are pushing the state budget out of balance. In this tightening fiscal climate, there is even more debate than usual about the cost of Maine's Medicaid program, MaineCare. Very often, this debate has focused on overall cost comparisons among states, typically painting MaineCare in an unflattering — and as it turns out — unjust light. Such comparisons tend to ignore the crucial underlying factors which give rise to variations among states in Medicaid spending. A closer examination of these factors reveals both why MaineCare's costs appear higher than those of many other states, and more importantly, how these higher levels of spending on MaineCare actually save Maine money. Our analysis concludes that the single most important strategy for reducing costs in the MaineCare program will be to address the high *overall* cost of health care in Maine.

In looking at state-to-state Medicaid cost comparisons, beware of comparing apples to oranges

Each state designs and administers its own Medicaid program within a broad federal framework, which is then supported at varying rates by federal dollars. Significant differences in cost exist among these state programs. These differences result from a combination of: 1) a given state's **geographic location** and **population characteristics**, and 2) the particular **program design** a state adopts, which is based on a series of policy choices. Let's look first at the effects of geography and population.

Geography and population determine the "cost context" in which each Medicaid program must function

The cost of a state's overall health care spending is influenced by its geographic location**;** health care costs in any state tend to be driven by regional influences. Maine is situated in a high-cost region. Of eight regions throughout the U.S., total personal health care spending per capita is highest in New England at $6409 annually, or some $1200 above the national average.[1] This is due in part to differences in regional practice norms, rates of utilization, and overall regional economic variations. Low population density (how rural a state is) is also associated with higher per unit costs of operation for facilities and providers, and Maine is among the most rural of all states.[2]

The cost of MaineCare reflects the high cost of health care in Maine generally.

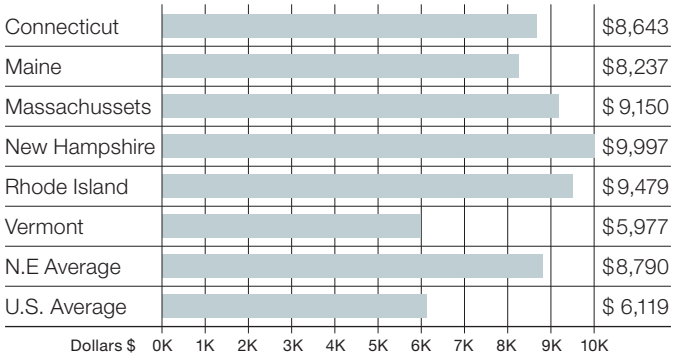
For Maine, this translates into overall per capita health care spending (from all payment sources) that exceeds the national average by 21 percent.[3] It follows that Medicaid spending in Maine will reflect these higher general health care costs.

Figure 1 shows the most recent National Health Expenditure Data from the Center for Medicare and Medicaid Services (CMS is a part of the federal Department of Health and Human Services). It compares costs per enrollee for Medicaid expenditures among states and the nation as a whole. Under this comparison Maine's per enrollee spending was $8,237 — higher than the national average of $6,119, but lower than the New England average of $8,790.[4]

One reason for the difference in cost is the unusual composition of Maine's population. As noted above, Medicaid costs are influenced by the characteristics and health status of a state's general population. Costs naturally will tend to be higher in a state with more seniors or more people with chronic illness and disabilities. Relative to other states, Maine has a disproportionately high percentage of both of these groups. With 14.6 percent of the population above the age of 65, by this measure Maine ranks fourth among all states (the national average is 12.4 percent).[5] In terms of residents with disabilities, Maine ranks anywhere from first to seventh among all states (depending on the specific age group considered), with rates of disability ranging from 25-50 percent higher among those under the age of 65.[6]

The fact that Maine's Medicaid costs per enrollee and per capita are higher than many other states is directly related to this more costly population composition; fully 5.4 percent of MaineCare enrollees are considered "high-cost". This figure is nearly 50 percent higher than the national average of 3.7 percent.[7] However, the state's population composition alone does not determine the make-up of MaineCare's beneficiary population. Policy choices leading to program design are equally important.

FIGURE 1
CMS 2004 STATE ESTIMATES BY STATE OF RESIDENCE: MEDICAID PER ENROLLEE PERSONAL HEALTH CARE EXPENDITURES



Source: Center for Medicare and Medicaid Services, http//www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccounts.asp#TopOfPage

Policy choices and program design play a major role in the cost of MaineCare

Beyond the inherent cost differentials imposed by geography and population, it is the specific design of each state's program that determines its final cost. The two key design elements to consider are 1) the breadth of services that will be provided within the Medicaid program, and 2) eligibility. Not surprisingly, the more kinds of services covered and the greater the numbers of eligible beneficiaries, the more expensive a state's Medicaid program will be. As we shall see, however, depending on how the program is designed, increased spending on a state's Medicaid program actually can lead to still greater savings in other areas, both for the state and for consumers.

States vary considerably in the range of services they provide through their Medicaid programs. By design, MaineCare covers a relatively wide range of services. For more than two decades, Maine deliberately and systematically has brought state-funded health care services that meet federal Medicaid criteria into the MaineCare program. This has proven to be an effective cost-saving approach, allowing Maine to replace state spending with federal matching funds.

Maine has a high federal matching rate; at almost 65 percent, the federal government contributes two out of every three dollars invested in the MaineCare program. In comparison, Massachusetts, Connecticut, New Hampshire and New York have matching rates of 50 percent, receiving just one dollar of federal support for each state dollar invested.[8] For Maine, providing services to its people as part of the MaineCare program is a particularly cost-effective strategy.

An excellent example of this cost-saving approach is Maine's systematic effort to move people with mental retardation out of large, state-funded institutions into much smaller, community-based settings, while shifting funding for these services into the MaineCare program. This approach has improved the overall standard of care while allowing federal dollars to help support these improvements. Many other states continue to provide mental retardation services in institutional settings, foregoing federal support. As a result, their Medicaid programs may look smaller, but their general fund budgets assume a greater burden.

Similarly, Maine has worked to shift medical costs for children from other areas of the state budget into the MaineCare program. This has helped to reform a fragmented, uncoordinated, and inefficient system of care in which Maine children with special needs were often treated in out-of-home placements. Now, more children receive coordinated health services in their homes. Although this approach has increased overall per-enrollee expenditures in the MaineCare program (and particularly expenditures for children), it has reduced the *state's* overall cost for these services once federal matching funds are taken into account. This strategy also has allowed school districts to reduce costs by billing the Medicaid program for qualifying school-based health services, again, thereby allowing federal dollars to cover two-thirds of the bill.

Transferring costs to the MaineCare program indeed has the effect of making MaineCare appear larger and more costly, both as a percentage of Maine's

budget and in comparison to Medicaid programs in other states. Despite initial appearances, however, this strategy saves Maine millions of general fund dollars, replacing these state dollars with generous amounts of federal funding. Equally important, MaineCare administrators have done a very good job of controlling the *growth* in costs. Per enrollee average spending from 1998-2004 grew at 3.0 percent annually within the MaineCare program compared to a national Medicaid program average of 3.4 percent and a New England average of 4.3 percent.[9] The MaineCare program is maximizing federal contributions while effectively controlling cost growth, a winning strategy for Maine.

In terms of the second major cost-defining factor, eligibility, Maine likewise has cast a relatively wide net, bringing more people under the MaineCare umbrella. Addressing the widespread decline in employer-based health coverage and the rising rate of uninsurance that plague most states, Maine has been particularly successful in using its Medicaid program as a tool to reduce uninsurance.

As an example, while some states have lowered their overall program costs by focusing coverage on children (who tend to be healthier) and excluding many high-cost adults, MaineCare is designed to cover significant numbers of Maine's low-income adults, including many elderly and chronically-ill adults. The result is that Maine, of all 50 states in the nation, has the lowest rate of uninsured, low-income people. But how did Maine achieve this and what impact has it had on costs?

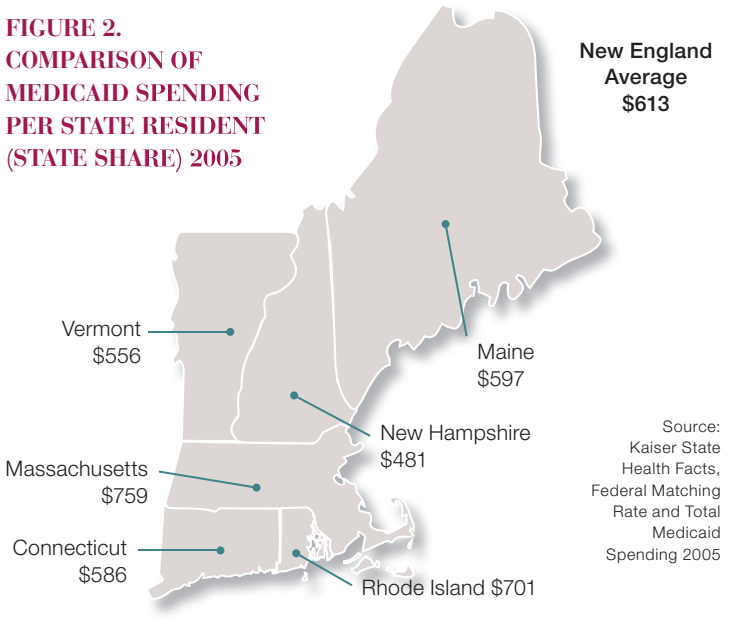
In 2001, Maine applied for and received a federal waiver allowing "childless adults" with very low incomes to be covered under the MaineCare program (a majority of other states only cover adults if they are the parents of minor children). The per capita cost for these childless adults is generally higher than that of low-income parents. Many of these childless adults previously went without health insurance — some for many years. Many of the individuals who qualify for this coverage also have chronic health conditions.

Bringing these adults under the MaineCare umbrella has increased program costs, but it also has generated savings within Maine's overall health care system. More than 90% of those enrolled now have a "medical home"— that is, a primary care manager. Current research and the experience of other states indicate that the case management model can significantly reduce costs through coordinating care, avoiding duplication of effort, and improving outcomes.[10]

These adults are now less likely to go without preventive care and less likely to be cared for in expensive emergency room visits. When people served by this program do need to go to the hospital, there is now a payment source for their care. In fiscal year 2007, hospitals provided $55 million of care to waiver enrollees. As is true with Maine's Medicaid costs overall, two-thirds of that amount is paid for by the federal government - a cost that otherwise would be passed on to all of Maine's health insurance purchasers through higher premiums. Thus, bringing these adults into the MaineCare program has improved their health, reduced their dependence on high-cost emergency room care, and created a funding source that moves two-thirds of the cost burden off the shoulders of Maine's other health care consumers. By including these adults, MaineCare becomes more costly, but other costs to Mainers are reduced.

On a per capita basis, MaineCare costs less and gets more for its money than other Medicaid programs

FIGURE 2. COMPARISON OF MEDICAID SPENDING PER STATE RESIDENT (STATE SHARE) 2005



Source: Kaiser State Health Facts, Federal Matching Rate and Total Medicaid Spending 2005

Another way to compare Medicaid spending among the states is to calculate each state's share of Medicaid program spending per state resident. This method provides for a more direct comparison of a state's true financial contribution to its Medicaid program. This calculation is performed by dividing the state-only portion of Medicaid spending by a state's total population. As described above, Medicaid is funded by both federal and state dollars, and the ratio between these amounts varies among states; therefore, comparing state-only expenditures gives the most accurate picture of what a state actually contributes from its own funds to cover Medicaid beneficiaries.

Figure 2 shows that in 2005 Maine spent $597 annually of its own dollars on MaineCare per state resident, compared to the New England average of $613.

Given that Maine has a high-cost population and has created the lowest levels of uninsurance in the country among low income adults, what these figures tell us is that Maine gets significantly greater value for its investment than its New England neighbors. Through creative and resourceful design of the MaineCare program, Maine provides quality health care to greater numbers of its citizens at a cost that is lower than the New England average.

Summary

Snapshots comparing state-to-state spending on Medicaid programs are interesting, but they must be viewed in context and with careful attention to the factors and policy decisions behind the numbers. MaineCare indeed costs more, but these costs are driven by geographic

Through creative and resourceful design of the MaineCare program, Maine provides quality health care to greater numbers of its citizens at a cost that is lower than the New England average.

and population variables, as well as by deliberate efforts to bring qualifying state services into the Medicaid system. The result is that Maine provides quality coverage to more people, and does so while spending fewer state dollars per resident than its neighbors. Moreover, MaineCare has held per-enrollee expenditure growth essentially to the rate of inflation, and well below the national average.[11] The design and implementation of the MaineCare program is decidedly a story of success.

Before introducing cuts to the MaineCare program, policy makers must consider the important contribution that MaineCare makes to the health care system as a whole, including its success in decreasing the numbers of uninsured, and the resulting savings in health insurance costs for other consumers. The reality is that health care spending — whether by private consumers or through the MaineCare program — reflects the high cost of health care in Maine generally. Controlling these overall costs must be the principle strategy in responding to concerns about growth in MaineCare expenditures.

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1 Anne B. Martin, et al (researchers with the Center for Medicare and Medicaid Services), Health Affairs, 26, no. 6 (2007): w651-w663 , doi: 10.1377/hlthaff.26.6.w651

2 Wolf, Wendy, *An Overview of Maine's Health System,* 2007

3 U.S. Department of Health and Human Services; CMS National Health Expenditures and U.S. Census Bureau.

4 Several other highly reputable organizations track Medicaid spending. Each produces slightly different estimates of spending. As the designs of state programs vary widely, and as the complexity of these programs is well known, it is not surprising that discrepancies in cost estimates exist. These variations reflect differences among researchers over which state health care services are best included in order to properly smooth the data. For the unique structure of MaineCare, the CMS model provides the most accurate total spending estimates for use in making meaningful cross-state comparisons. The general conclusion – that spending in New England significantly exceeds the US average and that Maine's spending approximates that of its neighbors – remains constant across data sets produced by different organizations.

Anne B. Martin, et al (researchers with the Center for Medicare and Medicaid Services), Health Affairs, 26, no. 6 (2007): w651-w663 , doi: 10.1377/hlthaff.26.6.w651

5 US Census Bureau, 2006 population estimates: http://factfinder.census.gov/

6 Ibid

7 Anna S. Sommers and Mindy Cohen, "Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?" The Henry J. Kaiser Family Foundation, March 2006

8 Rhode Island and Vermont also have matching rates that exceed 50 percent but are still well short of Maine's level. They match at 52 percent and 59 percent respectively.

Kaiser Family Foundation, State Health Facts: http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4

9 Ibid

10 University of California, Los Angeles, California Center for Long-term Care Integration: http://www.ltci.ucla.edu/ccltciproducts/cost_savings_research_abstracts/_Cost%20savings%20grid-web.pdf

11 http://www.cms.hhs.gov/NationalHealthExpendData/downloads/res-mcaid.pdf

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