

The MassHealth Waiver

Issue Brief

April 2005

Executive Summary

Massachusetts recently renegotiated major provisions of the state's Medicaid program with the federal government. These provisions are part of an agreement commonly referred to as the "MassHealth waiver," originally implemented in 1997.

The MassHealth waiver has been very successful. It has increased the number of people with Medicaid coverage by 300,000, and brought in significant additional federal funding. Federal revenues were increased both by permitting federal reimbursement for some health spending that had previously been paid for solely by the state, as well as providing a means for new supplemental payments to certain Medicaid health plans. These resources have helped the state expand MassHealth coverage, support hospitals and other providers (particularly safety net providers), and fund care for the uninsured.

The new waiver agreement, which becomes effective on July 1, 2005 and runs through June 30, 2008, makes significant changes. These changes are complex, and some critical details of the waiver have yet to be finalized. But it is clear that the new waiver will have significant implications for the state's Medicaid program, the uninsured, and the providers that care for them. Among the most important changes and issues in the new waiver are:

The new waiver may result in a reduction in the overall amount of federal revenues available to the state compared to the current waiver. Under the terms of the new waiver, the state must terminate some of the financing mechanisms it has used to fund supplemental payments to hospitals and managed care plans operated by Boston Medical Center and the Cambridge Health Alliance. In particular, intergovernmental transfers, a financing mechanism used to obtain federal revenues, will no longer be allowed in their current form. The federal government has also imposed a cap on the total amount of

This issue brief is intended to provide an overview of the MassHealth waiver from the layperson's perspective and it does not necessarily use precise legal or regulatory language in describing all aspects of the waiver.

supplemental payments to managed care plans for FY2006. Effective July 1, 2006, this amount plus the current cap on Disproportionate Share Hospital funds, another source of funding for safety net providers, will be combined to create a Safety Net Care Pool of approximately \$1.3 billion in total state and federal spending, the uses of which must receive federal approval. The waiver has no provision to adjust this amount for inflation over the term of the waiver, which will effectively lessen its value over time. Imposing this cap will require the state to bear the full cost of any growth beyond the capped amount.

Finding enough current state or local spending or revenue to enable the state to draw down the full potential amount of the federal funding will be challenging. The termination of the IGTs will require the state to find alternative sources for the state match in order to maintain the current level of federal funding. To do so, the state must identify either approximately \$600 million in current state spending that is eligible for federal matching funds, \$300 million in new state revenues or provider assessments, or some combination. If the state cannot do this, it will not be able to obtain the maximum federal funding available, reducing the resources available to support health care in the Commonwealth.

On the spending side, the new waiver gives the state much greater flexibility than under the current waiver. In the new waiver, the federal government will match state spending for a new Safety Net Care Pool, to provide health care services to the uninsured and to cover “unreimbursed Medicaid costs.” The waiver does not dictate the specific way in which these funds can be used, and so offers flexibility for a range of possible approaches, including the current Uncompensated Care Pool, support of providers not currently reimbursed through the Pool, insurance products, or other approaches.

While this flexibility creates the opportunity to develop new ways to provide services to the uninsured in the most cost-effective way possible, it also raises difficult policy and political issues, particularly given competing claims for the available resources and different views about how best to finance and deliver care to the uninsured.

Among the more contentious issues that must be resolved are:

- how available resources should be allocated between supplementing unreimbursed Medicaid costs and serving the uninsured;
- the level of available resources that should be used to support safety net providers, particularly Boston Medical Center and Cambridge Health Alliance, and their affiliated managed care plans; and,

- whether services to the uninsured should be financed through the current Uncompensated Care Pool, an insurance-like product, or some other approach, and how whatever approach is developed should be structured and financed.

The new waiver may also create additional state budget pressures in the future because it permits Medicaid spending to grow by less than in the current waiver. The new waiver has cost trend factors that are lower than in the current waiver. These factors are used by the federal government to determine if the waiver has met the requirement of “budget neutrality” (i.e., a requirement of the waiver to limit overall federal funding). The reduction in these cost trend factors will make it more difficult for the state to meet the requirement of budget neutrality in the future, which could require limits on spending otherwise allowed by the waiver.

Certain key provisions in the waiver still need to be resolved to determine what state and/or local funding mechanisms will be permissible, and the amount of the potential federal funding gap that confronts the state. In particular, the state needs to change or remove language in the waiver provisions that requires that any certified public expenditures that are used as a source of funding for the non-federal share of Medicaid expenditures to be state or local *tax* dollars. As written, this language could limit the ability of the state to access federal funds.

The possibility of federal reform of Medicaid makes the future even more uncertain: If the federal government makes any major changes to the Medicaid program, this could affect the waiver. The waiver requires the state to come into compliance with any changes in federal law affecting the Medicaid program, unless it receives an exemption. The Bush administration’s current budget proposal contains several provisions that would further constrain current state options.

Successfully navigating the challenges that lie ahead will require strong leadership, close collaboration and broad public discussion and decision-making: The waiver has been an innovative and very successful public policy tool over the past eight years, but critical issues are ahead. There is a significant and growing part of the Massachusetts population whose health and well-being are dependent on the quality of our decisions, and their interests must be represented in the policy conversations now beginning.

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Introduction

Massachusetts has recently renegotiated with the federal government major provisions of the state's Medicaid program, referred to as MassHealth. This renegotiation affects the parts of MassHealth governed by, and commonly referred to, as "the waiver," or "the 1115 waiver," an agreement through which the state successfully expanded Medicaid coverage to an additional 300,000 people who would otherwise not have been eligible and enrolled. The new terms of the waiver, which become effective on July 1, 2005, are significantly different from the current terms, particularly in the details of how the program is financed. These new terms have major implications for the financing of the MassHealth program, the uninsured, and the providers that care for them.

The purpose of this issue brief is to describe the most significant changes in the new waiver agreement and identify the major issues that will need to be resolved as the state implements the changes.

Background and Current Situation

1. What is the MassHealth waiver?

The waiver is an agreement between Massachusetts and the federal government that allows the state to operate part of the Medicaid program under rules different from those that usually apply.¹ Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to authorize experimental or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program. Projects must be budget neutral, meaning they cannot be expected to cost the Federal government more than the traditional program without the waiver would.² Many states have used Section 1115 waivers to make broad changes in eligibility, benefits or cost sharing in their state Medicaid programs.

In 1994, Massachusetts submitted "MassHealth" (the official name of the waiver program) for approval as a five-year Medicaid Research and Demonstration Project. The federal

¹ Federal regulations require that Medicaid consumers have freedom of choice of providers, that the program be available statewide, and that services to all covered individuals be comparable in amount, duration and scope. States must cover certain services and eligible groups. States can also choose to cover optional services and optional groups. Some options are specified in law, while other options can be requested through "waivers." Massachusetts has other waivers in addition to MassHealth, including several that expand the number of people who can receive long term care services at home rather than entering a nursing home.

² Under the Medicaid program, Massachusetts receives federal reimbursement, or federal financial participation (FFP), for qualified expenditures. Most expenditures are reimbursed at 50%, although some are reimbursed at higher levels, including the SCHIP program which is matched at 65%. The overall percentage of federal reimbursement for Medicaid in Massachusetts is approximately 54%.

government approved the waiver request in 1995, subject to a set of special terms and conditions. The program was implemented in 1997 after state law enabling implementation of the program was passed (Chapter 203 of the Acts and Resolves of 1996). In 2001 the waiver was extended for three years, from July 1, 2002 to June 30, 2005, without any changes to program or financing rules. It has just been renewed for another three years, from July 1, 2005 to June 30, 2008, with some significant amendments to both program and financing rules.

2. What is MassHealth?

MassHealth is the portion of the Massachusetts Medicaid program that provides health care coverage to Medicaid-eligible people who are not over 65, under 65 with Medicare, receiving institutional long-term care, or receiving home and community-based services. (The term MassHealth is also often used to refer to the entire Massachusetts Medicaid program.) MassHealth covers a diverse group of low-income people, including children and their parents, adults with long term unemployment, and children and adults with disabilities. The waiver significantly expanded the number of people that are eligible for MassHealth coverage and allowed additional programs to qualify for federal matching funds, including health benefits for those on unemployment compensation and programs to subsidize employer-sponsored health insurance for low-wage workers at small companies.

3. Why did Massachusetts initially request the waiver?

Massachusetts believed that by expanding Medicaid eligibility, it could reduce the number of and cost of caring for the uninsured and get federal payment for several existing state-funded health programs for low income residents. There are many advantages to covering the uninsured through Medicaid rather than through the state's Uncompensated Care Pool. MassHealth members have access to a broader range of services, care can be purchased and managed more effectively, and the federal government reimburses half the cost. The state projected that the cost of uncompensated care would decrease and new federal funds would be generated on existing state programs, more than covering the cost of expanding Medicaid.³ The waiver also proposed that the majority of MassHealth members would be enrolled in managed care programs, emphasizing comprehensive, coordinated and preventive care to improve quality and reduce cost.

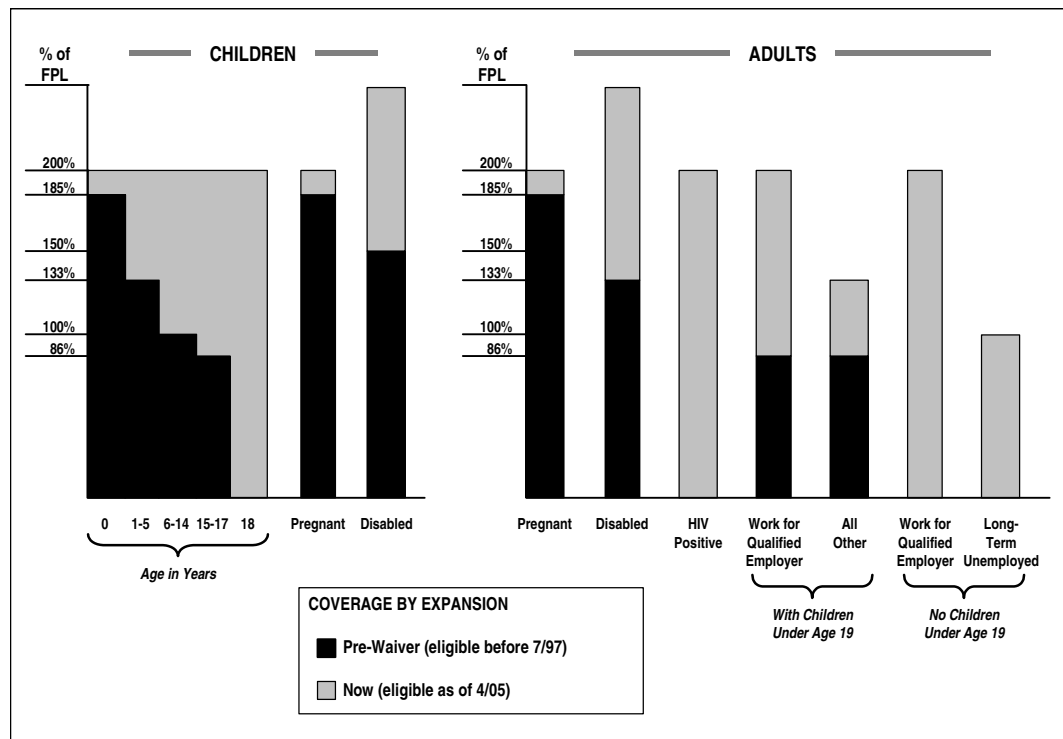
³ The state legislature also provided some funding for the program through imposition of a new tobacco tax.

4. What are the major provisions of the current waiver (prior to the most recent extension)?

The original waiver allowed four major changes from the traditional Medicaid program:

- It increased the number of people covered by Medicaid by creating new categories of eligible people and expanding income limits for some existing categories. The new categories were primarily adults without children, in particular the long term unemployed. The expanded income limits allowed coverage of more low-income children and families and more people with disabilities (see Chart 1).

Chart 1: Overview of MassHealth Waiver Eligibility Changes



- It expanded the number of Medicaid enrollees in managed care by allowing the state to require that certain groups of MassHealth members join managed care plans, either a private MCO or the Primary Care Clinician Plan (PCCP) administered by MassHealth.
- It authorized federal matching funds – “FFP” – for some expenditures usually not eligible for them, such as
 - employer and employee contributions to health insurance premiums for low-wage workers in the Insurance Partnership Program,
 - certain services provided in Institutions for Mental Disease (IMDs)⁴, and

⁴ An Institution for Mental Diseases is defined as a public or private facility with more than sixteen beds that is “primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases” and includes hospitals, nursing homes and other long-term care facilities. Federal Medicaid matching funds are not usually allowable for the costs of any Medicaid covered

- expenditures to provide Medicaid coverage through Medicaid-only Managed Care Organizations (MCOs).⁵
- It allowed Medicaid payments to certain managed care organizations to exceed the usual Upper Payment Limit (UPL).⁶ The most important purpose of this provision was to allow higher premium payments to the MCOs sponsored by the Boston and Cambridge Public Health Commissions (hereafter referred to as the public MCOs). These MCOs are the Boston Medical Center HealthNet Plan (“BMCHP”, the Boston MCO, operated by Boston Medical Center under contract to the Boston Public Health Commission) and Network Health (the Cambridge MCO, operated by Cambridge Health Alliance). A series of supplemental payments were negotiated that resulted in premiums for these MCOs that were significantly above the UPL level.^{7,8} A portion of the supplemental payments funds \$70 million in free care at Boston Medical Center and Cambridge Health Alliance, substituting for funds that would otherwise have been due from the Uncompensated Care Pool. The supplemental payments to the public MCOs also help finance the Essential Community Provider Trust Fund.

5. Who benefits from the waiver?

The waiver has had many positive effects. More individuals have health insurance coverage. MassHealth enrollment is 300,000 higher than before the waiver, even with the cutbacks that occurred over the past two years. As a result, Massachusetts has one of the lowest rates of uninsurance in the country, particularly among children. Waiver programs have helped many

services furnished to an individual aged 21 through 64 years of age who resides in an IMD; the waiver allowed those services to be matched for limited number of days.

⁵ In 1997, Boston Medical Center and the Cambridge Health Alliance created affiliated Managed Care Organizations (Boston Medical Center HealthNet Plan and Network Health, respectively) to serve the MassHealth population. At the time, Medicaid payments to MCOs were only eligible for federal matching dollars if Medicaid enrollment was less than 25% of total membership. The waiver allowed an exception to this rule for these health plans.

⁶ At the time the waiver was approved, premiums for Medicaid MCOs (paid as a per member per month capitation) were based on 100% of the expected fee for service expenditures for a similar group of members. Federal regulations now require states to set “actuarially sound rates.”

⁷ The three major types of supplemental payments that are paid the BMCHP and Network Health MCOs are: payments for newly insured patients from the BMC and CHA hospital systems who enroll in the Primary Care Clinician Plan (the “PCCP supplement”); payments to reflect the lower rates of payment BMC and CHA receive from premium payments relative to payments from the Uncompensated Care Pool (the “differential supplement”); and payments to recognize potential adverse selection among enrollees in BMCHP and Network Health (the “case mix supplement”). A fourth supplemental payment, the Free Care Supplement, is paid to the MCOs but passed through to the safety net hospitals to offset their draw on the Uncompensated Care Pool.

⁸ Boston Medical Center (BMC) and Cambridge Health Alliance (CHA) are often termed “safety net providers” because they serve a disproportionate number of public patients and low income, uninsured individuals according to both state and federal disproportionate share hospital designations. They and other designated hospitals (such as the UMass Memorial hospitals) receive policy consideration through a number of programs to ensure that they receive adequate resources. In addition to the supplemental payments made to the MCOs, the other major sources of support are supplemental hospital rate payments for Medicaid patients and Disproportionate Share Hospital (DSH) payments, which are required as part of the traditional Medicaid program to assist hospitals with a high percentage of Medicaid and uninsured patients to cover their costs. Medicaid DSH payments in Massachusetts have been capped at \$574.5 million annually through 2013, through amendments to federal Medicaid statutes that applied to all State Medicaid programs nationwide.

low-wage workers and employers buy or retain employer-sponsored health insurance. Safety net providers have received increased funding, reducing the contributions to free care funding that would otherwise have been required from employers, health plans and the state.

The waiver (and related State Medicaid Plan amendments for hospital rates) also allowed Massachusetts to pay significantly enhanced rates to safety net hospitals and to Medicaid MCOs without infusion of new state dollars. The State uses a mechanism called Intergovernmental Transfers (IGTs) to transfer funds from local public health entities to the state to finance the “state share” of the cost of these higher rates (see “How A Local Government “IGT” Works box).

For the MCOs, the supplemental payments covered the cost of care of enrollees and generated funds to support the hospital systems that operated them.⁹ Because the supplemental MCO payments were linked to membership, they provided a tremendous incentive for BMCHP and Network Health to grow. BMCHP now has approximately 133,000 members, making it the largest Medicaid MCO in the state. The CHA plan, Network Health, has nearly 70,000 members. The supplemental payments have enabled these MCOs to pay rates that exceed ordinary Medicaid payments to their contracting providers, making contracts with these two MCOs very attractive for other hospitals and providers and permitting the MCOs to expand geographically. Most (80%) of the members in both MCOs reside in areas outside the service area of their parent hospitals.

Medicaid Managed Care Organizations (MCOs)

Medicaid-only membership:

- Boston Medical Center HealthNet Plan (sponsored by Boston Public Health Commission)
- Network Health (sponsored by Cambridge Public Health Commission)

Medicaid and commercial membership:

- Neighborhood Health Plan
- Fallon Health Plan

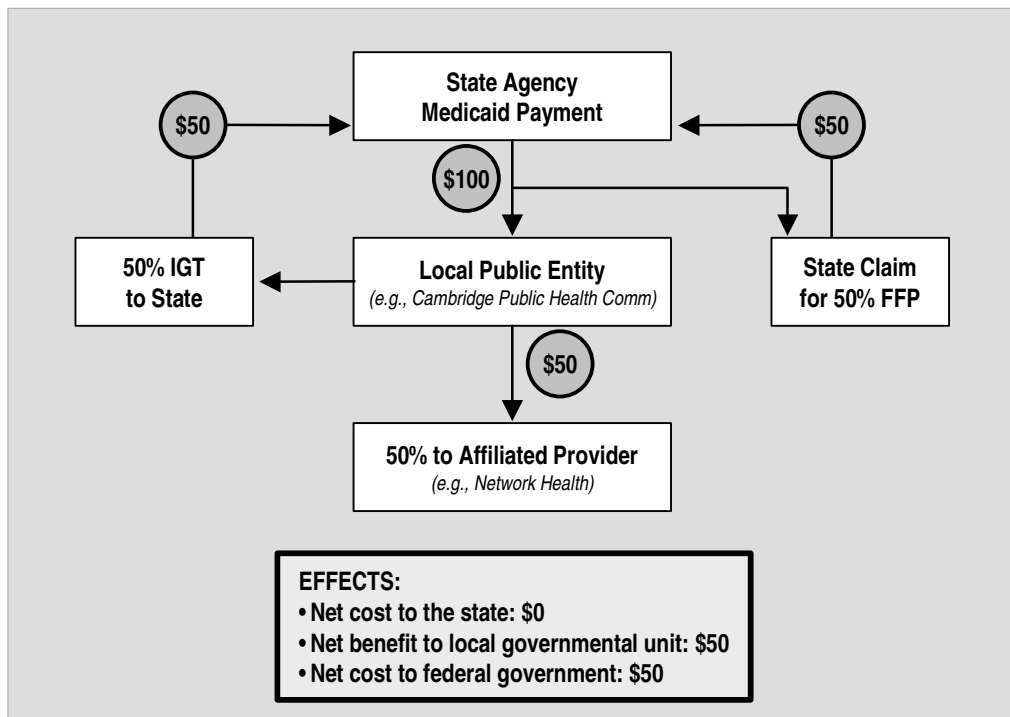
⁹ The hospitals operating the MCOs could receive support in a number of ways: through increased referrals, through higher payment rates for services provided to MCO enrollees, through more prompt payment and fewer denied payments, and through direct allocation of some of the surplus payments. Any surpluses (or deficits) of the affiliated MCOs also accrue to the hospital systems.

How A Local Government “IGT” Works

When a state makes Medicaid payments to providers or MCOs, it has to show that it used its own state funds to cover a defined portion (in Massachusetts, 50%) of the expenditure. The federal government allows a state to meet this 50% “non-federal” obligation with either *state*-budgeted funds or the transfer of *local* public funds from cities, towns, counties or public agencies. Generally, under the IGT mechanism, the same local entity that receives the enhanced rates as a Medicaid provider is also required by state law (usually part of the annual budget) to contribute its own IGT funds, equal to 50% of the enhanced rate, to the Medicaid program.

Under the Massachusetts IGT arrangement, the full, enhanced Medicaid payment is sent to the public entity providing the health service (for example, the Cambridge Public Health Commission, the sponsor of Network Health), which then has an IGT liability to the State equal to 50% of those payments. The State also claims federal reimbursement for half of the payment. By using the enhanced rate authority *and* the IGT mechanism, the State is able to “draw down” new Federal funds for these safety net providers without infusion of new state budget dollars because the local public entity paid the “non-federal” share. The net increased benefit or value to the local public health care entity is 50% of the payments it receives. The local entity incurs a new cost, but one that is only half the size of the new enhanced rate revenue, so it gains a sizable net benefit (see Chart 2).

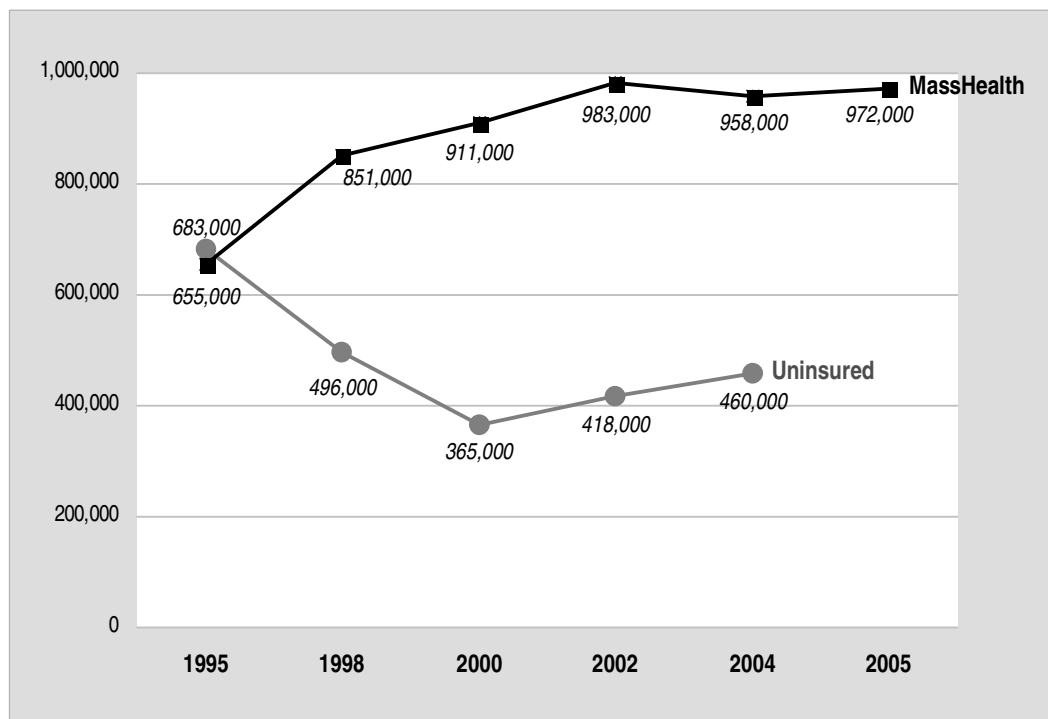
Chart 2: How A Local Government “IGT” Works – An Illustration



6. Did the waiver achieve its goal to reduce the number and cost of the uninsured?

Yes, though not in the ways originally intended. The number of uninsured was reduced by almost half, largely through the addition of 300,000 people to MassHealth (see Chart 3). However, the original expectation of high enrollment in the Insurance Partnership Program¹⁰ was not realized and the number of uninsured did not decline as much as projected.

Chart 3: Change in the Numbers of Uninsured and MassHealth Enrollees



Source: "Health Insurance Status of Massachusetts Residents," 1998, 2000, 2002, and 2004 Massachusetts Division of Health Care Finance and Policy. "Massachusetts Residents Without Health Insurance, 1995," Blendon, et al, Harvard School of Public Health. Office of Medicaid, EOHHS.

With the recent economic downturn the number of uninsured began growing again in 2000, although the percent of Massachusetts residents without insurance is still lower than before MassHealth was implemented and much lower than in most other states. The cost of the Uncompensated Care Pool also decreased during the original period of the MassHealth expansion, but then began to rise rapidly as a result of the increasing number of uninsured, expansion of services billed to the Pool,¹¹ and rising health care costs.

¹⁰ The original waiver projected enrollment of about 237,000 in the IPP, compared to actual enrollment of approximately 14,000 as of December, 2004 (Report of the Special Commission Established for the Purpose of Making An Investigation and Study of Methods for Achieving Universal Health Care Coverage for Residents of the Commonwealth, September 25, 1995.)

¹¹ Some safety net providers worked to increase access to medically necessary health services for the uninsured, especially pharmacy services.

The state estimates that the waiver saved money for the state and federal government, primarily through the expansion of managed care programs. According to state estimates required to demonstrate the budget neutrality of the waiver, the waiver reduced the cost of the Medicaid program by a total of \$1.8 billion over the past eight years compared to what program spending would have been without the waiver. The majority of the savings were accrued during the early years of the waiver.

The waiver was also extremely successful in increasing the federal dollars available to support hospitals and other providers. As much as \$599 million in federal funding is expected to flow to the Commonwealth in FY05 as a result of the IGTs (see Chart 4). A majority of it comprises supplemental payments to the public MCOs. Federal reimbursement will be increased by between \$344 and \$385 million (depending on membership growth) over what it would be without the waiver as a result of the supplemental payments to public MCOs. Not all of these funds are retained by the safety net hospitals; some are paid out as enhanced rates to hospitals and other providers serving MassHealth members enrolled in the public MCOs. Further, the \$70 million Free Care Supplement provides statewide benefit by reducing the demand on the Uncompensated Care Pool and the \$31.5 million Essential Community Provider Fund makes grants available to many other providers. (See box)

The Essential Community Provider Trust Fund

The Essential Community Provider Trust Fund was created as part of the FY04 budget (S. 133 of C. 140 of the Acts of 2003) and funded through an appropriation of \$14.5 million. It was renewed for FY05 with the intention to "...improve and enhance the ability of the essential community providers to serve the population in need more efficiently and effectively..." It is funded in FY05 through funds transferred from the Boston and Cambridge Public Health Commissions. The Secretary of EOHHS is authorized to issue regulations to administer the fund; the Legislature has earmarked 31 grants ranging from \$200,000 to \$5,500,000 to be made to hospitals and community health centers across the Commonwealth. These total \$31.4 million, virtually equaling the available funding.

Chart 4: Use Of Federal Funds Received Through IGTs And Enhanced Rates In FY05

Use of Federal Funds	Projected Amount
Supplemental payments to BMC/CHA MCOs (includes \$70 million Free Care Supplement, \$31.5 million Essential Community Provider Trust Fund)	\$ 385 M *
Supplemental payments made directly to BMC/CHA and UMass Memorial hospitals under DSH and hospital rate supplements transacted through IGTs	\$ 214 M
Total	\$599 M

**Final amount to be determined based on FY05 membership in BMCHP and Network Health*

The Opportunities and Challenges Ahead

7. What will change as a result of the recent waiver negotiation?

The new waiver provisions signal a significant shift in the approach to funding care for the uninsured. The waiver negotiation occurred in the context of budget pressures and a changing environment at every level of government. On a national level, the federal government is closely scrutinizing state use of IGTs and limiting state opportunities to access federal funds. It is targeting significant cutbacks in Medicaid spending as part of its FY06 federal budget process. There are also considerable differences of opinion in Massachusetts about how to cover the uninsured. Many believe that Uncompensated Care Pool dollars are not wisely spent and that expanding coverage for the uninsured is a more appropriate approach. At the same time, a new emphasis on individual choice is driving an interest by some in developing lower cost private health insurance schemes rather than expanded public coverage. In most cases, the emphasis is on basic coverage, with limited benefits, rather than the comprehensive coverage available through public programs. All parties want to limit their own financial responsibility, and everyone is looking to minimize costs.

There are currently a number of proposals under development in Massachusetts to address the issue of the uninsured. Governor Romney has proposed a four-part approach, which incorporates:

- enrolling all Medicaid eligible uninsured in the MassHealth program
- creating a low cost private health insurance product (Commonwealth Care) for those who can afford to buy insurance
- providing transitional coverage to the short-term unemployed and new employees
- designing an insurance-like Safety Net Care program for the low-income uninsured.

Reflecting all of these developments, several of the fundamental mechanisms in the current waiver, especially those related to supplemental MCO payments, were changed or eliminated in the process of negotiating the waiver extension. The overall result is significant restrictions

on how Massachusetts can access federal funds, but increased flexibility in how allowable funds can be spent. The terms of the new waiver are well-suited to support Governor Romney's health care reform proposal, although the waiver could be compatible with a variety of other approaches. *Overall, federal funding is likely to decrease.*

The major changes that will be phased in over the course of the three-year waiver extension are the following:

- Beginning in July 1, 2005, MCO supplemental payments will be capped, as the state's DSH allotment already is. The MCO supplemental payment cap will be based on FY 2005 year-end supplemental payments made to the Boston Medical Center HealthNet Plan and Network Health. Since supplemental payments vary with MCO membership, the final amount of FY2005 supplemental payments will not be known until June. The DSH cap will remain at the current annual allotment. The Centers for Medicare and Medicaid Services (CMS) projected in the waiver that the total cap on these combined state and federal expenditures would be \$1.23 billion per year, although the current estimate is approximately \$1.3 billion.
- Effective July 1, 2005 hospital rate supplements may no longer use IGTs to finance the 50% "non-federal" share. Certified Public Expenditures are allowed.¹²
- Effective July 1, 2005, a Safety Net Care Pool (SNCP) will be established for the purpose of reducing the rate of uninsurance in the state. It is funded up to the total cap amount and will be available starting July 1, 2006 subject to allowable state expenditures for federal matching. These funds may be used to provide health care services to the uninsured and to cover "unreimbursed Medicaid costs," subject to the approval of the federal Centers for Medicare and Medicaid Services (CMS). Up to 10% of the SNCP may be used to "improve health care delivery to uninsured/SNCP populations, such as capacity building and infrastructure."
- For FY2006, the Commonwealth is specifically permitted to continue making supplemental payments to the Boston and Cambridge MCOs and using IGTs to access federal matching funds. Expenditures will be subject to the cap.
- Effective July 1, 2006 (the start of FY2007), the Commonwealth must terminate these funding mechanisms (i.e., IGTs). Beginning in FY2007, the state may only access federal funds in the SNCP if the source of the state share has received prior approval from CMS. Certified Public Expenditures (CPEs) are one mechanism that is allowed, as will be other eligible state health spending that is not currently federally matched. Payment mechanisms must also be approved by CMS.

¹² Certified Public Expenditures means spending by State and local units of government, including governmentally operated health providers.

- Starting in FY2007, the expanded federal match for services provided in Institutions for Mental Disease (IMDs) for individuals between the ages of 21-64 will be phased out over two years. IMD payments can be made under the SNCP program and thereby may qualify for FFP, but will count against the overall cap. IMD payments for MCO enrollees may be able to be made via actuarially sound managed care capitation rates.

These changes effectively end the use of the existing IGT mechanism to obtain federal funding for unreimbursed Medicaid costs and care for the uninsured. They signal a return to a more traditional Medicaid funding process, in which 50% of state expenditures are matched by federal funds, reducing the net cost to the state by half. They will permit a transition to a new mechanism called “Certified Public Expenditures” if the waiver terms and conditions are interpreted favorably.¹³

The waiver continues to operate under a budget neutrality provision, enforced over the life of the demonstration. However, the new agreement also reduces the annual growth factors used to calculate the aggregate spending limit, from a 7.71% annual growth factor for families down to 7.3% and from a 10% annual growth factor for the disabled down to 7%. This will make it more difficult for the State to meet the requirement of budget neutrality in the future, and may require limits on state spending (for example, enrollment caps) on populations or programs that are otherwise allowed by the waiver, or other actions to reduce spending, such as reductions in rates of payment to providers.

8. Who is most affected by these changes?

Because of the significant level of federal dollars that are affected by the new provisions, the sizeable enrollment levels and broad service areas of the public MCOs, and the fact that the Safety Net Care Pool will incorporate all of the DSH funds that currently flow through the Uncompensated Care Pool, the impact of these changes is potentially very broad:

- State and local governments: To retain the federal dollars currently being leveraged through IGTs, the state and local governments will need to either identify current spending that is eligible for federal matching dollars but not being claimed or commit to new state or local spending. If the state is able to identify sufficient funding (as much as \$632 million) in current spending not being matched, it may be able to retain the current level of total funding at no net cost. If not, maintaining the current level of support in the system will require up to \$316 million in net new state or local spending, or new assessments on provider “classes” such as Medicaid managed care organizations. A

¹³ The waiver terms and conditions indicate that federal Medicaid matching funds will be authorized only when State or local tax dollars have been expended. This would prohibit publicly operated health entities – such as Cambridge Health Alliance – from using rate revenues as a source of IGT. It appears that this language is more restrictive than statute and regulations require, and discussions concerning how this provision will be administered are continuing.

combination of all three approaches may be needed to retain the FY2005 levels of federal revenue support.

- **Safety net providers:** There is a significant potential impact on safety net providers and the public MCOs. Boston Medical Center and Cambridge Health Alliance both provide a high level of public and free care and are heavily dependent on public payers for their revenue (see Chart 5). The public MCOs that they operate will receive as much as \$385 million in FY2005 financial support through the MCO supplemental payment mechanism, much of which is retained in the system and which constitutes a significant part of the hospitals’ operating budgets. Since their revenues could be substantially reduced, the financial position of the MCOs could also be adversely affected. They are significant providers of managed care services to the MassHealth population. Together, the two MCOs enroll about 200,000 MassHealth members – about 20% of total MassHealth enrollment and 62% of MassHealth enrollment in managed care plans.

Chart 5: Percent of Free Care Costs and Gross Revenue Distribution at Safety Net Providers

	% Total Statewide Allowable Free Care Costs (Pool Fiscal Year 2003)	— Percent FY04 Gross Revenue — From	
		Public Payers and Free Care	From Free Care
Boston Medical Center	33%	72%	26%
Cambridge Health Alliance	20%	78%	31%
Next Highest Providers	6%		7%

Sources: DHCFP: UCP PFY03 Annual Report, FY04 Medicaid DSH Calculation

- **Providers that contract with BMCHP and Network Health:** because BMCHP and Network Health serve a large number of MassHealth members across the state, they have contracted with other hospitals, physicians and community health centers to serve their members locally. The payments made by the MCOs help support local providers’ participation in MassHealth. Because of the supplemental payments, the safety net MCOs are often able to offer rates of payment that are higher than those offered by the traditional MassHealth program. The loss of the supplemental payments and the ability to offer enhanced rates have implications for the finances and continued participation of a broad range of providers that serve MassHealth members enrolled with BMCHP and Network Health.
- **Essential Community Providers:** Part of the IGT funding was used to support the Essential Community Provider Trust Fund, which in FY2005 will offer \$31.5 million in grants to 31 facilities, primarily hospitals and community health centers across the Commonwealth.

- **The Uninsured and the Uncompensated Care Pool:** Currently, payment for some health care for the low income uninsured in Massachusetts is provided through the Uncompensated Care Pool (UCP). A significant portion of the current funding of the UCP is federal funding that is in question due to the waiver changes. In FY 2007, up to \$140 million in federal funding for free care that was generated through supplemental hospital and MCO payments using the IGT mechanism is at risk pending the clarification of the CPE language in the waiver. Some of these funds were paid to Boston Medical Center and Cambridge Health Alliance directly, reducing the amount due them from the Uncompensated Care Pool, and reducing the overall demand on the Pool.

The Safety Net Care Pool anticipates a new but undefined approach to financing care for the uninsured beginning July 1, 2006. The design of this program will be important for the entire health care consumer, advocacy and provider community. It will require authorizing legislation at the state level that will address issues of eligibility, coverage and funding. Because portions of any new program also require federal approval, the program will need to be developed in consultation and partnership with CMS.

9. What are the major policy questions and decisions that lie ahead?

- ***Can funds be identified to sustain the current level of funding?***

In all, the state will receive up to \$632 million in federal funds in FY05 that are at risk in the future as a result of changes in the waiver. After FY2006, federal funds will only be available in the form of matching funds for documented expenditures from approved sources. To maintain the current level of spending in the system, the state must identify \$632 million in new claims for federal matching dollars based on current spending or \$316 million in net new state spending, provider assessments, or some combination thereof.

Chart 6: Summary of Potential Changes in Revenue Due to New Waiver Provisions

	FY05	FY06	FY07 & FY08
Supplemental Payments to Public MCOs Operated by BMC/CHA (includes \$70M in lieu of UCP payments and \$31.5 M for ECTF)	\$ 385 M (estimated; depends on MCO enrollment)	No change	Must discontinue supplemental payments; may replace with CPE
IGTs from BMC, CHA and UMass Memorial	\$214 M	Must replace IGT; CPE for actual costs* is allowed	Must replace IGT; CPE for actual costs* is allowed
IMD payments for members age 21-64	\$32 M	No change	Phased out over two years
Total	\$632 M		

**from Medicare cost report*

Several issues will be key in determining how much federal funding will be retained:

- If the CPE language in the waiver is favorably interpreted, supplemental hospital payments using IGTs can continue in their current form for FY06 and under the Safety Net Care Pool in FY07.
- Federal flexibility in determining what elements of current State spending are eligible for federal Medicaid matching dollars will make a significant difference. Currently, the Children's Medical Security Program, Uncompensated Care Payments to Community Health Centers, Prescription Advantage, and DPH, DMH and some unreimbursed local spending are all potential candidates for new federal matching funds.
- There may be some additional potential for enhanced Medicaid rates within the federally mandated rate structure and limits.

There are also some other mechanisms that could be further explored, especially to fund new coverage for the uninsured:

- The concept of provider assessments can be reviewed. Although federal rules apply some limits to this mechanism, there are some promising areas which are as yet unexplored, such as assessments on Medicaid MCOs.

How viable any of the mechanisms continues to be depends in part on new developments at the federal level. The President's FY2006 budget contains many proposals to reduce Medicaid spending, including new controls on some of these mechanisms.

- ***What is the Commonwealth's policy on Boston Medical Center, Cambridge Health Alliance, and other safety net providers?***
 - ***What is their role in the health care system?***
 - ***What level of support is necessary to sustain them?***
 - ***What is the future role of MCOs?***

The entire Commonwealth has benefited by the infusion of federal funding support enabled under the previous waiver terms and conditions. The safety net systems have been the major vehicle for securing the supplemental federal funding. The safety net hospitals have been a primary source of expanded coverage for the uninsured. Their patient populations, the providers participating in their contracted MCO networks, Medicaid enrollees in their MCOs, and uninsured patients statewide have all benefited from the current federal waiver and its funding support. The safety net hospitals, along with other hospitals and community health centers, have developed programs and competencies in caring for the diverse low-income and uninsured populations, with culturally and linguistically responsive services.

At the same time, the safety net hospitals have been a major, although not the only, beneficiary of the current system. It has given them a significant source of funds with few constraints on growth or internal use of the dollars.¹⁴ Any significant restriction of funds will raise the question of what Massachusetts wants and needs from safety net providers and how they should be supported to carry out the role that society desires. The proposal by Governor Romney that at least some of the uninsured should be covered by an insurance product proposes a fundamental shift in state policy about the concept of care for the uninsured. To the extent that there is a real reduction in the number of low-income people without insurance, will patterns of care and spending change? In the absence of universal coverage, no insurance program is likely to cover everyone. Will the state continue to fund a safety net? If there is no residual safety net system or Uncompensated Care Pool, significant costs are likely to be shifted to providers and patients and access barriers could emerge. How should financing be redesigned to reflect new realities but maintain access to care?

The MCOs affiliated with the safety net providers offer coverage and care management to a significant portion of the MassHealth population across the state. Should they also become care managers for the low income uninsured? Their continued participation in the MassHealth program will require adequate and appropriate premiums in the absence of federal supplemental payments. How should these rates be determined and funded? How can adequate rates be established for the low-income uninsured?

▪ ***What are the implications of the funding and policy changes for other hospitals and community health centers?***

Because a significant portion of the federal funds that the safety net provider MCOs received were paid out as enhanced rates to contracted providers in their broad service areas, because \$140 million in supplemental federal funds are used to cover Uncompensated Care Pool costs, because IGT funds help finance the Essential Community Provider Trust Fund, and because of the significant changes in the financing of care for the low-income uninsured that may be contemplated in the new provisions, many hospitals and community health centers will be affected by the changes in the waiver.

The enhanced Medicaid rates paid to providers by the MCOs provided additional dollars that relieved pressure on a Medicaid reimbursement system that is believed by many to have significant shortcomings. However, they also raised some serious concerns. Competing non-public MCOs believed that the enhanced rates created an unfair competitive advantage for BMCHP and Network Health. And the distribution of these funds was based on private business decisions by the MCOs rather than a transparent public resource distribution based

¹⁴ Each year the flow of supplemental funds has been negotiated with EOHHS and authorized by State legislation

on public policy goals or need. The state now faces a decision on whether and how to reflect these past payments in MCO premiums, given the requirement that MCO rates must be actuarially sound. As an alternative, the state could allocate additional dollars throughout the system on some other basis.

The creation of the Safety Net Care Pool, which incorporates both the former IGT-funded MCO supplemental payments and DSH payments, raises the possibility of a dramatic revision in the way that uncompensated care is financed in Massachusetts. While some may believe that the current method of reimbursing hospitals and community health centers is not the most efficient or effective way to fund care for the uninsured, the current system is carefully balanced to take into account a wide variety of views and needs. The negotiation of a new insurance-like system will need to address many of the same issues, as well as address the continuing need to finance care for those who fall inside and outside of the insurance model.

- ***What principles and process should be used to design a new system to cover the uninsured?***

The changes in the waiver are taking place in the context of discussion of the growing number of uninsured and a variety of proposals to expand insurance coverage. Options include further expansion of current public programs, limiting benefit packages for at least some MassHealth members, and making commercial coverage more affordable and/or more limited. The discussion is happening on both a local and national level. The complexity and volatility of the uninsured population is a challenge, as are the fundamental questions of the obligation of society to the individual and the individual to society.

How the new system is designed will have a significant impact on the current delivery system. One major decision will be how a new system for the uninsured will be oriented. One option is to focus on financing providers by designating a group of safety net providers and providing sufficient financial support to support their mission. Another is to focus on the uninsured individual – that is, to pay for services provided to an eligible uninsured person, regardless of whether or not the provider is a designated safety net provider. An insurance-type program would have the money follow the individual more explicitly, and could result in significantly different patterns of care and spending. Another approach would meld the two approaches above, by establishing an insurance product for the uninsured that includes safety net providers in the delivery system and/or including the Medicaid MCOs as the platform for administering the uninsured product through their contracted provider networks.

Some argue that a focus on funding safety net providers ensures that there is a guaranteed point of access, that it supports the development of special resources and competencies to

adequately serve the low-income uninsured, and that it recognizes the preference of the low-income uninsured to be served at a facility that welcomes them and acknowledges their needs. Others argue that designating and funding only some institutions for this role limits geographic access, creates a two-tiered system, and eliminates the normal pressures to manage cost and quality that apply when multiple providers operate on a level playing field and compete to provide services. The ultimate question, from a public policy point of view, is which approach will use resources most efficiently and allow more people to have coverage and access to good quality care.

There are a number of associated questions relating to how provider networks should be established for the new Safety Net Care Pool program, whether they are funded directly as safety net providers, or indirectly through an insurance mechanism. Should the network be managed directly by the state as a fee for service network, a single statewide administrator procured by the state, or via the current MCOs and other MCOs who could administer and manage the care for the uninsured in a new product line? Alternatively, should the network be a dedicated provider network (i.e., closed or selective) managed by a health plan or administrator? Should the network carry financial risk (e.g., be paid on a premium or capitation basis) or should the state carry all of the financial risk? These are complex questions worthy of public debate, whose answers depend on a mixture of economic theory, public policy, system capabilities, public opinion, and politics.

The MassHealth waiver has been an innovative and successful public policy tool for Massachusetts over the past eight years, but critical issues lie ahead. Their successful resolution will require participation and leadership. There is a significant and growing part of the Massachusetts population whose health and well-being are dependent on the quality of our decisions, and their interests must be represented in the policy conversations now beginning. Because a fairly small group negotiated the waiver and its terms are very technical, an important starting point is to educate stakeholders in the broader community about the terms and their implications. This Issue Brief is offered as a start to that process.

Massachusetts Medicaid Policy Institute

The Massachusetts Medicaid Policy Institute (MMPI) is an independent and nonpartisan source for information and analysis about the Massachusetts Medicaid program (often referred to as “MassHealth”). MMPI seeks to promote broader understanding of the MassHealth program and a more rigorous and thoughtful public discussion of the program’s successes and the challenges ahead.

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