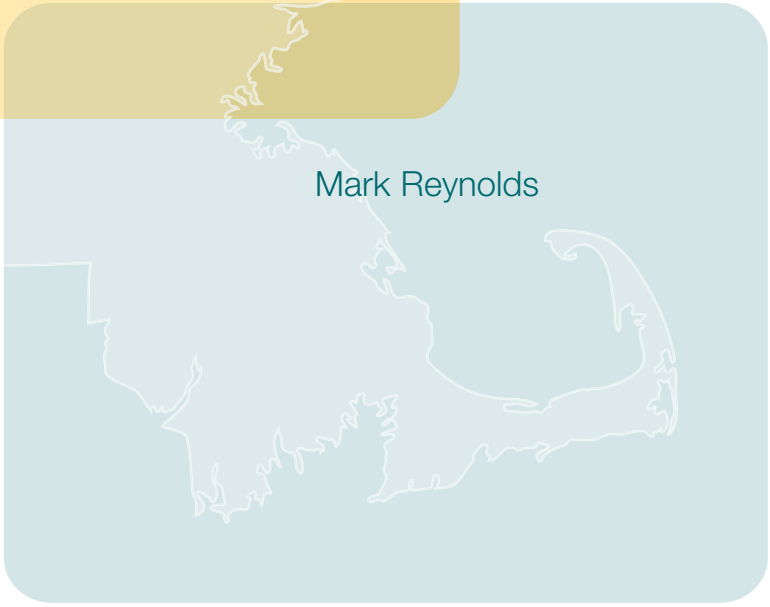
Maximizing the Use of Federal Matching Funds to Help Finance Universal Coverage

Mark Reynolds



roadmap
TO COVERAGE

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Funding for this report was provided by the Blue Cross Blue Shield of Massachusetts Foundation. The views presented here are those of the author and should not be attributed to the Foundation or its directors, officers, or staff.

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Introduction

Virtually any state level discussion about expanding health coverage must include a conversation about how federal support can be used to assist the effort. For Massachusetts, the federal government shares 65% of the cost of the State Children's Health Insurance Program (SCHIP) and 50% of the cost of Medicaid. It makes clear financial sense for SCHIP and Medicaid expansions to be part of any universal coverage plan.

The *Roadmap* to Coverage outlines a set of four building blocks for universal coverage:

- A MassHealth expansion
- Tax credits for working and middle class residents
- A voluntary purchasing pool to increase access to insurance for small firms and individuals
- Reinsurance to reduce prices in the non-group market.

It goes on to propose either an individual mandate alone or combinations of an individual mandate with either of two employer mandate alternatives.

Providing such coverage would require additional revenues. To the extent that federal revenues can be used to support these expansion efforts, less state revenue would be necessary. This paper clarifies the options the state has in pursuing federal revenue to achieve expanded coverage. It summarizes how the Commonwealth has used Medicaid and SCHIP money in the past to provide health coverage and support the safety net. It then outlines the forthcoming changes in patterns of federal reimbursement that are a product of recent negotiations over the state's Medicaid waiver program, followed by a discussion of possible impacts of current federal budgetary discussions. The most important section, which comes directly before the conclusion, reviews the options the state might exercise to expand coverage with federal financial support.

Past Use of Federal Medicaid Revenues

Massachusetts, for many years, has used Medicaid to cover many people who would otherwise be uninsured. Although Medicaid is an optional program for states, all offer the program. Once states opt to participate, they must cover certain groups but are given significant leeway in expanding coverage beyond this small required population. Massachusetts has used eligibility rules that permit more than the minimal required group to qualify for Medicaid for many years.

In 1997, the Commonwealth took a big step by expanding Medicaid coverage even further using a federally approved waiver of standard Medicaid rules. The waiver allowed for a number of changes in these rules. In addition to allowing the state to simplify eligibility rules and procedures, the waiver expanded coverage to traditional coverage groups at higher incomes, and offered coverage to long-term unemployed adults (originally through MassHealth Basic and now through MassHealth Essential). It also permitted Massachusetts to help certain low-wage workers buy into employer-based insurance.

In practice, the waiver granted Massachusetts more federal money than it had received before the waiver, because some spending that had previously been at full state cost was reimbursed as Medicaid spending under the waiver. Care for adults served by Institutions of Mental Disease (a category of care normally not reimbursed under Medicaid) was reimbursed, for example, in addition to costs associated with the Medical Security Program and CommonHealth, a program for the working disabled. This new revenue made it easier for the state to expand coverage.

The waiver also provided the means for new payments to be made to the newly formed Boston and Cambridge Medicaid health plans (the BMC HealthNet Plan and Network Health Plan). Since the waiver was structured to use managed care as the means to provide health care, these plans were formed by two of the state's key safety net hospitals in order to enroll members and prevent the loss of patient volume to other hospitals. The waiver encouraged development of these managed care plans by permitting supplemental payments to them. These payments were allowed to be more than the amounts permitted under federal upper payment limit rules that existed at that time (these rules have since been superseded by a requirement that managed care organization rates be actuarially sound). Because these payments were based on the number of people enrolled in each health plan, total supplemental payments grew with enrollment to be worth an expected $770 million for the two health plans for state fiscal year 2005 (representing $385 million in federal revenue).[1]

[1] The figures are an estimate provided by staff at the Massachusetts Executive Office of Health and Human Services. Although the fiscal year has ended, the state is still awaiting federal approval for certain supplemental payments related to Primary Care Clinician Plan (PCCP) enrollment, so the final value of supplemental payments is not finalized. It will, in any case, be no more than $770 million.

The impact of the waiver (along with the SCHIP expansion that was integrated into the waiver roll-out) was significant: Medicaid coverage expanded by over a third, growing from 672,400 to 901,600 in just three years.[2] This expansion of coverage had an immediate affect on the number of uninsured. An analysis by Nancy Turnbull of the Massachusetts Medicaid Policy Institute, relying on data from the Division of Health Care Finance and Policy and a study by Robert Blendon, suggests that the number of uninsured dropped by 315,000 (46%) over the five-year period following the expansion,[3] A decline to which Medicaid enrollment contributed significantly.

Medicaid has also served as a primary support for the state's health care safety net. Federal rules allow for Disproportionate Share Hospital (DSH) payments to be made to hospitals that provide a disproportionate amount of publicly reimbursed or uncompensated care. These payments have been capped by federal law since the early 1990s, but remain very important in providing support for safety net hospitals. For federal fiscal year 2005, the federal cap is $574.5 million in total payments ($287.25 in federal revenue). Of this, $118.1 million is planned to support state mental health and public health hospitals, $10.0 million will go to children's hospitals, $11.9 million will support what the state has classified as Basic DSH, $32 million will go to safety net hospitals, and $360.4 million will support the Uncompensated Care Pool (UCP). The funds supporting the UCP (not all of which are reimbursable under federal rules) are payments to hospitals with substantial free care burdens. Another $30 million will be spent on various Medicaid revenue activities. The remaining $12.1 million has yet to be allocated.[4]

When the UCP started it was supported without federal reimbursement. Hospitals, and later the state, contributed to the fund in order to reduce the cost burden for hospitals that had significant levels of uncompensated care. During the fiscal crisis of 1989 to 1992, major efforts were made to find ways of increasing federal reimbursement for state health activities as a means to resolving the state budget crisis. In 1991, the state categorized UCP spending (which was supported primarily by hospital assessments) as DSH spending in order to gain federal reimbursement. The new federal resources were used to resolve the general budget deficit (including the expanding need for Medicaid funds), but not for greatly expanding UCP payments. The legacy of this action remained until 2003, with the state receiving over $100 million a year as a support for the general fund. UCP reforms in 2003 changed this. This revenue now supports uncompensated care or coverage for people served by MassHealth Essential.[5]

In recent years, the state has sought additional federal revenue to support the UCP. It has turned to using Medicaid hospital rate payments in order to support uncompen-

[2]Data from state-reported enrollment as reported in E.R. Ellis, V.K. Smith, and D.M. Rousseau, "Medicaid Enrollment in 50 States June2003 Data Update," The Kaiser Commission on Medicaid and the Uninsured, 2004, p.8.

[3]Nancy Turnbull, Massachusetts Medicaid Policy Institute, unpublished presentation, 2004.

[4] Data provided by staff at the Massachusetts Executive Office of Health and Human Services.

[5]FY2005 total UCP revenues and expenditures are expected to be roughly $839 million, with $372 million coming from the General Fund and $467 million from other sources; Federal Financial Participation (FFP) will be roughly $329 million. The difference between the General Fund. Contribution and the FFP will be roughly $43 million, which is essentially the net General Fund contribution (although this funding actually stems from enhanced FMAP provided by the federal government).

sated care costs. In 2003, the state shifted some UCP payments to be paid as increases to Medicaid hospital rates, making these payments eligible for federal reimbursement. The state is able to do this because it does not pay hospitals the maximum amount that it could under federal law. Aggregate Medicaid hospital rates are constrained to a maximum upper payment limit which, roughly speaking, represents the amount Medicare would pay for the same services.[6] The gap between regular Medicaid payments and this upper limit gives the state room to make additional payments to hospitals that do substantial Medicaid business and receive federal reimbursement for those payments.

State Share of Medicaid Revenues

Most Massachusetts Medicaid revenues come from the state's general revenue sources, which include personal and business income taxes, capital gains taxes, sales taxes, and other fees. To support the Medicaid expansion in 1997, the state also raised tobacco taxes.

Massachusetts has also used intergovernmental transfers (IGTs) to support some of its DSH or Medicaid rate payments to hospitals and the supplemental health plan payments made under the waiver—lessening the burden of these payments on the general fund. In essence, the local government or state university involved has provided the state share of the Medicaid expenditure instead of the state's general fund. Massachusetts IGTs supported DSH (or supplemental Medicaid rate) payments to three hospital systems: Boston Medical Center (BMC), Cambridge Health Alliance (CHA), and University of Massachusetts Memorial Hospital (UMass Memorial).[7] Other IGTs supported Medicaid rate payments to safety net hospitals designed to reduce their need to draw on the Uncompensated Care Pool. Still other IGTs supported the supplemental managed care payments to Boston's BMC HealthNet Plan and Cambridge's Network Health Plan.

Another effort to maximize federal financial support through Medicaid has been the state's use of provider assessments. The state's Uncompensated Care Pool is financed in part by an assessment on hospitals and health insurers. Currently acute care hospitals and insurers are each assessed $160 million, for a total of $320 million in revenue, which serves as the state share for federally reimbursable UCP payments.[8] To the extent that pool funds are expended as either DSH payments or Medicaid rate payments, the assessed funds are matched with federal dollars. In 2002 (state fiscal year 2003), the state created a second provider assessment for nursing homes. The nursing home assessment, currently at 4.5% revenues, raises $144 million and serves as the state match for another $144 million in federal payments. These funds are used

6 There are actually 3 different hospital Upper Payment Limits: one for private hospitals, another for state-owned public hospitals, and a third for other public hospitals

[7]The UMass Memorial DSH funds actually go to support costs at the University of Massachusetts Medical School.

[8] It is not possible to specifically tie each revenue source for the UCP to each payment or to payments that are or are not federally reimbursable. In addition to this $320 million, $77million is contributed by HealthNet and Network Health from federal supplemental Managed Care Organization (MCO) payments, another $70 million is contributed as IGT funding supported by BMC and CHA. Although $372 million is contributed by the state, that is offset with $329 million in FFP.

to provide higher Medicaid nursing home rates. The nursing home industry was actively involved with lobbying for and developing this assessment in order to receive higher Medicaid rates, which are possible up to the upper payment limit for nursing homes.

State Share of Medicaid Revenues

The Massachusetts SCHIP program was implemented as part of the roll-out of the Medicaid waiver. Congress passed the SCHIP authorization in 1997, as the Commonwealth was planning implementation of the waiver. Both were implemented in July 1997. Instead of electing to use distinct benefits and health plans for SCHIP, Massachusetts chose to integrate its SCHIP program with its Medicaid program, offering the same benefits and delivery system for both. Massachusetts set its SCHIP eligibility at 200% of the federal poverty level, the upper limit specified in the authorizing federal legislation.[9]

As is the case for Medicaid, the state must come up with a share of the costs for SCHIP, although the state share is lower than for Medicaid, only 35% for Massachusetts. But unlike Medicaid, SCHIP funds are capped for each state. Unspent SCHIP funds from states that have not used up their allotments are periodically redistributed to states that have.

The New Waiver Agreement

This past year, the state's Medicaid waiver was up for renewal. The negotiation with the federal government was completed in January 2005, although many of the operational details are not yet finalized. The new waiver agreement will have a significant impact on the state's use of federal Medicaid revenues. The major issue at stake in the waiver negotiation was the state's use of IGTs to fund DSH, Medicaid payments to offset UCP costs, and managed care organization supplemental rates. The federal government has decided that most IGTs are inappropriate because they effectively permit states to receive a higher percentage of federal funds than the program was designed to provide. They are, thus, forcing states with Medicaid waivers to renounce their current IGTs in order to have their waivers approved, and have proposed that Congress take further legislative action narrowing IGTs.[10] In order to get its waiver renewed, Massachusetts had to agree to terminate its IGT programs.

Impact on How the State Generates Revenue to Match Federal Funds

The waiver negotiation process included agreements on items that are technically not part of the waiver but have a large impact on state revenues. IGTs are explicitly permitted under federal law. In recent years, however, the federal government has worried that these transfers have created a way for states to avoid paying any real state match for Medicaid dollars, effectively shifting the entire cost burden to the

[9]Section 2101(a) of the Social Security Act, 42 U.S.C. 1397aa(a) provides that "the purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children...." Section 2110(c)(4) of the Social Security Act, 42 U.S.C. 1397jj(c)(4) defines the term "low-income child" as "a child whose family income is at or below 200 percent of the poverty line for a family of the size involved."

federal government. This is possible because IGT arrangements often include full reimbursement of the governmental entity (generally a municipal government or a state university) that puts up the state share. Take the following hypothetical example: A municipal government puts up $1.00 as the state match of federal Medicaid spending, the federal government contributes its $1.00 share, the local hospital is paid an increased Medicaid payment of $2.00, but refunds the original $1.00 to the municipality. At the end of the whole transaction, the locality has been held harmless and the local hospital has received an extra $1.00 that is effectively federal money. The federal government has sought to close all IGT arrangements where the payers are held harmless, whether or not they are part of a Medicaid waiver.

IGTs that Support Hospital Payments

Under the new waiver agreement, the IGTs that provide the match for hospital payments (to BMC, CHA, and UMass Memorial) end on June 30, 2005.[11] Termination of these IGTs forces the state to seek alternative sources for the state match to continue these payments.

To find the requisite match for the hospital payments, the most likely approach would be to use the Certified Public Expenditure (CPE) mechanism, wherein public hospitals (or their municipal parents) must demonstrate that public dollars have been spent for Medicaid or uncompensated care purposes.[12] This mechanism has not previously been used by Massachusetts, but is an alternative way for municipal or university funds to be used to match federal Medicaid dollars. The advantage to the federal government of this over IGTs is that there must be proof that expenditures were made, effectively limiting reimbursements to 50% of demonstrable costs. No such constraint applies to IGTs.

Restrictive language in the waiver agreement also specifies that these funds be derived from tax revenues (prohibiting the use of other hospital or governmental revenues)[13] and that the CPE be based on current Medicare cost report forms (likewise limiting the items that could be certified as expenditures).[14] These restrictions make it unlikely that all of the needed state match can found using the CPE mechanism. The three hospitals are in different situations, however:

- CHA's issue is that the CPE mechanism will limit the match to the actual cost of services; the prior IGT mechanism allowed CHA to use charges. The IGT generated $24 million in revenue, which matched $24 million in federal funds).[15]

- BMC's issue is one of governance. They are not technically a public hospital. The federal government is likely, however, to treat them as if they are. They have

[10] The president's Federal FY2006 budget proposed restrictions on the use of IGTs "curbing the use of financing arrangements that States use to avoid legally determined State match requirements."(language from materials supporting budget document).

[11]Terms and Conditions, Attachment 6(f) and (g) as further explained by waiver approval decision letter from Dennis G. Smith, Director Medicaid and State Operations, CMS to Mark B. McClellan CMS Administrator, January 2005

[12]The state would need to identify current spending and would then receive 50% of that in federal participation

[13] "With regard to CPEs, only units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended to satisfy costs eligible for Federal matching funds under Medicaid." Terms and Conditions, Attachment A, item 4.

[14]Terms and Conditions, Attachment A, item 4.

[15] Figure supplied by EOHHS staff.

previously only been allowed to use actual costs, so if the governance issue is resolved, BMC should be able to match the full amount of past payments. The IGT was $32 million, which matched another $32 million in federal revenue).[16]

- UMass Memorial faces both issues. They are not technically public and they have been allowed to use charges in the past. In the end, they are not likely to be able to replace the prior level of match. It turns out that this will mostly hurt the UMass Medical School (as opposed to the hospital itself). The IGT was $62.5 million in revenue, which matched $62.5 million in federal funds.[17]

In its negotiations to finalize the operational details of the new waiver agreement with the federal government, the state is trying to convince the federal authorities to treat both BMC and UMass Memorial as public institutions. It is also attempting to remove the language requiring CPEs to be linked to tax revenue from the agreement. Neither of these issues has yet been finalized.

IGTs that Support Supplemental Hospital Payments to Offset UCP Costs

BMC and CHA are the biggest providers of uncompensated hospital care and as such draw the most upon UCP resources. Supplemental hospital payments totaling $140 million are made as Medicaid rate payments to these two institutions as part of the state statute governing the UCP. This $140 million in payment is supported by $70 million in IGTs from Boston and Cambridge. BMC and CHA's allowable free care claims are offset by the net value of these payments, or $70 million ($20 million CHA, and $50 BMC), thus reducing their draw on the UCP. As noted, The IGTs that supported these payments were terminated on June 30, 2005.[18] If these revenues are not replaced or the uncompensated care volume of the two institutions not reduced, current UCP rules would require other UCP funds to be distributed to them, thus harming other hospitals that draw from the UCP.

IGTs that Support Medicaid Managed Care Organization Payments

The IGTs that provide the match for Medicaid managed care payments are allowed to continue for the first year of the three-year waiver extension. They must end on June 30, 2006.[19] Expected FY2005 payments are $770 million, depending on final federal approval.[20] The total value of these payments net of the IGT cost is $385 million.[21]

These payments support the two health plans and their parent hospitals. About $77 million is drawn off to support the UCP. Some $31.5 million is used to support the Essential Community Provider Trust Fund. A loss of this funding would affect the institutions funded through this trust and the UCP. Providers that are part of the HealthNet

[16] Figure supplied by EOHHS staff.

[17] Figure supplied by EOHHS staff.

[18] Terms and Conditions, Attachment 6(f) and (g) as further explained by waiver approval decision letter from Dennis G. Smith, Director Medicaid and State Operations, CMS to Mark B. McClellan CMS Administrator, January 2005.

[19] Terms and Conditions, Attachment B, items 6(e) and (f)

[20] Final payments depend on whether the state can get CMS approval to pay some parallel supplemental payments for people enrolled in the Primary Care Clinical Program at BMC and CHA. The Terms and Conditions document uses a $636 million figure, but that is believed to be low.

[21] This figure was $70 million in 1997; current legislation transfers 55% (instead of 50%) of the gross payment amount to the state from the IGT.

and Network Health networks (including roughly 50 hospitals) would also be hurt.

The federal government has said that it will work with Massachusetts to identify current state expenditures that might be matched to replace these funds. The idea is similar to the concept of using Certified Public Expenditures. If the state can identify funds that it has spent to help the uninsured, the federal government will provide reimbursement of those costs. The state can then use that revenue as the state match for Medicaid spending. This is not a written part of the agreement, however, and it is not yet clear what state funds will be approved for this purpose by the federal oversight agency.

The funds that can be matched must relate to expenditures for Medicaid or the uninsured. The Children's Medical Security Plan and Uncompensated Care Pool payments to Community Health Centers are highly likely candidates. Others that should be reviewed are Department of Public Health spending, Department of Mental Health spending, and unreimbursed municipal spending for Medicaid patients and the uninsured. Fully replacing state fiscal year 2005 Medicaid managed care organization funds would require identifying $385 million of expenditures. The state has so far created a list of roughly $700 million in such spending that it has submitted to the Centers for Medicare and Medicaid Services (CMS). CMS has not yet responded on what they will approve, although they have already rejected some of the submitted items. Fully replacing the funds is dependent on the federal oversight agency being open-minded about what can be matched. Changes in federal staffing are likely to delay finalization of this discussion.

Other Revenue Changes and Summary

The new waiver agreement also reduces federal reimbursements for other state spending approved in the original waiver. Standard Medicaid rules generally do not give federal reimbursement for care of people 19-64 years of age who reside in Institutions for Mental Disease (IMDs). The original waiver provided federal reimbursement for these services, but the new agreement phases out this $32.5 million in reimbursement over two years, dropping it to 0% July 1, 2007.[22]

When all the new waiver agreement's revenue changes are combined, $606 million in state revenues will have to be replaced by 2007 (see chart). Replacing all of it with current state or local spending that is acceptable to CMS appears possible only if the federal government modifies some of the conditions they have placed on CPEs. The alternative would be raising new state revenues.

[22] Waiver number 9; EOHHS staff say that CMS is still discussing the possibility of finding other ways of supporting some of these expenditures with federal funds.

Summary of Revenue Changes in Waiver Agreement[23]

State Financing Source	State Share SFY2005	Renewal Year 1 (7/1/05–6/30/06)	Renewal Years 2&3 (7/1/06–6/30/08)
IGT for BMC	$32 million	Must Replace	Must Replace
IGT for CHA	$24 million	Must Replace	Must Replace
IGT for UMASS Memorial	$62.5 million	Must Replace	Must Replace
IGT to Offset Uncompensated Care at BMC	$20 million	Must Replace	Must Replace
IGT to Offset Uncompensated Care at CHA	$50 million	Must Replace	Must Replace
IGT for BMC HealthNet	$257 million	Must Replace	Must Replace
IGT for CHA Network Health	$128 million	Must Replace	Must Replace
Institutions for Mental Disease	$32.5 million	Must Replace	Must Replace
Total State Share to be Replaced		**$221 million**	**$606 million**

Impact on How Revenue Can Be Spent

To the extent that the state can find the matching dollars, CMS will reimburse a Safety Net Care Pool (SNCP) as an alternative to reimbursements for DSH and supplemental Medicaid managed care organization payments.[24]On the assumption that the match can be found, this pool will be worth the amount of current DSH payments ($574.5 million) plus the amount of the state fiscal year 2005 supplemental managed care payments, which are estimated to be $770 million, for a total of $1.3445 billion per year.[25] The value will not grow during the course of the waiver extension period, however, unless the federal government changes the terms of its DSH allotment.[26] The federal government has thus capped its liability. As costs grow over time, due to inflation or otherwise, which is likely for any program developed to use these funds, the state will have to bear the full price of cost growth beyond this capped amount.

The new waiver terms require that the state eliminate supplemental payments to the Medicaid managed care organizations.[27] Medicaid managed care rates will, thus, have to meet the standard federal test for actuarial soundness as of June 30, 2006.[28] This standard will reduce total rates for the BMC HealthNet Plan and the Cambridge Network Health Plan by roughly $32 million,[29] although it might be possible to structure other payments to the parent hospitals if desired.

Although the new waiver limits the ways in which the state can generate state funds and caps reimbursement for the SNCP, the SNCP greatly increases the state's flexibility in how it can spend Medicaid money, because the waiver removes current hospital disproportionate share (DSH) payment requirements as of June 30, 2005.[30]

[23] Financial detail provided by EOHHS staff.

[24] Not all the state share that supports the SNCP is at risk: the Medicaid MCO supplemental money is at risk but only $54.5 million of DSH spending ($27.25 million in federal revenue) is at risk because it is supported by IGTs. The rest is supported by other state or UCP revenues which include a hospital assessment, an insurer assessment, and other state revenues.

[25] Provided by EOHHS staff.

[26] It is possible that the SNCP cap will increase or decline during the waiver, depending on congressional action on the DSH allotment, which current law sets for the next few years but could be modified.

[27]Terms and Conditions, item 5 as modified by Attachment B, item 6(e).

[28] 42 CFR Part 438.

[29] Estimates based on current payments and an actuarial review contracted for by EOHHS.

[30] Waiver number 10.

Although the purposes designated for the SNCP are very broad, spendable to either supplement unreimbursed Medicaid rates or serve the uninsured, the form of these payments will need prior CMS approval.[31] Subject to this approval, the state could use these funds to continue current DSH and some portion of the supplemental managed care rate payments (but only up to an actuarially sound level), to do something new. Options include:

- Paying providers for unreimbursed Medicaid costs
- Creating a new Medicaid benefit package to cover the uninsured
- Creating a less expansive insurance product to cover the uninsured
- Reimbursing uninsured people who purchase private coverage (either though direct • payments or tax credits)
- Perhaps paying for reinsurance to reduce the cost of insurance premiums and increase enrollment

Thus, much of the *Roadmap's* outline of Medicaid expansion (premium subsidies, and perhaps reinsurance) could be at least partially funded through this mechanism.

Up to 10% of the SNCP can also be used for capacity building or infrastructure (as opposed to services).[32] It appears, therefore, that this 10% can be used for state or provider costs for information systems, training, or other administrative activities. The state can also use the SNCP for costs related to individuals in Institutions for Mental Disease (IMDs), in order to replace the federal funding that has been withdrawn for these services.[33]

While the SNCP gives the state more flexibility, it is bound to create a political battle over its use. Current recipients of DSH payments and supplemental managed care payments, in particular, will expect to continue to receive as much of these funds as possible and not have them diverted to another purpose (i.e., covering the uninsured).

Budget Neutrality

Each waiver has a "budget neutrality ceiling" that represents the expected cost of services without the waiver. This is the maximum spending allowed and governs the maximum federal financial participation in the waiver. Legally, the waiver can only be approved by the U.S. Secretary of Health and Human Services if the maximum spending limit is no more than the state's program under standard Medicaid rules. Evaluating the cost and savings of waivers compared to traditional Medicaid is a difficult task, however, particularly over time, because it requires a number of counterfactual assumptions about what costs would be without the waiver. The rules applied to such an evaluation are somewhat subjective and change over time with each waiver extension.

[31] Terms and Conditions, Attachment B, item 6(g)

[32] Terms and Conditions, Attachment B, item 6(d)

[33] Terms and Conditions, Attachment B, item 6(i)

Under the new waiver, the budget neutrality ceiling has tighter growth allowance ceilings than before:[34]

- Per capita cost growth for the disabled limited to 7% a year (vs. 10% in the prior agreement).
- Per capita cost growth for families limited to 7.3% a year (vs. 7.71% in the prior agreement).

CMS estimates that Massachusetts has underspent the total budget neutrality cap by roughly $1.8 billion over the life of the waiver to date.[35] Due to the tighter-than-before trend rates, expected increases in hospital rates, and an anticipated uncapping of MassHealth Essential Enrollment, and other expected changes the state believes it will be very close to the calculated budget neutrality ceiling by the end of the 3-year waiver extension period. Since the state is using somewhat conservative estimates to calculate these figures, it may not end up as close to the ceiling expected. But it will undeniably be much closer to the budget neutrality limit than in the past.

Possible Federal Budget Action

Medicaid has come under scrutiny as part of this year's federal budget discussions. In February, the Bush administration proposed changes designed to reduce federal spending on Medicaid by $20.2 billion over 5 years, according to its estimates.[36] The Congressional Budget Office estimated that the President's budget proposals would reduce federal Medicaid spending by $13.9 billion over 5 years.[37] The final budget agreement established a commission to study reform of the Medicaid program and propose $10 billion in spending reductions over the next five years. The commission's report is due in September.

If, as seems likely, Congress decides to reduce federal Medicaid spending, the resulting legislation could have a significant impact on the state's future options for using Medicaid revenues to support coverage expansions. This is because the waiver renewal agreement expressly provides that its terms and conditions will be adjusted to comply with any statutory changes Congress might enact.[38]

At this point it would be foolish to predict the outcome. But it would be equally foolish to ignore this debate. Even though Massachusetts has, in good faith, negotiated a 3-year extension of its waiver, Congress could still make material changes in the terms and conditions that could significantly reduce the resources

[34] Terms and Conditions, Attachment B, item 5.

[35] Waiver approval decision letter from Dennis G. Smith, Director Medicaid and State Operations, CMS to Mark B. McClellan, CMS Administrator, January 2005.

[36] The savings figures presented are gross and do not reflect the offsetting cost of proposed initiatives. Office of Management and Budget, Major Savings and Reforms in the President's 2006 Budget (February 11, 2005), p. 188, www.whitehouse.gov/omb/budget/fy2006/pdf/savings.pdf

[37] CBO Estimates of Medicaid and SCHIP Proposals in the Presidents' Budget for Fiscal Year 2006 (March 2005), p. 1.

[38] Special Term and Condition 1(a) provides "The Commonwealth shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the approval date of this waiver." (emphasis added) The state may request an exemption from any statutory change, but "[t]he cost to the Federal government of such an [exemption] must be offset to ensure that [budget neutrality is maintained]."

available to Massachusetts for expanding coverage for the uninsured, by either limiting federal Medicaid matching funds, constraining state revenue options, or both.

Options for the Future

The Roadmap includes an expansion of Medicaid coverage as one of the key building blocks for universal coverage. There are a variety of options for expanding such coverage in a way that draws in federal financial support.

Safety Net Care Pool

The new waiver's SNCP provides a very flexible funding vehicle for providing additional coverage, as noted, with few constraints other than that the money be spent on the uninsured or on uncompensated Medicaid costs. As also noted, the state may have a difficult time finding sufficient matching expenditures to utilize the full potential of the SNCP. But the state will accomplish this task if the federal government is supportive and flexible in accepting current matching state and local expenditures for the uninsured. Even if other state revenues need to be generated to support SNCP expenditures, its flexibility makes it an attractive use of Medicaid funds

The pool could be used to provide benefits for people who do not meet Medicaid's regular criteria (childless adults who are not disabled or elderly) with Medicaid benefits or with a less expansive benefit package. Thus, the *Roadmap's* proposed MassHealth expansion for childless adults up to 133% of federal poverty levels could be supported through the SNCP.

Alternatively, the SNCP could be used to subsidize private insurance coverage for low-income populations not covered by Medicaid or SCHIP. Medicaid rules typically constrain the types of coverage that can be supported by Medicaid funds, or at least require that other services be "wrapped around" private insurance; but there are no such constraints with the SNCP. The funds can be used with no restrictions on cost sharing requirements or covered benefits.[39] Unlike regular Medicaid funds, the SNCP could also be used to support tax credits to support premiums for people under 400% of the federal poverty level, as proposed in the *Roadmap*.

A MassHealth expansion for more traditional populations to higher income eligibility levels, as proposed in the *Roadmap*, could also be supported by the SNCP, if traditional Medicaid or SCHIP could not be used for this purpose.

One issue with the use of the SNCP would be competing political claims for funds. The SNCP replaces current spending on disproportionate hospital payments and supplemental Medicaid managed care organization rates. The hospitals and managed care organizations that currently receive these funds will want this funding to continue despite the new flexibility given to the state and despite the required new revenue

[39] Attachment B, item 6 of the Terms and Conditions outlines the SNCP and lists few restrictions on the use of funds, other than requiring that payments "be made in accordance with payment methods that have been approved by CMS." The general description of the SNCP is: "Effective July 1, 2005, the Safety Net Care Pool (SNCP) will be established for the purpose of reducing the rate of uninsurance. It may be used for expenditures made for the provision of health care services to uninsured individuals and unreimbursed Medicaid costs, through any type of provider (e.g. hospitals, clinics etc.) or through insurance products."

sources to support the spending. Much of this current spending is viewed by providers as supporting unreimbursed Medicaid costs, not uncompensated care for the uninsured. The waiver language permits the SNCP to be spent on unreimbursed Medicaid costs or reduction in the uninsured, so it may be possible to use the SNCP to continue some portion of the current payment system. CMS, would however, have to approve the plan and might not support a proposal that is largely a preservation of the status quo.

Possible Uses of Safety Net Care Pool

- Continue support for Dispoportionate Share Hospital and Managed Care Organization payments
- Provide a Medicaid-like benefit to people above Medicaid income eligibility guidelines or not traditionally eligible for Medicaid
- Provide a private insurance-based benefit to people above Medicaid income eligibility guidelines
- Provide sliding scale subsidies for people above Medicaid income eligibility guidelines to buy private insurance

The Romney administration has recently proposed its own plan for use of the SNCP, also as part of a broader effort at health care reform. The governor's proposal is that an SNCP be developed to serve the low-income (under 200% of poverty) uninsured, and that SNCP funding subsidize the cost of this care.[40]

This proposal conflicts with the *Roadmap* in that it proposes no Medicaid expansion for the lowest income people. Both propose coverage for those above current Medicaid levels by trying to create lower-priced insurance plans. But the Romney proposal would do this with reduced benefits, directed networks, increased cost-sharing, and subsidies for those under 200% of poverty, whereas the *Roadmap* would do this with reinsurance, a purchasing pool, and tax credits for premium payments for families and individuals up to 400% of poverty.

Although Governor Romney has proposed using the SNCP in a specific way, alternative uses, such as specified by the *Roadmap*, are possible. CMS has stated that it intends the SNCP to be used to reduce the number of uninsured but is otherwise quite flexible: "the Safety Net Care Pool (SNCP) will be established for the purpose of reducing the rate of uninsurance. It may be used for expenditures made for the provision of health care services to uninsured individuals and unreimbursed Medicaid costs, through any type of provider (e.g. hospitals, clinics etc.) or through insurance products."[41]

[40] The broader plan includes the development of a new group of lower premium insurance products called Commonwealth Care with reduced benefits, directed networks, higher co-pays and deductibles; an insurance Exchange to permit individuals to buy insurance with pre-tax dollars; and various forms of public data on providers to improve consumer information. The plan also calls for greatly reduced spending on safety net provider payments, no coverage supports for undocumented or special status immigrants, and an individual mandate. No new revenues are assumed or proposed.

[41] Waiver Terms and Conditions, Attachment B, item 6.

Using the SNCP for the *Roadmap's* mix of MassHealth expansion, tax credits, and perhaps even reinsurance should meet this goal (the SNCP would not, however, be sufficient to cover all of these costs). The key, however, is that CMS must approve whatever plan is developed. Predicting what CMS will approve is a difficult enterprise. But if a strong case can be made that a specific proposal will reduce the number of uninsured (the *Roadmap* building blocks certainly meet this standard), it would be difficult for CMS to oppose the use of SNCP funds under the terms of the waiver agreement.

Even if CMS approves the governor's Safety Net Care Plan, the state legislature would have to authorize the proposal. If the legislature modifies the proposal so that it more closely matches the *Roadmap*, CMS would be hard pressed to reject those modifications as long as they met the standard of reducing the uninsured. Such modifications by legislatures are a regular part of the waiver process. When the MassHealth waiver was first created, the federal government approved it, only to have the state legislature make changes that then needed a second round of review and approval by the federal authorities.

Timing is also an issue. The waiver extension calls for supplemental MCO payments to end on June 30, 2006. The $385 million in federal revenues associated with these payments can be retained by the state as part of the SNCP, but only if the state has a plan for spending that is approved by CMS. The practical reality is that any plan to be implemented July 1, 2006 would require a clear plan of action today. Legislative vetting and approval would take a few months at a minimum. The implementation process would likely take much longer: regulatory changes, eligibility procedures, information systems changes, and contracts would all have to be developed or modified in order to implement a new program. Any plan that would start next July would need to be moving already for all this to be done. The Governor's SNCP Plan may be ready to implement next July, because he has his staff working on implementation issues in parallel with legislative authorization and CMS approval. An alternative plan is much less likely to be ready for implementation by then.

But July 1, 2006 need not be the full start date. Full federal reimbursement might still be retained if a program started a few months late. Also, a transitional plan could be developed that leaves time for the new program implementation, while authorizing certain spending as of July 1, 2006.

If Governor Romney's proposal is adopted by the legislature and approved by CMS, the *Roadmap* is unlikely to be substituted for that plan by the state legislature, at least until the next administration. In effect, this means that a conversation with CMS about modifying the state's plan would only occur in Spring 2007, as part of the next waiver reauthorization negotiations scheduled for that time.

Medicaid

Beyond the SNCP, Medicaid might be used to bring additional federal support for coverage. This is not straightforward, however, given the existing waiver. Regular

Medicaid, unlike SCHIP and the SNCP, is uncapped and Massachusetts has the right to expand Medicaid coverage for current Medicaid categories under section 1902(r)(2) of the Social Security Act. But the existence of the waiver complicates the issue of federal reimbursement for such an expansion, because it may effectively limit the state's ability to expand Medicaid up to the level that is affordable within the waiver's budget neutrality ceiling.

Generally speaking, states can expand Medicaid income eligibility levels with fairly straightforward changes to the "state plan" submitted to CMS. States can thus expand coverage for children, families, or the disabled to higher income levels and the federal government will pay at least half the cost.[42] The program and benefits offered to this expansion population would then be restricted to Medicaid rules.

Since Massachusetts' 1902(r)(2) populations are currently part of the state's waiver program, however, Massachusetts would need to modify its waiver in order to provide expanded coverage for these populations.[43] It is unclear if such an expansion would have a negative effect on the finances of the waiver.[44]

Massachusetts, as noted, is currently spending less than the budget neutrality ceiling agreed to in the waiver. Roughly translated, this means that the current Medicaid waiver has saved the federal government money since its inception. However, the state expects the margin of saving, or "available headroom," under budget neutrality to be very small by the end of the next three-year period. If so, Massachusetts will have limited ability to propose a modification in the waiver to cover more people outside the SNCP.

An expansion of coverage for traditional Medicaid populations (families or children) under 1902(r)(2) (as proposed in the *Roadmap*) may still be possible. Expansions for other groups would definitely count as a cost against budget neutrality. But it is not as clear for 1902(r)(2) populations. Since the current 1902(r)(2) populations are part of the state's waiver, in budget neutrality calculations they are counted as part of the base costs. Thus, as enrollment in this group rises, the base on which budget neutrality is calculated rises along with costs, so the state is held harmless for population increases. Per member per month costs must stay below growth levels established in the agreement or costs above that level count against the budget neutrality ceiling. But population growth for this standard Medicaid group is assumed to be inevitable and would be expected to happen even without the waiver.

The state could (and should) argue that changing income eligibility standards for this group could happen without the waiver and so should be treated the same as any other increase in enrollment under 1902(r)(2). CMS might or might not accept this argument; there is no language in the waiver that governs how to deal with such changes.

[42] The ratio of federal payments for each state's program is determined by federal law and is 50% for Massachusetts.

[43] Both Massachusetts EOHHS staff and federal CMS staff concur on this point.

[44] EOHHS staff has said that this is unclear; CMS staff has said that they would need to review whatever is proposed.

This issue is important because it will determine how open-ended federal support can be for coverage expansion. Without the waiver there is no fixed cap on federal Medicaid participation. (Medicaid is an entitlement, not a block grant.) With the waiver, CMS may act as if there is a cap: the budget neutrality ceiling of the waiver.

SCHIP

SCHIP receives a higher match of federal funds (65%) than Medicaid and should therefore be used to the maximum in any coverage expansion plan. Unlike Medicaid, however, SCHIP is capped, with allotments specified for each state by federal law. Since its enactment, Massachusetts has used less than its full SCHIP allotment. This means that Massachusetts could expand SCHIP to cover children at higher income levels and still receive federal funds.

SCHIP is designed to serve children at higher than Medicaid income.[45] If Medicaid eligibility for children is expanded, it makes sense to revise SCHIP eligibility to continue to serve children above Medicaid income levels and maximize the available funding associated with SCHIP.

Since the start of the program, the maximum eligibility level for SCHIP in Massachusetts has been set at 200% of the federal poverty level. Because the congressional authorization language does not prohibit states from "disallowing" certain income, many states have effectively set eligibility maximums at higher levels. New Jersey has gone the furthest, permitting SCHIP eligibility for children whose families earn up to 350% of the federal poverty level. Massachusetts could similarly modify its SCHIP eligibility to cover children above the state's revised Medicaid income eligibility standards. The eligibility level attainable within the capped SCHIP funding stream will depend on how much Medicaid eligibility levels are increased. Massachusetts officials believe there is enough SCHIP allotment available to cover children up to 400% of federal poverty levels at least through FFY2007 when the program needs to be reauthorized.[46]

An alternative way to maximize federal reimbursement at lower income eligibility levels would be to request a waiver to cover SCHIP children's parents using SCHIP funds. Such an alternative is consistent with the *Roadmap's* proposal to expand MassHealth coverage to 200% of federal poverty level. As part of the arrangement the state may also need to shift some SCHIP children to Medicaid and reallocate some current SCHIP funds to the parents of SCHIP children.

By way of hypothetical example, Medicaid eligibility for children and parents might be increased from the current 133% of federal poverty levels to 166%. SCHIP might cover children with family incomes between 166% of poverty and 200% (instead of

[45] Under SCHIP, federal matching funds are available for the costs of child health assistance for "targeted low-income children," section 2105(a)(1)(A) of the Social Security Act, 42 U.S.C. 1397ee(a)(1)(A). The term "targeted low-income child" is defined in section 2110(b)(1) of the Social Security Act, 42 U.S.C. 1397jj(b)(1) as, among other things, a child who is not eligible for Medicaid and whose family income exceeds the state's Medicaid applicable income level by no more than 50 percentage points.

[46] Total available allotments in FFY 05 are $179.5 million, plus an FY 02 redistribution allotment of $12.3 million, for a total allotment of $193.8 million available in FFY 05 (some of which can be carried over into FY 06 and beyond). Centers for Medicare and Medicaid Services, as supplied to the Senate Finance Committee on January 14, 2005.

between 133% and 200%). And a waiver might be created to cover their parents between 166% and 200% of poverty with the reallocated SCHIP funds.

Health Insurance Flexibility and Accountability (HIFA) demonstration waivers allow SCHIP funds to be spent on parents of SCHIP children, on the view that covering them together in the same health plan may make it more likely that children will receive regular physician visits. These waivers are also designed to promote broad-based coverage of people under 200% of poverty and encourage the maintenance of private insurance coverage where available. Thus, it would be necessary to include some design elements focusing on maximizing private insurance (such as linking the expansion to a modified Insurance Partnership program).[47] Using HIFA waiver to support the MassHealth expansion proposed in the *Roadmap* would maximize federal financial support and reduce the need for additional state revenues.

Revenue Needs

Although identifying revenue sources is not the mission of this paper, it is important to point out that all expansion options discussed here require state funds to match the federal support. One of the challenges of the new waiver agreement, as noted, is that the state will have to identify current spending or new revenue simply to maintain the level of federal reimbursement it has today. For the SNCP, the state match will be partially satisfied by current provider and insurers' assessments for the UCP, newly identified Certified Public Expenditures, and current state spending on Medicaid and uninsured, although how much is unclear at this time.[48] Additional revenues may be needed in order to maximize what federal reimbursement is available through the SNCP. Additional Medicaid expansion beyond the SNCP through 1902(r)(2) will surely need new sources of revenue. In any event, the SNCP is not large enough to cover all the spending outlined in the *Roadmap*. New revenues will be required, and many options for raising this revenue exist, including increases in provider, tobacco, sales or income taxes; or, if the *Roadmap* employer mandate is implemented, an assessment on employers who do not pay for health care (with credits to employers that do, as outlined in the *Roadmap*).

Conclusion

Medicaid and SCHIP can be used to bring federal financial support for a coverage expansion. Federal Medicaid funds can either (a) be used to support a direct Medicaid expansion, as proposed in the *Roadmap*, or (b) by use of the Safety Net Care Pool, support tax subsidies and perhaps reinsurance if used to expand coverage and reduce the number of uninsured.

Further use of non-SNCP Medicaid may be constrained by the existence of the waiver. But the state should fight for an interpretation of the waiver that preserves its right to increase the eligibility level for standard Medicaid groups. The state needs to argue

[47] www.cms.gov/hifa/hifagde.asp

[48] $385 million of federal revenues attributable to Medicaid MCO payments and $27.25 million in federal revenues associated with DSH are at risk.

that a standard Medicaid expansion should not be considered a cost against the budget neutrality of the waiver.

One issue not so far mentioned is that the waiver is only approved for the next three years. The federal government will have to approve any extension beyond that period. Historically, approvals have not been a problem. No major demonstration waiver has been cancelled by the federal government over a state's objection. The more likely difficulty will be getting agreement on cost growth rates that work for both CMS and Massachusetts. In the recent waiver extension, annual growth rates are tight and there is no growth planned for the SNCP. A similar issue exists for SCHIP. The current federal SCHIP program is only authorized for the next two years. It is unlikely to be terminated, however. The issue, again, is how much state allotments will be permitted to grow.

The big concern for the Commonwealth under the recent waiver agreement is the difficulty of preserving existing federal dollars. Existing state spending or new revenues must still be identified in order for the state to continue receiving even the $606 million previously available in federal revenues but now at risk because IGTs and IMD spending have been disallowed as state matching funds. Significantly expanding coverage with federal money will require preserving as much in the way of existing federal revenues as possible, and then taking advantage of additional federal matching revenues to cover more people.

Fully maximizing what is available from the federal government to support the SNCP, SCHIP, or other areas of Medicaid expansion is likely to take some new state revenues. But doing so will also permit the state the use federal dollars to cover a significant portion of the costs of expanding coverage to the uninsured.

About the Author

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