

# Blue Ribbon Commission on the Future of MaineCare

## November 1, 2005 Meeting

### MEETING NOTES

**Members in attendance:** Senator Michael Brennan (co-chair), Senator Richard Nass, Representative Darlene Curley, Nancy Kelleher, Christine Hastedt, Paul Saucier, Jean Cotner

#### 1. Welcome and Introductions

- Commission members introduced themselves and welcomed member Jean Cotner.

#### 2. Review of meeting agenda and information requested at October 11 meeting

- Staff reviewed the meeting agenda.
- Medicaid Managed Care
  - Lucia Nixon, OPLA, presented handouts and a brief overview of Medicaid managed care.
  - Two key managed care models were described: (1) risk-based model or managed care organization (MCO) model and (2) primary care case management (PCCM) model in which the primary care provider coordinates care and acts as a gatekeeper. Maine utilizes the PCCM model, with over 150,000 or 61% of all MaineCare members enrolled in PCCM.
  - *Information requests:*
    - *Is there evidence regarding the impact of Medicaid managed care on patient outcomes and quality of care?*
    - *What are the reasons for the differences in Medicaid enrollment between Maine and New Hampshire?*
- Match Rate – Federal Medical Assistance Percentage (FMAP)
  - Christopher Nolan, OFPR, presented handouts and discussed the Medicaid federal match rate (FMAP).
  - Several issues with the formula were discussed: (1) match rate is based on a 3-year average of relative per capita personal income; (2) state fiscal capacity is measured based on per capita personal income; and (3) the demographics of the Medicaid population.
  - Preliminary estimate of 2007 FMAP for Maine was 61.64%; more recently revised estimate is 63.27%.
  - It was noted that Senator Snowe has introduced a bill regarding the FMAP formula. There was some discussion of the possibility reform on the federal level and consensus that reform debate in Congress would pit states against each other, unless additional money is added to the system so that all states gain.

#### 3. MaineCare Responsibilities and Policy Goals

- Jane Orbeton, OPLA, presented handouts and information on the responsibilities of Medicaid. See 10/31/05 memo to Commission re: MaineCare Responsibilities and Policy Goals, Populations and Services.
- Key sections of Federal and State law were reviewed.
  - Federal law: “Medicaid is charged with providing medical assistance for families with dependent children and aged, blind and disabled persons, whose income and resources are insufficient to meet the costs of necessary medical services. Medicaid also provides assistance in the form of rehabilitation and other services to families and individuals to assist them in attaining or retaining capability for independence or self-care.”
  - Maine law: “The Department is authorized to administer programs of aid, medical or remedial care and services to medically indigent persons.” And “The mission of the department is to provide health and human services to the people of Maine so that all persons may achieve and maintain their optimal level of health and their full potential for economic independence and personal development. Within available funds, the department shall provide supportive, preventive, protective, public health and intervention services to children, families and adults, including the elderly and adults with disabilities. The department shall endeavor to assist individuals in meeting their needs and families in providing for the developmental, health and safety needs of their children, while respecting the rights and preferences of the individual or family.”
- Commission members discussed the responsibilities and policy roles of MaineCare. Ideas included the following:
  - Provide more policy guidance for MaineCare in statute; current language is sufficiently broad that it does not provide clear guidance for policy decisions
  - Return Medicaid eligibility to a focus on income and asset tests
  - Simplify Medicaid eligibility rules.
  - Connect eligibility to the cost of health care and the concept of medical indigency.
  - Establish clear goals for the program as a basis for developing benchmarks and outcome measures.
  - Recognize connections between the MaineCare, individual health (and who gets served and who does not) and the greater community, including providers of care.
  - Consider implications if you start peeling back eligibility for MaineCare.
  - Concern about program sustainability and affordability.
  - Concern about the ease of explanation of MaineCare/Medicaid to the public.
  - Concern about the connections between the cost of health insurance and people’s ability to afford care, the need for state and federal leadership, and the need to set state spending priorities.
  - Consider how changes in the economy may change the role of MaineCare.
  - Concern that the Federal match for Medicaid spending is addictive, encourages growth; concern that “Medicaid maximization” efforts haven’t had desired effects
  - Is MaineCare the medical safety net, for people who are at poverty level? Or does it have a broader mission and purpose today? Should it serve the employed?
  - Is MaineCare spending its resources most effectively?
  - How can Maine better manage its program, restrain growth and use innovation to secure sustainability?
- *Information requests:*
  - *Further discussion of “sustainability.” What does the Legislature want to sustain or not sustain with respect to MaineCare?*
  - *Further discussion of current cost drivers in MaineCare.*

#### 4. Policy Innovations and Alternatives in State Medicaid Programs

##### **Neva Kaye, National Academy for State Health Policy**

- Neva Kaye presented information and discussed state innovations in Medicaid
- 7 types of innovations were reviewed:
  - “Traditional” Managed Care
  - Disease Management
  - Selective Contracting
  - Pay for Performance
  - Managing Mental Health Services
  - Leveraging Employer Health Insurance
  - Consumer Empowerment
- Managed Care and Disease Management: Discussion of the potential benefits in health outcomes and spending from managed care and disease management, the need for infrastructure, the possibility of management in-house or by contract, and long-term benefits.
- Selective Contracting: It was noted that under a Section 1915(b) waiver can waive “statewide” requirement; noted that this type of approach limits choice and brings forth the importance of quality of care issues
- Pay for Performance: Discussion of the California approach; noted that Maine Health Access Foundation is analogous to CA Healthcare Foundation.
- Managing Mental Health Services: Importance of managing the behavioral health organization when that is used; members noted that aside from pharmaceuticals there are few medical treatments/services with proven scientific evidence.
- Leveraging Employer Health Insurance: Discussion of models for leveraging employer insurance including premium assistance programs; commission members were directed to the “premium assistance toolbox” on the NASHP website for additional information; commission members asked how applicable employer-sponsored insurance is to the MaineCare population.
- Discussion of policy innovations to apply to Maine; Kaye suggested that the commission consider:
  - Expanding PCCM beyond the current populations (families)
  - Combining behavioral health management with pay for performance
  - Selective contracting
- *Information requests:*
  - *Information on Maine’s previous experience with MCOs*
  - *Research on the impact of Medicaid managed care on outcomes (Neva Kaye)*
  - *Information regarding California’s experience with “pay for performance” (see: [www.chcf.org](http://www.chcf.org))*
  - *Information regarding Maine’s behavioral health managed care initiative and educational initiatives for prescribers of psychotropic drugs (DHHS)*
  - *Information on New Mexico program to leverage employer insurance*

#### 5. Estimating Future MaineCare Costs

##### **John Nicholas, Commissioner, DHHS**

##### **Bill Gardner, Medicaid Forecasting Manager.**

- Gardner described the microsimulation model which is under current development for MaineCare forecasting. Noted that the model will provide for transparency, consistency and flexibility.
- Gardner indicated that the microsimulation model will not be completed and available for use within the Commission's time frame.
- *Information requests:*
  - *Any information DHHS can provide related to MaineCare trends and forecasting by the next meeting on 11/15/05. Is the Medicaid trend information contained in NCSL State Health Notes of 10/31/05 true for Maine? Commission Chairman Brennan asked Christopher Nolan to work with DHHS on these requests.*

## **6. MaineCare Issues and Policy Options**

### **A. Trish Riley, GOHPF and Mike Hall, DHHS**

- Trish Riley and Mike Hall provided handouts in response to questions from the 10/11/05 meeting.
- Discussed mandatory vs. optional populations and mandatory vs. optional services under Medicaid.
- Discussed the federal match rate. Cited two key issues: (1) counter cyclical nature, (2) Maine's relatively high proportion of disabled and elderly population. Trish noted that she does not expect any changes in the formula to get through Congress this year.

### **B. Maura Howard and Brenda McCormick, DHHS**

- Maura Howard and Brenda McCormick provided information regarding the current use of managed care approaches in MaineCare.
- McCormick noted that PCCM has connected MaineCare members to primary care physicians; also mentioned the High Cost Member Pilot Project which will involve 300 members and include a pilot within the pilot for members with severe and persistent mental illness; DHHS is currently bidding out this pilot project in response to RFP
- *Information requests:*
  - *DHHS feedback and reactions to the presentation by Neva Kaye. Request that the department consider each of the 7 policy innovations in her presentation and provide information on feasibility/applicability in Maine. Hall indicated that DHHS could do a side-by-side with Kaye's presentation. Members specifically expressed interested in feedback from DHHS re: (1) disease management; (2) PCCM - opportunities for expansion, (3) evidence-based medicine, (4) premium assistance / primary health insurance purchase option, (5) selective contracting*
  - *Brenda Harvey was asked to speak about behavioral health managed care initiatives at the November 15 meeting of the commission*

## **7. Planning for Future Meetings**

- The next meeting is November 15
- Agenda will include:
  - Former Governor Angus King discussing the federal Medicaid Commission
  - DHHS presentation/discussion of MaineCare initiatives and policy options
  - Public comment on the future of Medicaid, and MaineCare initiatives and options.