Eliminating the Maintenance of Effort Requirement: The Wrong Solution to a Real Problem

States are facing significant budget stress. In response, Republican governors recently asked the White House and Congressional leadership to eliminate the Maintenance of Effort (MOE) requirement in the Affordable Care Act (ACA).

Eliminating the MOE requirement would set us backward in our attempt to secure health care coverage for more Americans. It would:

- **Hamper long-term care options for seniors and Americans living with disabilities.** States must cover nursing home care in their Medicaid programs. However, most seniors and people living with disabilities would prefer to stay in their own homes, and states have the option of providing personal care and other home- and community-based long-term care services to enable them do so. Many of these home- and community-based services are provided through waivers, and eligibility for these programs is at risk of being cut if the MOE is eliminated. This would reduce long-term care options for seniors and people with disabilities, forcing many into nursing homes against their will.

- **Increase the ranks of the uninsured.** Without the MOE requirement, states will cut eligibility in their Medicaid and Children's Health Insurance Programs, not only for seniors and those with disabilities but also for low-income children and parents. This would increase the number of uninsured, moving us backward in our efforts to expand coverage.

- **Create new barriers to implementing the ACA.** The ACA expands Medicaid significantly beginning in 2014, and it commits the federal government to paying the full cost of those made newly eligible for the first few years. But this 100 percent federal funding applies only to those beneficiaries who would not have qualified for their states' Medicaid program as of March 2010. If states lower their eligibility criteria in the next few years, they will have to reinstate eligibility at their regular matching rate in 2014. This will add to the perceived burden of complying with the Medicaid expansion, and may lead to a stronger voice for dismantling this critical component of the ACA.

  Similarly, the elimination of the MOE would open the door for governors to erect new barriers to Medicaid enrollment, such as face-to-face interviews and asset tests. Imposing new administrative hurdles to enrollment moves state programs in the wrong direction since the ACA requires that they be removed by 2014.

There are other budget-balancing alternatives. States should not consider eligibility cuts until they have exhausted the alternatives. To date, no state has used every option for improving the cost-effectiveness of its Medicaid program.

States have numerous policy options for cutting Medicaid costs quickly, including:

- **Reduce or altogether eliminate payments for preventable complications and preventable readmissions**. The Centers for Disease Control estimates that hospital-acquired infections alone add as much as $45 billion to hospital costs paid each year by taxpayers, insurers, and patients. A

2007 study by the Association of Professionals in Infection Control and Epidemiology found that Medicaid was the payer for 11.4 percent of hospital-acquired infection cases nationwide. Similarly, preventable hospital readmissions exact a high price: a 2009 study in the New England Journal of Medicine found that the estimated cost of preventable re-hospitalizations nationwide is $17 billion a year.

- **Obtain enhanced federal dollars for creating health homes for the most vulnerable enrollees.** Through a new option created by the ACA, states can apply for a two-year 90 percent matching rate to create health homes for Medicaid beneficiaries with chronic physical or mental illnesses. This program would bring new federal money into states in the short term, and potentially reduce state Medicaid expenditures. For example, Illinois saved $220 million in the first two years that its Medicaid medical home program was fully implemented.

- **Bring new federal funding into the state to shift long-term care to more cost-effective settings.** Through another new ACA initiative, most states can receive either a 2- or a 5-percentage point increase in federal matching funds for their expenditures on Medicaid home and community-based services. This brings new federal funds into the state in the short run, and over time may reduce state expenditures because to qualify, states must adopt program changes designed to increase the proportion of long-term care spending that goes to home- and community-based services.

Beyond short-term savings options, the ACA sets us on a path to a better and more sustainable Medicaid program by:

- **Investing in primary care.** The ACA invests $11 billion dollars – a 40 percent increase over current allotments – in Community Health Centers to provide primary care to vulnerable Americans including Medicaid beneficiaries. It also increases Medicaid primary care reimbursement rates to Medicare rates for 2013 and 2014.

- **Improving care coordination for the chronically ill**. The ACA creates new payment reform demonstration projects – like bundled payments, global payments, and accountable care organizations – to better align incentives for coordinated care. It also creates the Center for Medicare and Medicaid Innovation to design and evaluate other payment and delivery system models, and to expand those that successfully reduce costs and improve quality.

- **Improving care delivery for people eligible for both Medicaid and Medicare.** The ACA creates a new Federal Coordinated Health Care Office with funding to assist states in better integrating the especially costly care for this vulnerable population. For instance, a new demonstration program offers 15 states up to $1 million each to design a program to better integrate their care.

- **Improving public health.** Seventy-five percent of our health care dollars are spent on chronic illnesses, many of which are preventable. The ACA makes a $15 billion dollar investment in prevention in public health programs, like community-based initiatives to reduce the incidence of chronic illness. It also includes $100 million targeted specifically at reducing the burden of chronic illness among Medicaid beneficiaries.

Key Takeaway: The Centers for Medicare and Medicaid Services should work with governors to improve the cost-effectiveness of their Medicaid programs, but Congress should not repeal the MOE requirement.