

The Role of MassHealth “Budget Neutrality” Requirements in Designing Policies to Expand Health Coverage

Issue Brief
January 2006

The feasibility of certain aspects of the various health care reform proposals currently being considered in Massachusetts is heavily dependent on the availability of federal dollars. Determining how much federal funding will be available is an essential part of deciding how many additional persons the state can cover under the MassHealth program and how much MassHealth provider payment rates can grow.

Massachusetts operates a large part of its Medicaid program — MassHealth — under a special waiver of normal federal Medicaid rules. The Commonwealth’s Section 1115 demonstration project¹ was initiated in 1997 for a five-year term, extended in 2002 for three years, and renewed in 2005 for a three-year period (Fiscal Years 2006-2008). The waiver offers Massachusetts flexibility in how the MassHealth program is managed. It allows coverage of certain populations, such as childless adults without disability, which could not be covered under normal Medicaid rules, and provides that the federal government will share the cost of covering them. (Massachusetts usually receives 50 cents from the federal government for every Medicaid dollar it spends.) The programmatic flexibility and increased funding are significant advantages for the state, and they are linked in an important way.

In contrast to traditional Medicaid spending, operating MassHealth under a waiver imposes a limit on the total federal dollars available for the population and services covered by the waiver. This limit is the “budget neutrality ceiling.”² In assessing the health care reform proposals, the state must project what the budget neutrality ceiling will be through FY2008 (the end of the current waiver) and how spending will compare to the ceiling under various scenarios. The calculation is complex and dynamic, requiring the projection of spending and

¹ Section 1115 of the Social Security Act

² The term refers to the federal requirement that any deviations of the waiver program from traditional Medicaid must be “budget neutral” to the federal government; that is, it must not increase federal Medicaid costs beyond what they would be absent the waiver.

trends over a five-year period (Fiscal Years 2004 through 2008),³ and is periodically revised based on new information. The estimates rely on some key assumptions, reasonable alternatives to which can substantially alter the projections.

The Executive Office of Health and Human Services (EOHHS) estimates that, at the end of the next three years of running MassHealth, Massachusetts will have used much of the available federal funds under the budget neutrality ceiling, thus constraining future programmatic flexibility such as extending the program to more people or increasing payments to providers. (State dollars, and not just budget neutrality headroom, are also needed to expand the program or increase provider payments.) Recent revisions to and further review of certain elements of the Administration's analysis suggest there may be somewhat more room than the current official estimate. There could also be less room, depending on the outcome of negotiations between state and federal Medicaid officials. Additionally, some projected spending that is already part of the budget neutrality calculation offers some further flexibility. This issue brief reviews how the level of potential available federal funding is established, the range of the projected budget neutrality cushion, and the options available to maximize and spend federal dollars available for coverage of the uninsured.

What is the “Budget Neutrality Ceiling”?

Many states have Section 1115 demonstration waivers and most have a budget neutrality ceiling. The ceiling is the maximum spending a state may undertake in a waiver program and still receive federal reimbursement. A waiver will only be approved by the U.S. Secretary of Health and Human Services if the projected federal spending anticipated under the proposed waiver program is no more than the projected costs to the federal government of the state's program under standard Medicaid rules.⁴ In Massachusetts, this limit is calculated on a per capita basis and applied to the entire waiver-based program. Within this limit, the Safety Net Care Pool, a new feature of the renewed Massachusetts demonstration project, also has an absolute dollar cap. Evaluating the cost and savings of waivers compared to traditional Medicaid is a difficult task, particularly over time, because it requires a number of assumptions about what costs would have been without the waiver and about future spending under the waiver. The rules applied to a budget neutrality evaluation are somewhat subjective and are at the discretion of the federal oversight agency, the Centers for Medicare

³ Accounting is not yet complete for actual spending for the two most recently completed fiscal years, so estimates are still required. While these five years are the focus of the current analysis, the budget neutrality evaluation is done for the entire 11-year life of the waiver.

⁴ If actual spending does exceed the budget neutrality ceiling at any time during the operation of a waiver program, the state will not receive federal matching funds for the spending above the cap and must finance this spending with state dollars only, or reduce its spending on the waiver program to below the ceiling.

and Medicaid Services (CMS), with significant input from the federal Office of Management and Budget. The rules may change with each waiver extension or renewal. During the term of a waiver, CMS also requires the State to update its budget neutrality calculations annually and when it amends the waiver.

The Massachusetts budget neutrality agreement, like most others, recognizes that traditional Medicaid enrollment may increase over time. The agreement is therefore structured so that added *costs due to enrollment growth* in traditional populations (poor children and pregnant women, for example) are *not counted* against the budget neutrality ceiling. *Growth in the per capita cost* of these enrollees above the projected trend rate, on the other hand, as well as *growth in the costs from increased enrollment of expansion populations* not eligible under traditional rules (such as childless adults), *are counted*.

The latest figures provided by EOHHS suggest that as of June 2005, Massachusetts had underspent the total budget neutrality ceiling by an estimated \$1.446 billion, in combined state and federal funds, since the waiver program began in 1997.⁵ This figure can be interpreted as the amount of state and federal spending that has been saved by the waiver during its eight years of operation compared with what spending would have been in a traditional Medicaid program.

How Much Can the State Expand MassHealth Spending and Still Receive Federal Matching Funds?

This is a substantial savings. Moving forward over the next three years, what will happen to this cushion? EOHHS's last official estimate was that the cushion has been shrinking since FY2003 and, by the end of this waiver extension period in June 2008, the Commonwealth will have spent more than \$1 billion of the accrued savings, leaving about \$338 million. EOHHS's projections assume no expansions in MassHealth eligibility beyond the current levels. Recent revisions to the estimates and reconsideration of some underlying assumptions suggest that additional cushion in the range of \$350-400 million may be available, for a total of \$700-750 million. These numbers, however, might be adjusted downward by a pending CMS policy decision on how to treat a \$322 million adjustment related to the introduction of the Medicare drug benefit that is now included in the EOHHS budget neutrality projection.⁶

⁵ Based on materials provided by state administrators dated September 30, 2005. This document represents the official State position on budget neutrality as of this writing, and provides most of the detail explained in this paper. As noted earlier, the budget neutrality calculation is dynamic and periodically revised.

⁶ This is the amount that MassHealth estimates it will no longer have to spend to cover prescription drugs for MassHealth members covered under the waiver who are also enrolled in Medicare and are therefore eligible for the new Medicare drug coverage. EOHHS's budget neutrality estimate currently counts the savings from the Medicare drug benefit as an offset to projecting spending, thereby increasing the budget neutrality cushion.

These evolving estimates and the range of plausible amounts indicate the dynamic nature of the budget neutrality enterprise. Certain things are clear. One reason the cushion is shrinking is that the waiver renewal allows less growth than before in per capita spending on traditional populations, effectively lowering the budget neutrality ceiling:⁷

- Per capita cost growth for MassHealth members with disabilities is limited to 7 percent per year (vs. 10% in the last extension, and 5.83% in the original waiver agreement).
- Per capita cost growth for families is limited to 7.3 percent per year (vs. 7.71% in the prior agreement).

Though these growth rates are part of the agreed-upon terms of the new waiver, the Administration is considering reopening this issue with CMS, in light of the fact that other states may recently have been granted more generous trends in their waiver agreements.⁸

Beyond this point, the budget neutrality estimate depends on assumptions about spending in the future and on actual spending in the recent past. It is the net result of a number of projected trends and policy decisions proposed or already implemented. Some *increase* the room under the ceiling:

- the EOHHS's estimate that actual per member spending will grow more slowly than the trend allowed in the waiver agreement;
- the EOHHS's projection that the new federal Medicare prescription drug benefit will raise the budget neutrality ceiling. As mentioned earlier, this piece of the calculation is uncertain.

Others work to *decrease* the room under the ceiling:

- increased Medicaid Managed Care supplemental payments in FY2005 and FY2006 made to maximize the future funds available in the Safety Net Care Pool (SNCP) created under the waiver renewal;
- supplemental Medicaid rate payments to hospitals made to maximize the funding available for the SNCP and to continue payments formerly funded by intergovernmental transfers (IGTs) that must be discontinued under the new waiver extension. (IGTs may also be replaced by Certified Public Expenditures from other non-State sources.)

In total, using the EOHHS's assumptions and recent actual spending, these changes reduce the overall savings from the waiver to \$338 million at the end of the next three years. More recent reevaluation of some of the underlying assumptions, and updates to and revisions of actual past spending trends — a routine, ongoing administrative task of the Medicaid

⁷ Terms and Conditions, Attachment B, item 5.

⁸ Vermont, for example, has a trend rate of 9 percent, but it is a global cap based on total expenditures not per capita costs, so it is not directly comparable to the Massachusetts arrangement.

program — indicate that there may be more cushion — in the range of \$700-750 million — under budget neutrality. Again, this total may be reduced if CMS denies the State’s argument that the advent of the Medicare drug benefit effectively raises the ceiling. And because of the dynamic nature of the process, these numbers are subject to ongoing revision as time passes and “projected” figures become “actual.”

Can Any Spending Already Counted Against the Budget Neutrality Ceiling be Redirected?

The availability of room under the budget neutrality ceiling allows some limited flexibility to expand programs and/or increase provider payment rates and obtain federal matching funds, provided state funds are committed to draw the federal match. Even within tight constraints, however, projected expenditures that are currently counted against the ceiling in the EOHHS budget neutrality calculation but are not yet formally committed to be spent in specific ways offer some additional flexibility to policy makers.

The Safety Net Care Pool (SNCP) is the primary example. Under the new waiver, the state will have up to \$1.3 billion (state and federal share) in FY2007 and FY2008 to spend, according to the waiver terms and conditions, “for expenditures made for the provision of health care services to uninsured individuals and unreimbursed Medicaid costs, through any type of provider or through insurance products.”⁹ CMS has subsequently stated — in a September 29, 2005 letter to EOHHS Secretary Timothy Murphy — that, in order to gain federal approval, the SNCP should focus on lowering the rate of uninsured. In complying with this instruction, various approaches are possible, either alone or in combination. More affordable private insurance through combining a purchasing pool with income-based subsidies is one option. An expansion of MassHealth eligibility is another. Because the SNCP has an absolute cap, though, which is already figured into budget neutrality estimates, any decision to use funds for one purpose is an implicit decision not to use them for something else, such as provider rate increases or supplemental payments to Medicaid MCOs or other providers.

Coverage Expansion Strategies Outside the Waiver

Beyond these options, certain strategies may be possible in the parts of the Medicaid program outside of the waiver, which would allow expansions of coverage. One option is to focus on coverage expansions that do not affect the waiver and thus budget neutrality. A State Children’s Health Insurance Program (SCHIP) expansion to cover additional children,

⁹ MassHealth Special Terms and Conditions, Attachment B, “Monitoring Budget Neutrality for the MassHealth Demonstration.”

for example, is possible as long as federal SCHIP funds, which are not part of the Medicaid budget neutrality calculation, are available.¹⁰

Certain types of Medicaid coverage expansions could also be proposed. The state has the authority¹¹ to expand Medicaid to traditional coverage groups with higher incomes than are now eligible. The budget neutrality calculation accounts for the cost of these traditional populations, but only penalizes the state for growth in the per capita cost above the established trend rates (7.0% and 7.3%, described above). Enrollment increases in these groups do not harm budget neutrality.¹² The Commonwealth might argue that, because such a policy change could be made without a waiver, expansion of eligibility for these traditional groups should be treated in the same way and not be counted against budget neutrality. It is not clear if CMS would support this view, but the Commonwealth would have a strong case to argue the point, according to several experts consulted by MMPI.

Expanding coverage in this way would increase Medicaid spending as populations become eligible for or shift into more comprehensive benefit packages, as well as become eligible for the emergency care available under the MassHealth Limited program. In both of these cases, therefore, new state funds would be needed in order to receive the federal match.

¹⁰ The Commonwealth's federal SCHIP allotment is used up, though the federal budget reconciliation bill currently pending in Congress appropriates \$283 million for states with SCHIP shortfalls in FY2006, so some additional funds may be forthcoming to the Commonwealth. It may also be possible to free up SCHIP dollars by expanding Medicaid coverage for children up to 200% of FPL (many of whom are now covered by SCHIP funds), which would not use up budget neutrality surplus. These SCHIP funds could then be used to expand SCHIP to cover children above 200% of FPL.

¹¹ Section 1902(r)(2) of the Social Security Act allows states to disregard some or all of an individual's income in determining Medicaid eligibility, thus making it possible to increase the number of eligible people without changing the income eligibility standard. (Kaiser Commission on Medicaid and the Uninsured, *The Medicaid Resource Book*, July 2002.)

¹² Enrollment increases for this group could even increase the room under the cap, if per capita costs grow more slowly than the allowed trend.

Conclusion

Expanding health insurance coverage to those in Massachusetts who lack it has become a priority for policy makers in the state. The goal is ambitious, and various strategies to increase coverage are being explored. The use of one important policy lever — extending MassHealth eligibility to more people — may be constrained by the budget neutrality requirement of the federal waiver under which the program operates. Though the requirement is simple to understand in the abstract — a program operated under a waiver must cost the federal government no more than the program would cost without the waiver — the methods for quantifying that requirement and measuring whether it has been fulfilled are, to most interested observers, exceedingly complex and opaque. There is not one “right” answer, and reasonable interpretations vary. These interpretations should be debated openly, so that decision makers clearly understand the constraints on program design. In addition, alternative approaches to covering the uninsured are not equivalent with regard to the budget neutrality ceiling. Expanding coverage using public programs may not count against the ceiling, it might reduce the room under the ceiling, or it might even increase it. Both within and outside of the budget neutrality thicket, then, it appears that some scenarios would enable MassHealth expansions to play an important part in reducing the ranks of the uninsured.

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.

Additional copies of this Issue Brief may be obtained from the Massachusetts Medicaid Policy Institute website at www.massmedicaid.org.

Copyright © 2006 Massachusetts Medicaid Policy Institute.