The Outlook for Medicaid in Massachusetts

March 2007

A Report from the Massachusetts Medicaid Policy Institute

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Acknowledgements

The authors would like to thank the following people for taking the time to share their insights, provide data, and review and comment on drafts:

Stephanie Anthony, Jennifer Davis Carey, Elizabeth Childs, Diane Flanders, Gerry Morrissey, Tim Murphy, Phyllis Peters, Tricia Spellman, Perry Trilling, Beth Waldman, and Brian Wheelan from the Executive Office of Health and Human Services;

Emily Sherwood and Christine Barber from the Joint Committee on Health Care Financing;

Charlotte Yeh, Richard McGreal, and Irv Rich from the Centers for Medicare and Medicaid Services;

Elisabeth Babcock, Bruce Bullen, Matt Fishman, Josh Greenberg, Phil Johnston, Katharine London, John McDonough, Bob Master, Kate Willrich Nordahl, Brian Rosman, and Nancy Turnbull.

This paper is based on a series of interviews with experts and policy-makers inside and outside of the government who have a broad perspective on the challenges and opportunities that will face the new administration. In addition, MMPI asked several seasoned observers of Medicaid policy and programs to add their own personal perspective on various aspects of the program and the environment. Their comments appear in summary form throughout the document.

About the Massachusetts Medicaid Policy Institute

The Massachusetts Medicaid Policy Institute is an independent and nonpartisan source for information and analysis about the Massachusetts Medicaid program ("MassHealth"). MMPI seeks broader understanding of MassHealth and public discussion of the program's successes and challenges ahead.

Executive Summary

Introduction: What is MassHealth Today?

Massachusetts Medicaid — MassHealth — is a vital source of health insurance coverage for over 1 million residents, nearly half of them children.

- Insurance coverage is an important gateway to health care and better health; if not for the access that MassHealth provides, Massachusetts would not be among the states with the lowest levels of uninsured.
- Over three-fifths of MassHealth members are children and families, one-fifth are eligible because of disabilities, 11 percent are elderly, and 6 percent are poor adults who have been unemployed for more than a year.
- Over the past decade, MassHealth members have come to include many low-income workers (and their families) who are not able to get coverage through their employers, or who need MassHealth to subsidize or supplement other coverage; many of these people would not be able to continue working were it not for MassHealth.

Funding

The bulk of MassHealth funding comes through appropriations from the General Fund, with additional funds from designated trust funds, cities and towns, and assessments. The State claims federal reimbursement of at least 50 percent for all MassHealth spending, which replenishes the General Fund. The Commonwealth derives substantial benefit from its expansive use of the Medicaid program, using federal funds to provide care to residents who would otherwise be medically indigent, benefiting not only enrollees but providers, employers and the Massachusetts economy.

Health Reform

Medicaid is central to the structure of health care reform and critical to its success.

- Expanded Medicaid eligibility and enrollment will cover a large percentage of the lowest income uninsured.
- Reallocation of Medicaid dollars currently in the system is the primary source of private insurance premium subsidies.
- MassHealth and the Commonwealth Health Insurance Connector Authority are programmatically and administratively intertwined.
- The entire reform framework, as well as significant federal financing needed for health care reform, depends on the continuation of the MassHealth waiver, which expires in June 2008.

Looking Forward: Issues, Opportunities and Challenges

There are opportunities to use Medicaid to reduce the number of uninsured and help drive better care for the whole health system. Four important issues facing MassHealth encapsulate some of the opportunities and their attendant challenges.

Renew the MassHealth Waiver

Since July 1997, all Medicaid enrolled children and adults under age 65 have been provided health services under the Massachusetts Medicaid Demonstration Project, known as the MassHealth waiver. The terms and conditions of the waiver were recently renegotiated to extend it for an additional three years. This waiver sets the framework for the Massachusetts health reform legislation, and the legislation in turn implemented the terms of the waiver. The MassHealth waiver expires in June 2008, and the renewal application must be filed as early as July 2007.

To renew the waiver with terms that will allow the State to operate the current MassHealth program, including Commonwealth Care, beyond June 2008, the State must show significant progress in reaching the current waiver's policy objectives — reducing the number of uninsured and redirecting uncompensated care funds to finance coverage — while maintaining "budget neutrality." State negotiators also face a challenge to secure a favorable level of continuing federal financial support. While progress to date has been excellent, documenting success and negotiating favorable waiver terms will be a technical and political challenge.

Improve the Value of MassHealth Purchasing

Because of its central role, MassHealth requires a large share of public resources, and it competes with other priorities in the state budget process. Successful management of MassHealth depends on increasing the value of the services Medicaid purchases and provides. This can be done through innovation, the efficient management and coordination of care for high-cost populations, and the elimination of error and waste.

Total spending on Medicaid services in Massachusetts increased 30 percent between fiscal years 2002 and 2006, compared with a 45 percent increase in premiums for employer-sponsored coverage. Increases have been primarily driven by increases in spending per member, with both total spending and spending increases concentrated in a few categories.

MassHealth faces a challenge in managing its spending trends. It is essential to the future of the MassHealth waiver and to the vitality of the program overall. Conventional strategies to reduce spending — eligibility, caseload or service cuts — are counterproductive and ineffective because they simply shift costs of needed services to more expensive settings, such as emergency departments. Programmatically, tools and strategies more subtle and targeted than cutting benefits and caseloads are available to help MassHealth purchase services more effectively. Strategies include coordinated care management; strong public health programs; aligning payment and quality; using data to find opportunities to improve value; and using cost-effective, appropriate, high-performing networks. One vehicle by which these strategies may be implemented is the reprocurement of the MassHealth managed care contracts, which affect care for over 360,000 members.

Rebalance Long-Term Care

The Massachusetts "Equal Choice" law and Community First initiative, the federal Deficit Reduction Act, and the preferences of seniors and people with disabilities create an environment for altering the balance between institutional and community-based long-term care. Elements of such a rebalancing include establishing a new federal waiver for community-based services, developing models to provide services more cost-effectively, coordinating Medicare and Medicaid funding streams, and addressing workforce issues. Improvements in long-term care can forestall institutionalization, increase patient satisfaction and provide lower cost options for many.

Provide Strong Leadership and Bolster Staff

MassHealth is a complex program with a very small administrative budget. A reorganization of EOHHS has had some positive results but has also weakened the Office of Medicaid's control over its resources and priorities. The current structure requires effective matrix management processes and a well-defined and supported role for the Office of Medicaid. Strong leadership to meet both Medicaid program and waiver requirements must come from the Medicaid Director.

The proliferation of programs has made operations difficult. The health care reform process has put new demands on the staff. Pressures are intense, as is oversight. Most systems are antiquated. Turnover and understaffing are significant barriers to achieving the challenging goals of the program. It will be important to retain experienced staff and to provide competitive salaries to attract new staff, as well as to create a culture that supports and embraces the complex matrix structure that has been adopted.

Conclusion: Medicaid in Context

Medicaid is the program that delivers on the State's commitment to provide equal access to health care. It is the program to which policymakers have turned to meet basic health needs, address special populations, and sponsor innovation and creativity in program design and purchasing. Medicaid is the most cost-effective way to provide health care services for many populations. It has low administrative costs, demonstrated effectiveness in purchasing, and unequaled success in reaching and enrolling those in need.

Massachusetts has set a goal of replacing costly and inefficient episodic use of hospital care by the uninsured with a comprehensive system of health care coverage, subsidized for the low income population. Medicaid is a large part of this vision, and intelligent use of its potential offers the best opportunity for the State to achieve it.

The Outlook for Medicaid in Massachusetts

What is MassHealth Today?

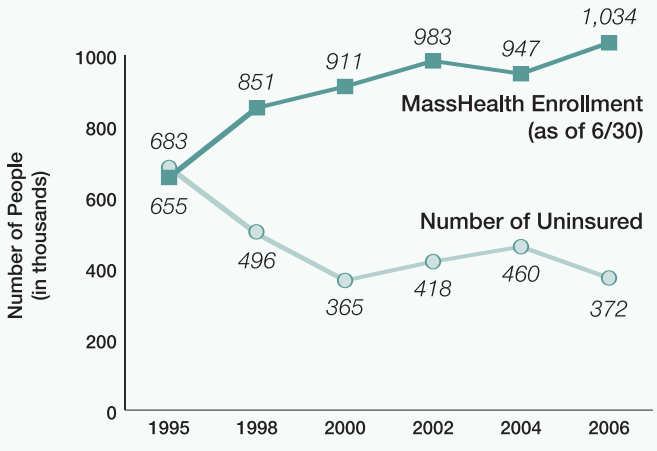
The Medicaid program in Massachusetts is the foundation of our drive to achieve universal access to health care. It marshals resources from society to realize the strongly held belief among people in Massachusetts that people who need medical care should get it, regardless of their economic circumstances.[1]

Always important for low-income women and children, the disabled, and the elderly, it has moved over the past ten years to expand its scope far beyond those groups. It now provides health care coverage and support to over a million residents of Massachusetts — from the neediest and most vulnerable, to low-income workers and employers struggling to afford private coverage, to middle income families committed to caring for severely disabled children at home, to disabled workers who want to remain in the workforce, to seniors with increasing physical limitations who want to remain in the community. Through the flexibility it gains from a federal waiver of usual program requirements, Massachusetts Medicaid — MassHealth — has reallocated money to make coverage available to most of the uninsured.

The Commonwealth derives substantial benefit from its expansive use of the Medicaid program, using federal funds to provide care to residents who would otherwise be medically indigent, benefiting not only enrollees, but providers, employers and the Massachusetts economy.

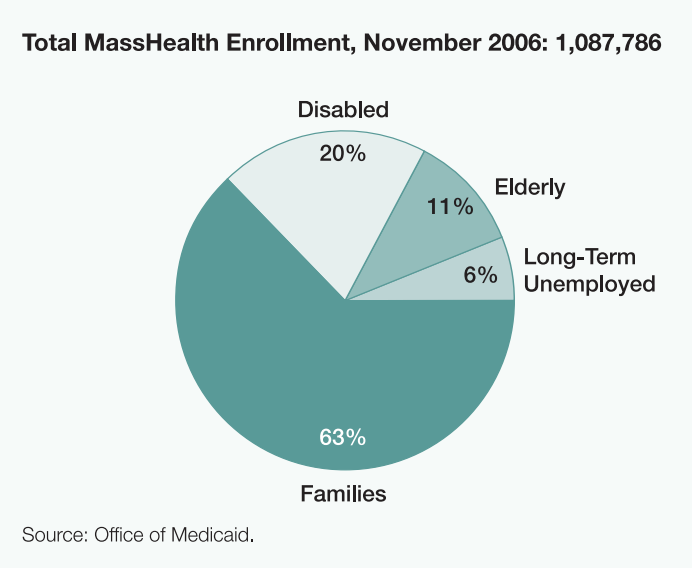
Enrollment

Insurance coverage is an important gateway to health care and better health; if not for the access that MassHealth provides, Massachusetts would not be among the states with the lowest levels of uninsured. The following chart, which illustrates the trends in Medicaid enrollment and numbers of people without insurance, shows that relationship clearly.



Sources: Office of Medicaid; DHCFP.

[1] In a 2003 survey of Massachusetts residents, 76 percent believed that "people who are unemployed and poor should be able to get the same amount and quality of medical services as people who have good jobs and are paying substantial taxes." Robert J. Blendon et al., "The Uninsured in Massachusetts: An Opportunity for Leadership." Blue Cross Blue Shield of Massachusetts Foundation, October 2003.



Source: Office of Medicaid.

As of November 30, 2006, MassHealth covers about one out of every six Massachusetts residents, a total of 1,088,000 people. The program covers 462,000 children and 626,000 adults. There are 118,000 elderly members, 65,000 adults who have been unemployed for more than a year, and 217,000 people who are eligible and enrolled because of disabilities, including 23,000 children.[2]

How MassHealth is Funded

The bulk of MassHealth funding comes through appropriations from the General Fund, but there are a number of other sources as well. Two new trust funds were created in the health reform law, which support supplemental payments to providers and health plans and fund the public subsidies in the Commonwealth Care program. Some funding comes from cities and towns, from tax revenue and from spending by public hospitals. A number of provider assessments or user fees also help fund specific program expenditures. The state claims federal reimbursement of at least 50 percent for all MassHealth spending, which replenishes the general fund.

Appendix A contains a simplified diagram of MassHealth funds flows.

Medicaid and Health Care Reform

Medicaid is central to the structure of health care reform and critical to its success. Expanded Medicaid eligibility and enrollment will cover a large percentage of the lowest income uninsured. Further, the entire reform framework, as well as significant federal financing needed for health care reform, depends on the continuation of the MassHealth waiver, which expires in June 2008.

The Commonwealth Health Insurance Connector Authority (Connector), an independent authority that administers Commonwealth Care, is intertwined with MassHealth in two significant ways. First, Commonwealth Care was created in direct response to requirements of the MassHealth waiver, and the insurance premium subsidies that are the centerpiece of the program are funded through the waiver. Second, the two programs are administratively tied: the Connector uses MassHealth systems for Commonwealth Care applications and enrollment, and coordination of

[2] Under the Commonwealth Care programs being implemented as part of Chapter 58, an additional 150,000 to 212,000 individuals will be eligible for full or partial subsidies of private health insurance premiums paid for by re-allocated Medicaid funds.

Commentary by Judith Solomon

FEDERAL ACTIVITY IN 2007 WILL HAVE AN IMPACT ON THE MEDICAID PROGRAM IN MASSACHUSETTS……

1. *The State Children's Health Insurance Program (SCHIP) must be reauthorized by Congress in 2007.* In addition, Congress will likely again take up SCHIP funding for federal fiscal year 2007. Massachusetts is one of 17 states facing a funding shortfall in its SCHIP program in FY 2007. Before adjourning, Congress passed legislation that provides some help to Massachusetts by providing additional funds for FY 2007, but the state will still face a shortfall by February 2007 without further action by Congress. Beginning in FY 2008, Massachusetts faces a large shortfall of funds in its SCHIP program, which will grow larger each year without Congressional action to increase SCHIP funding levels. The estimated shortfall for FY 2008 is $161 million, and the funding gap will grow to $248 million by FY 2012. Congressional action to fund the SCHIP program will be complicated by reinstatement of the "pay-as-you-go" rules by the new Congress, which will require offsetting savings or revenue for any new funding for SCHIP. Congress can waive application of the rule, but it would take 60 votes in the Senate and agreement by the House.
2. *The Bush Administration is likely to issue regulations that will have a fiscal impact on state Medicaid programs.* The 2007 and 2008 Bush Administration budgets included a number of changes to Medicaid that the Administration plans to make through regulations rather than changes to the Medicaid statute. A proposed rule that would limit reimbursement for public providers to their costs and limit funds available for the costs of providing services to uninsured patients was issued on January 18. Other regulations that may be issued over the coming months would limit reimbursement for health services provided in school settings and limit the scope of the rehabilitation option, which states use to fund a variety of services such as special instruction and therapy for Medicaid beneficiaries with mental illness or developmental disabilities.
3. *CMS is likely to issue regulations to implement the changes to targeted case management made in the Deficit Reduction Act.* The DRA changed how states can provide reimbursement for targeted case management. Targeted case management allows states to pay for the coordination of health care and other services for defined groups of Medicaid beneficiaries. Regulations to implement the DRA provision will likely be issued in early 2007. These regulations could have a fiscal impact on Massachusetts. According to a report by the Congressional Research Service, Massachusetts spent a total of $335.8 million on targeted case management in 2003, including services to people with mental retardation, severe mental illness, and HIV/AIDS, and children at risk of abuse and neglect
4. *The Tax Relief and Health Care Act of 2006 (TRHCA) reduced the maximum amount of provider taxes that can be used as state matching funds for Medicaid.* The TRHCA modified the maximum allowable level for health care provider taxes that may be applied in Medicaid from 6 percent to 5.5 percent for the period from January 1, 2008 to October 1, 2011. Massachusetts currently has a nursing home provider tax at 6 percent, so the reduction in the maximum allowable level of the tax may have an impact on the Massachusetts budget for state fiscal year 2008.
5. *A slowdown in the growth of state and federal Medicaid spending is likely to have an impact on the renegotiation of the Massachusetts Medicaid waiver.* The growth in state and federal Medicaid expenditures was low in 2006 compared to earlier years and the slowdown is likely to continue in 2007. This slowdown in the rate of growth is likely to be reflected in the trend rates that Massachusetts will negotiate with CMS for its waiver extension. A reduction in the trend rates that are used to compute the budget neutrality ceiling for Massachusetts waiver increases the likelihood that the state will reach its budget neutrality ceiling, forcing difficult choices such as increasing state expenditures, cutting provider rates or scaling back eligibility or benefits.

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the programs is necessary because the populations they serve overlap to a great degree. Many of the policy issues for the two programs — benefits, cost sharing and consumer outreach, for example — are similar. Also, until at least July 2009, Commonwealth Care is exclusively offered through the four managed care organizations currently under contract with MassHealth.[3] The Medicaid Director sits on the Connector Authority's board.

The Federal Environment

Federal funds account for more than half of total Medicaid expenditures. The federal Medicaid statute guarantees that states will receive open-ended matching payments if they meet certain minimum standards with respect to eligibility and covered services. In return for accepting federal funds, states must abide by the rules of the program. Importantly, the Secretary of the U.S. Department of Health and Human Services has broad discretion to waive requirements in federal Medicaid law.

The ability to operate a program pursuant to a waiver agreement with Health and Human Services has been attractive to many states, including Massachusetts. It also gives the federal government significant leverage in the design of state Medicaid programs, since the Secretary is under no obligation to approve a waiver request. Therefore, the operation of the Medicaid program at the state level is heavily influenced by the priorities of the existing federal administration and, to a lesser extent, the Congress.

A theme of the Bush administration's Medicaid strategy is to limit federal payments to the states, while offering the states greater flexibility with respect to eligibility and benefits within that limit. This begins to move the Medicaid program away from a "defined benefit" model (where the federal government contributes its share of the cost of a pre-defined set of benefits) to one where there is a defined contribution (where the federal government contributes a pre-defined and limited amount toward the cost of the program). The Bush administration is also interested in promoting greater use of cost-sharing requirements for beneficiaries in order to reduce expenditures. Waivers in a number of states, including Florida, Vermont, Utah and West Virginia incorporate various aspects of this orientation.

As discussed below, this orientation has played a significant role in shaping the current Medicaid waiver that undergirds Massachusetts's health reform initiative and is likely to play a significant role in coming waiver renewal negotiations.

[3] If the MassHealth program reprocures its contract prior to July 2009, this feature of parallel contracting could change if new MMCOs enter the MassHealth market or existing MMCOs no longer participate in MassHealth.

Looking Forward: Issues, Opportunities & Challenges

MassHealth today is a program that operates on two levels: it is a traditional Medicaid program that continues to serve a vulnerable, low income population through the purchase and management of health care services. It is also an innovative funding mechanism that is working to reallocate spending from support of safety net programs and providers to subsidies for private health insurance coverage.

There are opportunities to use Medicaid to reduce the number of uninsured and help drive better care for the whole health system. The following discussion presents four important issues facing MassHealth — renewing the MassHealth waiver, improving the value of MassHealth purchasing, rebalancing long-term care, and providing strong leadership and bolstering staff — and encapsulates some of the opportunities, and their attendant challenges.

Renew the MassHealth Waiver

The Issue

Since July 1997, all Medicaid enrolled children and adults under age 65 have been provided health services under the Massachusetts Medicaid Demonstration Project, known as the MassHealth waiver. The terms and conditions of the waiver were recently renegotiated to extend it for an additional three years.[4] This waiver sets the framework for the Massachusetts health reform legislation, and the legislation in turn implemented the terms of the waiver. The MassHealth waiver expires in June 2008, and the renewal application must be filed as early as July 2007.[5]

Background

To obtain a renewal of the waiver that will allow the state to operate the current MassHealth program, including Commonwealth Care, beyond June 2008, the State must show significant progress in reaching the current waiver's policy objectives and must secure a favorable level of continuing federal financial support. While progress to date has been excellent, documenting success and negotiating favorable waiver terms for the future will be a technical and political challenge.

The policy goals set forth in the waiver are (1) to reduce the number of uninsured by covering low income populations through Medicaid expansion and subsidized private market products, and (2) to redirect funds currently used for uncompensated care and safety net provider support to insuring the expansion populations. These goals must be achieved while maintaining "budget neutrality."

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[4] For a comprehensive statement of the MassHealth waiver requirements, see "CMS Special Terms and Conditions, amended July 1, 2006" for the "MassHealth Medicaid Section 1115 Demonstration, number 11-W-00030/1, awarded to Massachusetts Executive Office of Health and Human Services" and related correspondence between CMS Administrator Mark McClellan and EOHHS Secretary Murphy, dated July 26, 2006 and August 28, 2006.

[5] The waiver may be extended under section 1115 of the federal Social Security Act; but there is also some question as to whether CMS will require a new demonstration waiver submission, rather than accept another renewal application. Regardless of how soon CMS may require the application process to begin or whether it is considered a renewal or a new waiver application, the deadline for securing federal approval for another term is June 30, 2008.

Opportunities and Challenges

1. Reduce the Number of Uninsured

Substantial progress in new coverage through MassHealth and Commonwealth Care has already been made. The MassHealth caseload began to rise significantly when the on-line, dual application for MassHealth and the Uncompensated Care Pool (UCP) began in October 2004, and the number of UCP users declined by more than estimated. The data gathered through this process also made it possible to identify those UCP users whose incomes were under 100 percent of the Federal Poverty Level (FPL) and, therefore, eligible to enroll in Commonwealth Care in the fall of 2006. For its part, the Connector has been impressive with the quick start-up of its operations for covering newly eligible people at the lowest income level.

The extension of MassHealth to children up to 300 percent of FPL and the raising of caseload caps in the MassHealth Essential and HIV programs and the elimination of the caseload cap in the CommonHealth program have also contributed significantly to early progress in reducing the number of uninsured. The cumulative effect of all of these interventions is substantial progress toward a key goal of the waiver. MassHealth added about 45,000 members in FY 2005 and another 42,000 in FY06. Over roughly the same period, state surveys indicate that the number of Massachusetts residents without health insurance fell by about 88,000.

It will be important, but harder, to extend this success to the rest of the low income uninsured population. The task will be to convince a diverse pool of adults, especially healthy adults, to enroll in Commonwealth Care and bear cost-sharing responsibilities in what is essentially a voluntary enrollment environment for most of the remainder of the waiver period.[6] The risk of early enrollees being predominantly those in worse health will make it all the more difficult to ensure the ongoing availability of affordable plans and ultimately to enroll all of the uninsured under 300 percent of FPL.

An important issue is whether the State will be held accountable for counteracting reductions in coverage and offers in the employer-sponsored market. If reductions in employer coverage are not tracked, the net effect of MassHealth waiver programs in reducing the number of uninsured will likely appear to be smaller. To properly account for the effect, the State will need to establish a baseline of recent levels of employer participation in the coverage of employees.

2. Reduce Uncompensated Care Spending

The financing structure of the new expansion programs such as Commonwealth Care relies on the reallocation of funds from the Uncompensated Care Pool. Reducing the demand for free care to free up these funds will be essential to the financing of new insurance coverage.

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[6] For tax year 2007, the cost to subsidized populations (through Commonwealth Care) of complying with the individual mandate that begins July 2007 will range from $84 to $636 in premiums for the 6 months of 2007 when the mandate is in effect, *plus* co-pays and deductibles. This compares with the cost of losing one's personal income tax exemption — the penalty for defying the mandate in its first year — about $204 per individual.

Reductions in free care utilization, however, do not necessarily result in comparable reductions in payments to providers. If payment levels to hospitals for remaining uncompensated care increase (as they are expected to do), if the total number of uninsured rises due to changes in the larger environment, or if hospital rates increase faster than projected, reductions in free care spending may not occur despite reductions in the overall numbers of uninsured. If reductions in UCP spending do not balance the increases in Commonwealth Care subsidies, the excess will have to be financed by state funds only, because the amount available through the waiver for these purposes is capped.

3. Maintain Budget Neutrality

In its simplest terms, budget neutrality means that the State may not spend more on its waiver program costs over the full term of the waiver — now 11 years — than it would have projected to spend on its Medicaid program without a waiver in place. In practice, the budget neutrality limit is governed by federally imposed trend rates on annual spending growth. If the State comes too close to exceeding this "ceiling," it must take steps to curb its spending for certain components of its waiver program spending, or risk losing federal funding. If it elects to cut back the scope of its waiver programs, it must protect certain populations and programs in a defined order of descending priority set out in the waiver terms and conditions.[7] The state may also elect to keep its program elements intact by covering costs of this excess spending with full state funding, without federal participation.

Adding to the fluidity of the definition of budget neutrality, and the determination of when it might be exceeded, is the broad degree of federal discretion in the matter. The Centers for Medicare and Medicaid Services (CMS) works with the Office of Management and Budget and is cognizant of federal budgetary targets when it exercises this discretion on behalf of the Secretary of Health and Human Services.

Most recent displays of this calculation indicate that staying below the ceiling will be extremely challenging, given projected growth rates and commitments to provider rate increases and safety net supplemental payments. Current projections indicate that at the end of FY 2008, spending will be very close to the budget neutrality limit, leaving little to no margin. There is further uncertainty related to the reauthorization of the State Children's Health Insurance Program (SCHIP), which will be considered by Congress this year. If Massachusetts does not receive more funding under SCHIP, some of the state's SCHIP expenses could revert to MassHealth and put further pressure on the budget neutrality ceiling.

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[7] See Centers for Medicaid and Medicare Services Special Terms and Conditions for MassHealth Medicaid Section 1115 Demonstration No. 11-W-00030/1, Attachment C, "Monitoring Budget Neutrality", section 9. "Corrective Action Plan." For further discussion of budget neutrality, see also the MMPI issue brief "The Role of MassHealth 'Budget Neutrality' Requirements in Designing Policies to Expand Health Coverage", available at http://www.massmedicaid.org/pdfs/Issue-Brief-budget.pdf.

4. Secure a favorable level of continuing federal financial support

As noted, the margin between projected waiver expenditures and the waiver's budget neutrality ceiling under the current methods is extraordinarily tight; the State is at risk of exceeding the ceiling even before June 2008. It is therefore all but certain that the State will have to persuade CMS to agree to a change in the budget neutrality *methodology* to allow for more generous trend rates for FY 2009, 2010 and 2011.

Four other elements of the current financing structure will be important to address in the next negotiation with CMS: (1) increasing the federal funding cap and securing a reasonable trend rate for the Safety Net Care Pool (currently fixed at $1.344 billion per year); (2) assessing the merits and risks of re-basing all or certain components of the "without waiver" expenditures, including the possibility of moving some of the new covered populations to the base Medicaid population; (3) securing reauthorization of federal reimbursement for the "Designated State Health Programs" (costs not otherwise matchable); and (4) securing reasonable levels of ongoing federal financial support for safety net providers and costs of caring for low-income people who remain uninsured.

The degree to which CMS is inclined to be flexible rather than exacting in exercising its discretion is greatly influenced by how successful a state has been in reaching or showing major progress toward the key policy and program objectives of the demonstration waiver. Thus, the effort to renegotiate a favorable budget neutrality ceiling is only in part related to mastery of the financial and spending projections for the program; it is equally important, if not more so, to demonstrate measurable and noteworthy progress toward the programmatic goals of the waiver, primarily a reduction in the number of uninsured state residents.

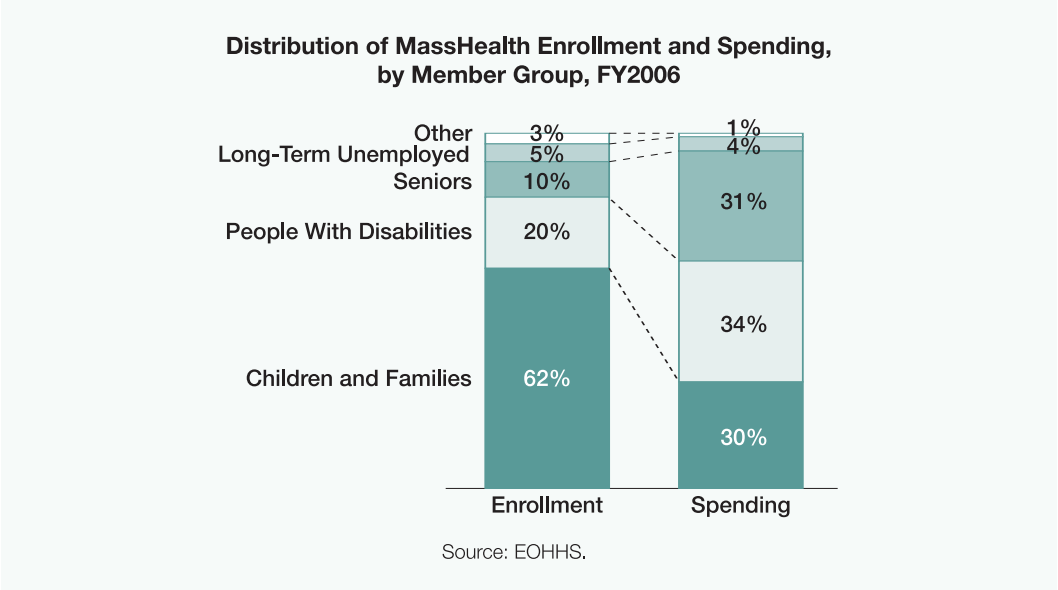
Improve the Value of MassHealth Purchasing

The Issue

Because of its central role, MassHealth requires a large share of public resources, and it competes with other priorities in the state budget process. Successful management of MassHealth depends on increasing the value of the services Medicaid purchases and provides. *Value* implies a more considered policy than simply reducing costs through indiscriminate cuts in benefits, eligibility or provider rates. Indeed, these levers by themselves are of limited use if improved coverage and access continue to be major health policy goals. Rather, the focus must be on improving value through innovation, the efficient management and coordination of care for high-cost populations, and the elimination of error and waste.

Background

In State FY 2005, Massachusetts spent $6.3 billion for the MassHealth program, about 27 percent of total state spending.[8] The projected expenditure for FY 2006 is $6.7 billion. (The federal government reimburses the Commonwealth for slightly more than half of this total.) MassHealth spending is not spread evenly across the various categories. Though children and families are the majority of MassHealth members, the majority of *spending* in the program — about 65 cents of every MassHealth dollar — is on seniors and people with disabilities.



Total spending on Medicaid services in Massachusetts increased 30 percent between fiscal years 2002 and 2006, an average of about 6.8 percent per year. Because enrollment increased about 4.5 percent over this period, the per-member spending trend was lower than the total, about 24 percent. In contrast, the Division of Health Care Finance and Policy reports that, over a similar period (calendar years 2001-2005) premiums for employer-sponsored coverage increased 45 percent. Though MassHealth spending increases were only 53 percent of private sector increases, they were still significant.

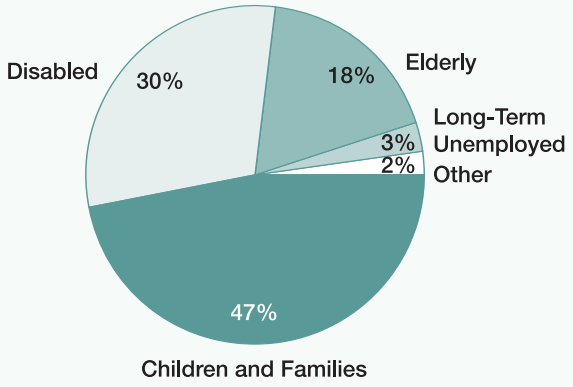
Over the past four years about half of the spending increase is attributable to children and families (who represent more than 60 percent of the caseload). Thirty percent of the spending increase went to services for people with disabilities, and 18 percent on seniors. This is because during this period spending for children and families grew faster than for other groups, averaging 10.2 percent per year, compared with 6.8 percent for people with disabilities and 5.3 percent for seniors. In FY 2006, a very small increase in spending for people with disabilities and an actual *decline* in spending for seniors was strongly influenced by the implementation of Medicare Part D drug coverage, which removed pharmacy expenses from the MassHealth books for many of these members who

[8] MassHealth figure is from EOHHS; total state expenditures from Massachusetts Office of the Comptroller, *FY 2005 Statutory Basis Financial Report*.

have both Medicare and MassHealth coverage.[9]

Overall, though MassHealth enrollment has been growing steadily, spending increases have been driven less by enrollment growth than by spending per member. Over the four-year period from 2002 to 2006, spending per member has increased an average of 5.6 percent per year, compared with enrollment increases of just over 1 percent on average.[10] Once again, the increase for children and families per member was disproportionately high, an average of 10.7 percent annually. Spending on seniors and people with disabilities increased more modestly, 3.4 percent and 4.1 percent per year, respectively.

Shares of MassHealth Spending Increase, FY2002-2006

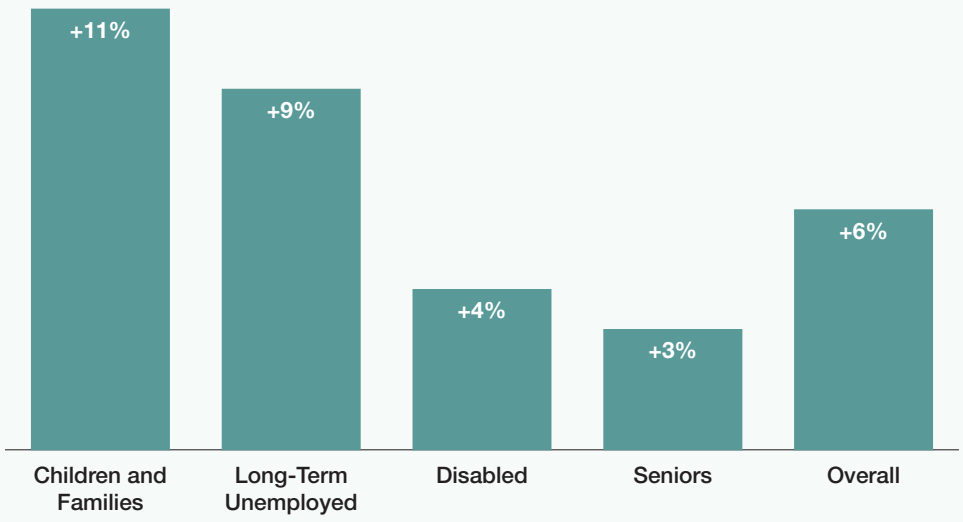


Source: EOHHS.

A few trends stand out as important for understanding and managing Medicaid spending:

1. Medicaid spending increases have been primarily driven by increases in spending per member, and the growth is greatest for families and children.

Average Annual Change in Per-Member Spending, FY2002-2006

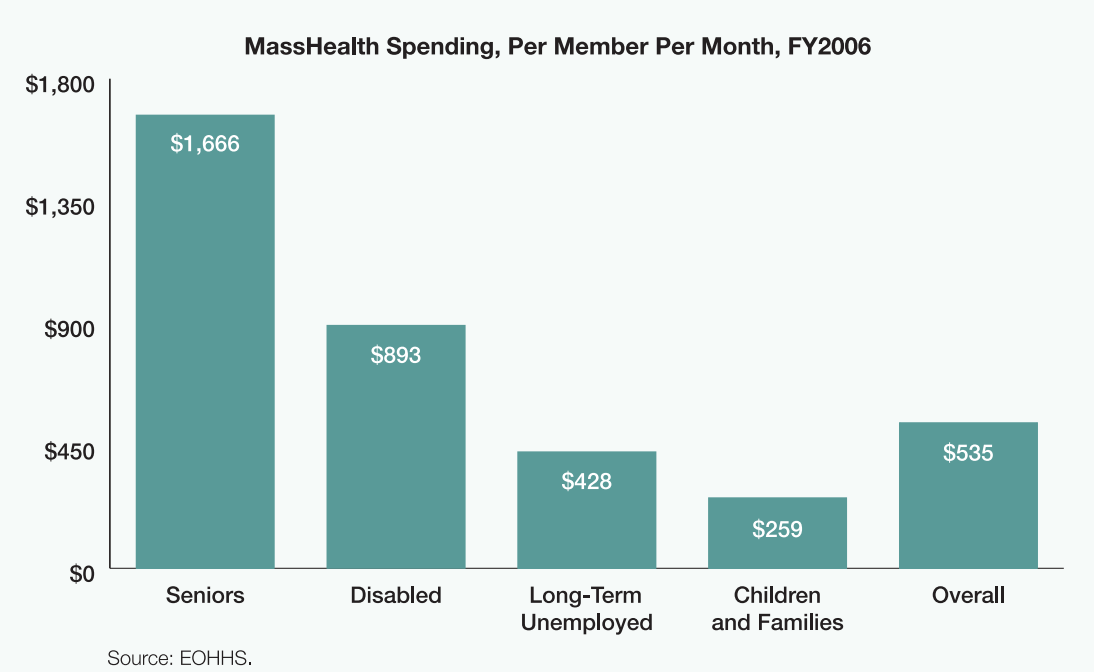


Source: EOHHS.

[9] Much of this spending remains part of the State budget, however, because the Part D requires states to retain only a portion of the savings and send the rest to the federal government. This is known as the Part D "clawback" payment.

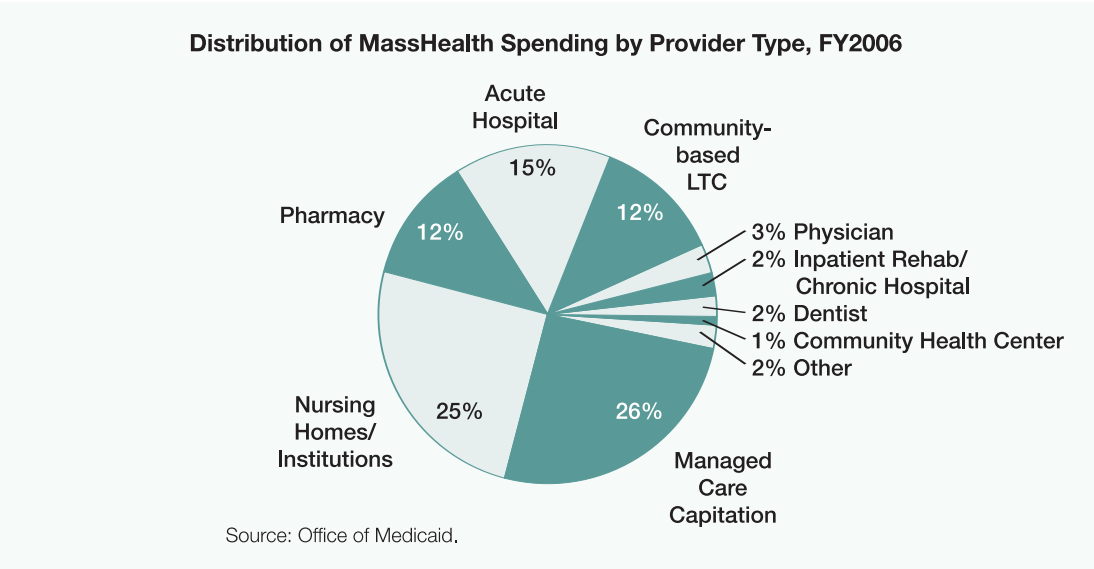
[10] This situation will likely change in FY 2007 with the upswing in MassHealth enrollment related to the implementation of health reform. Five months into the fiscal year, MassHealth enrollment had already increased 5 percent.

2. Despite the fact that the greatest rate of increase in spending per member is for children and families, the highest spending per member (and in aggregate) is for the disabled and seniors.



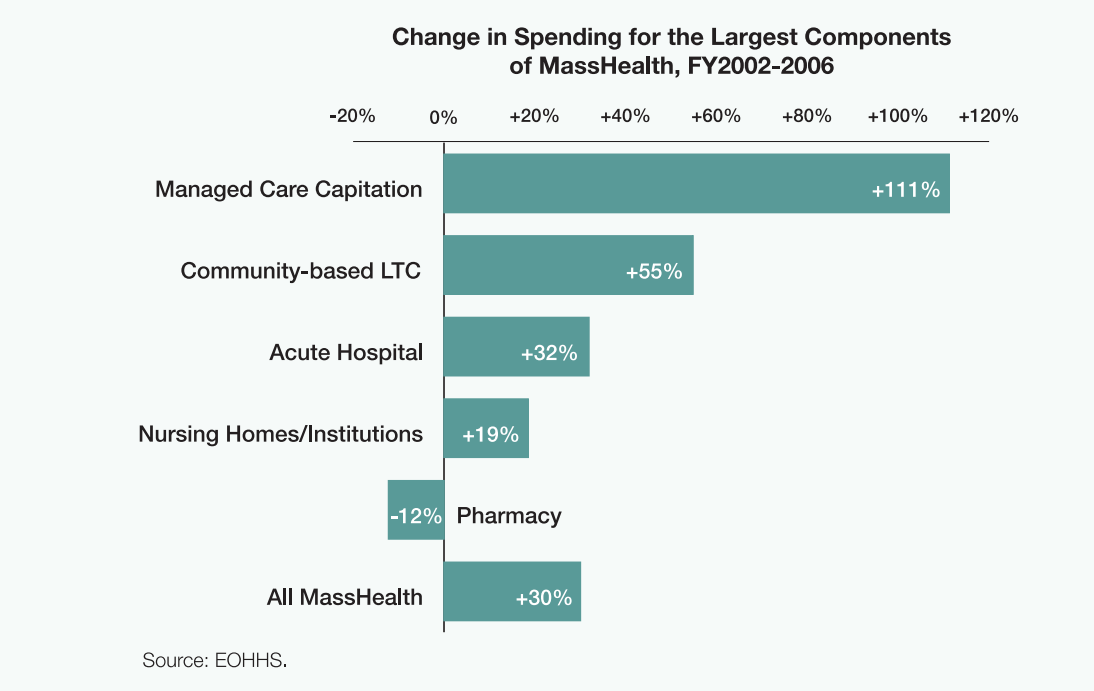
Source: EOHHS.

3. Medicaid spending is very concentrated, with 78% of expenditures occurring in four categories: managed care capitation (MCOs, MH/SA, SCO and PACE) (26%), nursing homes and institutional long term care (25%), acute hospital inpatient and outpatient services (15%) and pharmacy (12%).



Source: Office of Medicaid.

4. Significant rates of increase in Medicaid spending occurred in two of these four categories, along with community based long term care services such as personal care attendants (PCA), adult foster care and adult day health. Indeed, these community-based services were among the fastest growing of MassHealth spending components, increasing 55 percent from FY 2002-2006. Pharmacy spending declined in FY 2006 due to Medicare Part D, resulting in net negative growth over the entire 5-year period. These trends reflect changes in both the unit cost of services and utilization or enrollment.



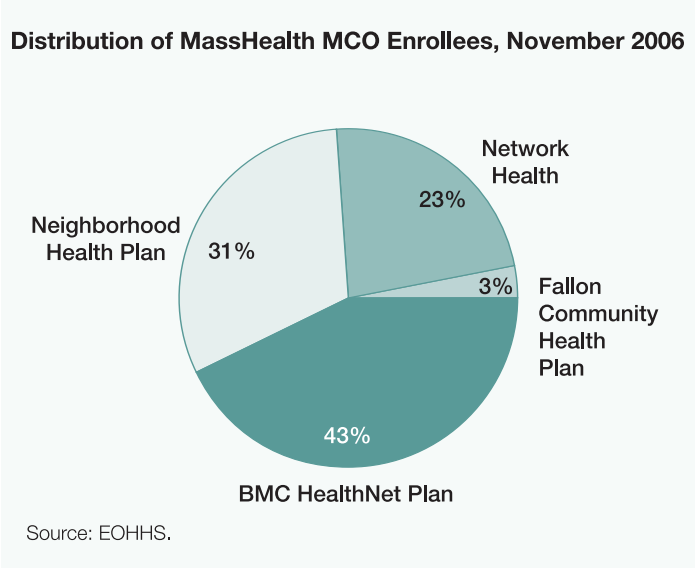
Source: EOHHS.

Opportunities and Challenges

1. Use MassHealth's Relationship with Managed Care Organizations to Improve Purchasing, Care Coordination and Management

Over 360,000 MassHealth members are enrolled in one of four managed care organizations (MCOs). MCOs can be a vehicle for innovation if their provider networks and care and payment practices reflect the most current thinking on delivering high quality, cost effective care. The MassHealth contracts with MCOs, however, reflect the thinking of the late 1990s, as they were executed in 1997 and have been extended annually since their initial five year term expired in 2002.

The value of the MCO contracts today is about $1.3 billion, more than 2.3 times what it was in FY 2002, reflecting both a policy decision to increase enrollment in MCOs as well as the annual capitation rate increases negotiated with the MCOs. Payments to MCOs represent nearly one-quarter of MassHealth spending.



Ten years ago, the primary tools for managing care comprised negotiation of competitive rates and utilization management to avoid unnecessary care. Today, the emphasis has shifted towards giving incentives to and contracting with high performing networks, identifying potentially high risk patients, and providing a variety of approaches to prevent and manage chronic disease. A competitive rebidding of the decade-old MassHealth managed care contracts is long overdue, and the process can be used to institute operational improvements, up-to-date quality improvement and purchasing strategies, and to better serve people with special needs. To the extent feasible, the MCO contract reprocurement should be coordinated with the Connector's Commonwealth Care contracting efforts to ensure that the state's purchasing power is leveraged rather than fragmented.

Questions remain as to how best to serve MassHealth managed care members. Should MassHealth continue to contract for a broad range of services from the MCOs, or would members be better served if certain specialized services (such as behavioral health services or prescription drugs) were purchased separately from the MCOs? Can the MCO contracts be structured to improve the coordination of care, especially for people with multiple chronic illnesses or disabilities, who have the most costly medical needs? Should there be more choices among MCOs, or should choices be more limited based on the plans that demonstrate the highest value and quality? Should there continue to be a Primary Care Clinician Plan operating in parallel to the MCO program, dividing administrative focus and resources? Or does the PCCP plan provide an important alternative to MCOs for some of the MassHealth population? How best to measure — and to report to MassHealth members — the quality of MCOs? The answers to these questions, as they are manifest in the MCO contracting process, can be of major importance to the effective management of an efficient, high-quality MassHealth program.

2. Manage MassHealth Spending Trends

Managing Medicaid spending trends is essential to the future of the MassHealth waiver and to the vitality of the program overall. The "budget neutrality" requirement limits federal contributions to an established ceiling with an annual trend factor. This was not a constraint in the early years of the waiver, but it is a very real one now. Managing spending trends, then, is an imperative simply for continuing MassHealth as it now exists.

Conventional strategies to reduce spending — eligibility, caseload or service cuts — are counter-productive and ineffective because they simply shift costs of needed services to more expensive settings, such as emergency departments. Programmatically, tools and strategies more subtle and targeted than cutting benefits and caseloads are available to help MassHealth purchase services more effectively — containing costs, improving quality and increasing value.

Management of care. There is a potential for improving the value of care purchased for high-cost groups through care management approaches that coordinate care to meet complex health care needs more efficiently. One such innovation is already underway, on a small scale, for dually-eligible seniors enrolled in the SCO program. Other efforts have been part of MassHealth's contracts with the MCOs and with the Massachusetts Behavioral Health Partnership; however, as mentioned above, contract requirements for the MMCOs in particular require updating. MassHealth also operates a community case management program for children who require private duty nursing services. This program offers nurse care managers who work with families to individually determine the appropriate services needed for a given case. More large scale, innovative care management programs for many other high-risk, high-cost MassHealth members could be developed.[11]

Strong public health programs can also help to limit the number of some high-cost conditions. Smoking cessation and tobacco control, for example, can address one of the causes of low-weight births, which give rise to high-cost health care needs over a lifetime. Environmental health programs might address some of the conditions associated with childhood asthma, and vaccination programs help prevent communicable diseases.

Aligning payment and quality. Medicaid can use performance-based contracting to motivate quality improvement through means such as medical error reduction, best practice approaches to managing chronic and complex medical conditions, and utilization management focused on the highest cost populations. Medicaid hospital rate increases for at least the next two years will be tied to certain "pay for performance" measures, yet to be defined. The Health Care Quality and Cost Council may focus the State's entire health care delivery system on the achievement of certain quality and cost goals; MassHealth can use its presence in the market to help shape the goals, promote their achievement, and hold its own contracting providers accountable to them. In addition, the new Medicaid Management Information System, scheduled to be implemented in 2008, will be an important step to support more flexible and creative payment methods and care models.

Using data for finding opportunities to improve value. Many states are becoming more sophisticated in their use of data to improve purchasing strategies, both to take advantage of their purchasing power and to support care management initiatives.[12] MassHealth has invested time and resources in gathering its vast amount of data into a "data warehouse," which may now be the foundation

[11] "Medicaid 'Best Buys' for 2007: Promising Reform Strategies for Governors." Center for Health Care Strategies. December 2006.

[12] "Seeking Higher Value in Medicaid: A National Scan of State Purchasers." Center for Health Care Strategies. November 2006.

Commentary by Brian Rosman

MASSHEALTH SHOULD IMPROVE ITS CUSTOMER SERVICE FOCUS...

The new administration brings an opportunity for MassHealth to rethink old practices. While the main paper looks at a number of the major policy issues facing the MassHealth program, we also hope that Secretary Bigby and the MassHealth administration look at a number of smaller, yet still important issues to improve MassHealth. Here are just a few:

1. *Better customer service:* By outsourcing their data entry to providers, the virtual gateway has speeded up the enrollment process. But any glitch in the system requires a lengthy call to an enrollment center or customer service line. The notices MassHealth sends out are abysmal — full of legalese and misleading information. Health reform has undeniably put more strain on the system, but more attention to the customer interface is essential.
2. *Assist with citizenship documentation:* A new federal law imposes a requirement that citizens provide documentation such as a passport, or a birth certificate and driver's license. Getting a birth certificate, particularly from out of state, takes time, money, and a lot of help. A number of states are actively assisting enrollees, and Massachusetts should too.
3. *Review premium policies:* In 2003, MassHealth increased premiums for some low-income children and disabled adults. Imposing premiums on MassHealth members makes little sense from a fiscal point of view, since half or more of the premium revenue goes back to the federal government. The premium schedule should be rethought. MassHealth should also make it easier for members to pay their premiums. The Connector is setting up streamlined payment options, which MassHealth should consider. MassHealth should at least provide a postage-paid reply envelope with the premium bill. Another issue is the requirement that people getting premium assistance must pay up front and then get reimbursed. This is sometimes very hard for low wage workers living month to month.
4. *Increase senior and disabled income eligibility levels:* Since the 1990s, Medicaid reform has focused on increasing eligibility for children, the disabled, the unemployed, and working adults. New programs have been started for those with HIV and breast and cervical cancer. Eligibility income levels for all these groups have been increased. However, seniors have been excluded from Medicaid reform. Seniors impoverished by high medical bills can get MassHealth if they meet the deductible income standard. This standard has been stuck in place for almost 20 years, and is now way below 100% of the poverty line. Similarly, the CommonHealth spendown level (the one-time amount disabled adults must pay in medical bills before they qualify for benefits) has been frozen at the same level for years. It's time to revisit these standards.

Brian Rosman is the Research Director of Health Care For All. Thanks to Vicky Pulos and Neil Cronin of Massachusetts Law Reform Institute for their ideas.

for a comprehensive, value-enhancing purchasing strategy. Strong analytical capacity is necessary to harness the potential of these data. In addition, the new Medicaid Management Information System, scheduled to be implemented in 2008, will be an important step to allow the system to implement and administer more flexible and creative payment methods and care models.

Use of cost-effective, appropriate, and high performing networks. For many years, Medicaid has been interested in developing care models that can serve its diverse population more cost-effectively. Certain trends in the MassHealth environment create a growing opportunity to adopt models of care that will provide appropriate care in the most cost-effective setting, emphasizing education,

prevention and primary care. The increasing availability and use of data on the cost and quality of care provides the basis for building partnerships with providers who demonstrate both good patient outcomes and efficient resource utilization. Increases in provider payment rates will help address provider concerns about serving patients with complex needs. The growing use of managed care offers the ability to contract selectively for high performing and specialty networks and develop other specialized programs. The increased use of technology to administer and monitor care allows for improved coordination and management across a variety of care settings. The long range goal should be provision of care through defined systems that are characterized by efficiency, quality, and service.

Rebalance Long-Term Care

The Issue

The Massachusetts "Equal Choice" law (Chapter 211 of the Acts of 2006) and Community First initiative, the federal Deficit Reduction Act, and the preferences of seniors and people with disabilities and their families create an environment for altering the balance between institutional and community-based long-term care. Elements of such a rebalancing include establishing a new federal waiver for community-based services, developing models to provide services more cost-effectively, rationalizing funding streams, and addressing workforce issues. Improvements in long-term care can forestall institutionalization, increase patient satisfaction and provide lower cost options for many.

Background

As is true in other states, most of the Medicaid population in Massachusetts consists of children and non disabled adults, but most of the money is spent on elders and people with disabilities. In Massachusetts in State FY 2006, elders and people with disabilities accounted for 30% of total enrollment, but 65% of spending. On a per capita basis, spending was $1,666 per month for seniors and $893 for members with disabilities, versus $271 for families and children.

Historically, the most significant component of the cost of long-term care has been institutional long term care. In State FY 2006, Medicaid spent 24 percent of its funds on nursing homes and other long-term care institutions versus 12 percent for all community based long term care services combined.[13]

The balance between institutional and community based care is shifting, however. Years of work by elder and disabled persons rights activists, supported by research evidence and service model innovations in Massachusetts and elsewhere, has moved the creation of a patient-centered system of community-based long term care up the policy agenda. The challenge for Massachusetts is to

[13] In this instance, "Community-based long-term care" includes MassHealth spending for: Adult Day Health, Adult Foster Care, Day Habilitation, Durable Medical Equipment, Group Adult Foster Care, Home Health, Hospice, Independent Nurses, Independent Therapists, Orthotics, Oxygen, Personal Care Attendant, Prosthetics, Rehabilitation Clinics, and Targeted Case Management, as well as the PACE and SCO coordinated care plans.

create a system that provides needed long-term supports in appropriate settings, with an emphasis on preventing or delaying admissions to institutions, while living within the resource constraints of the state budget.

Opportunities and Challenges

1. Expand Access to Community-Based Services as a Cost-Effective Alternative to Institutional Long-Term Care

There is little debate about the desirability of expanding home and community based services (HCBS). Elders and people with disabilities have long expressed preference for care in their own homes or other community settings less medically intensive than nursing homes. The State's Community First policy, adopted in 2003 with an explicit goal to prevent or delay admission to, or facilitate discharge from institutions, officially acknowledges this desire. Chapter 211 of the Acts of 2006, the Massachusetts "Equal Choice" law, gives statutory support to the policy by expanding Medicaid eligibility for community-based long-term care services (pending federal approval) and requiring the state to give eligible Medicaid enrollees a choice of care settings. The law also directs the state to conduct pre-admission counseling for every Medicaid beneficiary who needs long term care services to determine if community based services are a suitable option, and to offer counseling to people who are not Medicaid eligible.

The impact such an expansion will have on Medicaid spending for long term care is less clear. Typically, care at home is less expensive than nursing home care, but for very frail people and medically complex cases this may not be true. Successfully implementing Community First and Equal Choice in a cost-effective manner is a challenge that will require experimentation, innovation and flexibility. MassHealth members using long-term supports do not have homogeneous needs. In order to be maximally effective in allowing seniors and people with disabilities to remain safely in their communities, services must be available at different levels of intensity in various settings. The Community First research and demonstration waiver that the State submitted to CMS in December 2006 will test a particular approach for over 10,000 people. Alternative approaches might also be considered as this experiment is monitored and evaluated.

Placing greater emphasis on HCBS will also require addressing workforce shortage issues, including possibly increasing reliance on family caregivers. The state will need to work out the extent to which it is willing to pay for what may now be unpaid family labor. A first step in that direction is the new Enhanced Adult Family Care program, which allows certain family members to act as caregivers in a Medicaid-supported home-based care program. It is likely that the state will also have to address wage and benefit issues for community long term care workers in order to attract and retain an adequate workforce.

Finally, there are implications for institutional long term care providers. The nursing home industry is already moving away from an emphasis on long term residential patients to providing a variety

of services such as short term rehabilitation, respite, assisted living, adult day health and hospice care. A greater reliance on HCBS will accelerate this trend. This requires not only "right-sizing" our institutional capacity, but also making sure that the facilities that exist are equipped to play a different and more varied role in the continuum of care. This may require some short-term costs in order to realize long-term savings.

2. Coordinate funding sources to facilitate a continuum of services for "dually-eligible" seniors and people with disabilities.

Nearly 200,000 MassHealth members are also Medicare recipients. These "dual eligibles" create a challenge for MassHealth because of gaps in Medicare coverage. MassHealth supplements Medicare by filling in both the benefit gaps — mainly community-based and institutional long-term care — and the eligibility gap — people with disabilities who have not yet qualified for Medicare. Overall, the trend has been for states to pick up an increasing share of the cost for this population and for elders and people with disabilities to comprise a larger share of total Medicaid spending.

A significant challenge is the lack of coordination between acute and long term care services, which is particularly pronounced for the dually eligible, whose acute care, by and large, is paid for by Medicare, while Medicaid funds most long-term care. Different sources of funding, with their attendant different provider networks and payment incentives, reinforce the disconnect between acute and long-term care services for this population.

One effort to integrate acute and long term care services for dually eligible MassHealth members is the Senior Care Options (SCO) initiative. SCO is a capitated, managed care model that is testing the theory that, by providing enhanced access to community based services, SCOs can reduce reliance on both inpatient and institutional care — simultaneously improving care for their members and saving money.

What is particularly important about the SCO program is that it blends Medicare and Medicaid financing into one pool. This blending is crucial because investments made in reducing inpatient utilization may rely more on Medicaid financed services but the savings accrue mainly to Medicare. Unless the two funding streams are integrated, the State's financial incentive to invest in the community-based efforts is greatly attenuated.

SCO remains a very small voluntary enrollment program, with about 6,000 enrollees out of almost 200,000 dual eligibles. In addition, SCO is limited to the over 65 population, so the benefits of the blended capitation arrangement is not available to non-elderly, dually eligible people with disabilities. A new vehicle that might make that possible is the Medicare Special Needs Plan (SNP). SNPs are special Medicare managed care plans that were created by the Medicare Prescription Drug Improvement and Modernization Act of 2003. Although most SNPs nationally are targeted to dual eligibles, Medicaid services remain outside the SNP contract. This creates a significant potential

problem for states because SNPs have an incentive to shift expenses to the fee for service Medicaid system, which could raise Medicaid spending overall, a problem that SCO overcomes in Massachusetts by combining Medicare and Medicaid in a single capitated rate.

In order to make SCO-like capitation available to dually-eligible people under 65, the State will need to work with CMS to improve coordination of SNPs with Medicaid. The State needs to explore what legal or regulatory authority it has to manage SNPs, and may ultimately need to seek additional authority from CMS or Congress.

Commentary by Elisabeth Babcock

DEMONSTRATE SENSITIVITY TO THE SPECIAL NEEDS OF LOW INCOME POPULATIONS AND ELDERS...

1. *Challenges for Low-Income Adults and Families:* The recent release of the 2006 Family Economic Self-Sufficiency Standard for Massachusetts (2006 Mass FESS) shows that the income required to meet Commonwealth families' basic needs grew significantly between 2003 and 2006. In that period, the annual income needed to support a Boston family of three consisting of one adult, one preschool aged child and one school aged child rose from $51, 284 to $58,133, an increase of more than 13%. At this income level, the family is not able to save for emergency expenses or the purchase of a home; they are only able to cover the average monthly costs — for rent, food, child care, transportation, health-care, and expenses such as clothing and taxes — required for subsistence.

   At $58,133, this family is living at 350% of the Federal Poverty Level for a family of three and therefore not qualified for any form of support under Massachusetts'new healthcare reform, Chapter 58. Even though this family experienced an increase in healthcare costs of 50% from 2003-2006 and must pay over 7% of their gross monthly income for healthcare, there is no mechanism for mitigation of their costs in the Massachusetts plan. This highlights that although Chapter 58 attempts to create affordable and accessible health care coverage, the burden of health care costs on low-income families is likely to continue as a problem requiring public attention and creative public policy solutions.
2. *Challenges for Dually Eligible Elders:* Any family attempting to support a frail elderly member knows that aging is not a smooth and uniform process. Instead, it is a highly individualized experience where the combination of the individual elder's medical, behavioral, and social problems as well as resources create unique challenges to optimizing quality of life. Creating appropriate public policy responses for such individual circumstances is inherently difficult, but necessary, if we are to minimize costs of care. The good thing is that just as the Commonwealth seeks not to overpay for unnecessary services, elders do not desire the excess services either. Research has repeatedly shown that elders reject unnecessary intrusion into their lives and strongly desire as much independence as possible.

   The challenge this mutual desire creates is to formulate public policy responses that can be nuanced to meet elders' needs; nursing homes will work for some elders, assisted living facilities, supported housing programs, SCOs, PACE Programs, adult foster care, group home care, family home care, will be appropriate for others. All have relevant places in a well-crafted system of care. We should open our Medicaid public contracting, payment, credentialing, and quality monitoring systems to embrace these different options for caring for our elders. In doing so, we will find the highest quality/lowest cost options for maximizing elder health.

Elisabeth Babcock is the President and CEO of The Crittenton Women's Union. Previously, she was the President and CEO of HEARTH, a charitable organization dedicated to providing advocacy, outreach, and permanent housing for homeless elders. Her professional work has largely focused on development of services for underserved populations through community-based organizations.

Given their high average cost, dually eligible MassHealth members represent a population that could most benefit from coordinated care and blended funding, but they are also a group that, through experience, has developed an uneasy relationship with managed care plans. It is a challenge to realize the clinical and fiscal benefits that result from blending Medicare and Medicaid funding while protecting beneficiaries from some of the problems that have sometimes occurred in Medicare and Medicaid managed care, such as difficulty in accessing services and provider network instability. Meaningful oversight along with an emphasis on consumer protection will be critical. If enrollees are highly satisfied, the programs will grow and the state will realize the benefits of coordinated care.

Provide Strong Leadership and Bolster Staff

The Issue

The continued effectiveness of MassHealth and the implementation of health care reform depend on a robust Medicaid administration. Important human resource and systems issues should be addressed.

Background

Federal Medicaid law requires that a state designate a "single state agency" to administer its program. Prior to July 2003, the Division of Medical Assistance, a single unit of EOHHS, was the single state agency. As part of a reorganization of human services in that year, the Executive Office of Health and Human Services (EOHHS) was designated as the single state agency and Medicaid program, policy and administrative staff and responsibilities were assigned to various agencies within EOHHS. The principle was a recognition that Medicaid spending and populations reached across the Secretariat and so primary oversight of Medicaid should be elevated to the Secretary's office. This resulted in the relocation of certain policy and program management functions within the agencies that have primary responsibility for the population whose needs were being addressed.

The Office of Medicaid, within the EOHHS Secretary's office and led by the Medicaid Director, was designated by the Secretary to be the medical assistance unit required by federal Medicaid law. It is responsible for primary oversight and administration of the MassHealth program. The Office of Medicaid also oversees MassHealth's core operations (such as member enrollment and provider payment), strategic planning, clinical affairs, pharmacy management, maintenance of the Medicaid State Plan and federal waivers, and the evaluation of policy initiatives. It also contains the Office of Acute and Ambulatory Care, which administers the Primary Care Clinician Plan, the Managed Care Organization program, and other hospital and ambulatory care programs.[14]

[14] The Office of Acute and Ambulatory Care was originally planned in the reorganization to move to the Office of Health Services, which was to comprise the Department of Public Health, the Department of Mental Health, the Division of Health Care Finance and Policy, and the Betsy Lehman Center. This consolidation was reversed early in 2006.

Commentary by Bruce Bullen

FOCUS ON HIGH-PRIORITY ISSUES...

The top three Medicaid management issues are the following:

1. *Renewal of the MassHealth Waiver:* A strategy to renew the MassHealth waiver needs to be developed soon. The renewal will be more difficult than in years past because partisan politics could affect the outcome. The last renewal required a compromise, which may be more difficult to achieve this time with the Republican administration in Washington. CMS has many discretionary levers to pull that significantly affect the value of the waiver, including budget neutrality, allowable state spending, and upper limits. Unless a compelling case is made that federal spending has been and will be controlled, CMS will cap federal costs in a manner that shifts significant spending responsibility to the state.
2. *Management of Medicaid by the Executive Office of Health and Human Services:* The reorganization of Medicaid that made EOHHS the "single state agency" for Medicaid and gave it broad management responsibility for the program needs to be fully implemented. The current structure is fragmented and lines of accountability are confused. The only way for Medicaid policies to be consistent statewide and for the revenue-generating potential of Medicaid to be realized without creating a budgetary problem for the state is to control policy, spending, and revenues at the EOHHS level. Otherwise, state agencies will develop conflicting policies and shift costs from their own budgets to Medicaid in unplanned and uncontrolled ways. EOHHS authority over Medicaid policy and spending plans needs to be clear.
3. *Long-term care spending:* Long-term care spending for the elderly and disabled is by far the biggest and most volatile part of the Medicaid budget. This is an area that falls outside the MassHealth program and the waiver. There are three basic components: institutional, community, and pharmacy. Unless managed and coordinated, all three can drive large annual increases in Medicaid spending and devour all discretionary revenue available to EOHHS agencies for growth in any given budget year. Each component needs to be managed carefully (normal nursing home inflation alone can cost $50 to $100 million), and coordination through SCOs and other managed care approaches should be pursued, because dually eligible recipients and the counterproductive Medicare-Medicaid relationship are part of the problem. There is particular danger involved in moving too quickly to expand community-based services, unless it is clear that institutional costs will go down. Otherwise, the movement to community-based services is simply an added expense.

Bruce Bullen is Senior Vice President and Chief Operating Officer of Harvard Pilgrim Health Care. Previously, Mr. Bullen served for over twenty years with the Commonwealth of Massachusetts, most recently as Commissioner of the Division of Medical Assistance, a post he held for ten years.

Other EOHHS agencies have Medicaid-related responsibilities by virtue of the programs they administer and the population groups they serve. The Executive Office of Elder Affairs and the Office of Disabilities and Community Services provide health and social services, largely funded by Medicaid, to seniors and people with disabilities. Among other responsibilities, these offices jointly coordinate the provision of long-term care services to Medicaid enrollees. The Department of Mental Health manages the MassHealth behavioral health program.

Opportunities and Challenges

The EOHHS reorganization is a work in progress. Outside the affected agencies, it is not well understood. Inside, it has allowed better alignment of populations and programs, added new skills and resources to the lead agencies for the elderly and disabled, and facilitated communications and

planning. The formation of a single revenue and single human resources unit across all the agencies is also a plus.

However, the reorganization has weakened the Office of Medicaid's control over its resources and priorities. The current structure requires stronger matrix management processes and a well-defined and supported role for the Office of Medicaid. Strong leadership to meet both Medicaid program and waiver requirements must come from the Medicaid Director. Budget accountability must also be clearly located within the Office of Medicaid.

The EOHHS reorganization came at the end of a long period of rapid change and intense pressure on the Medicaid agency. The proliferation of programs and increased oversight by federal and state monitors has made operations difficult. The reorganization has made the job of coordinating policies and monitoring spending more complex. At the same time, the health care reform process has put new demands on the staff, which works within an administrative budget that is a very small percentage of the Medicaid program budget (approximately 2 percent). Pressures are intense, as is oversight. Most systems are antiquated and the effort to design and implement a new Medicaid Management Information System is complex and time consuming. Turnover and understaffing are significant barriers to achieving the challenging goals of the program. It will be important to retain experienced staff and to provide competitive salaries to attract new staff, as well as to create a culture that supports and embraces the complex matrix structure that has been adopted.

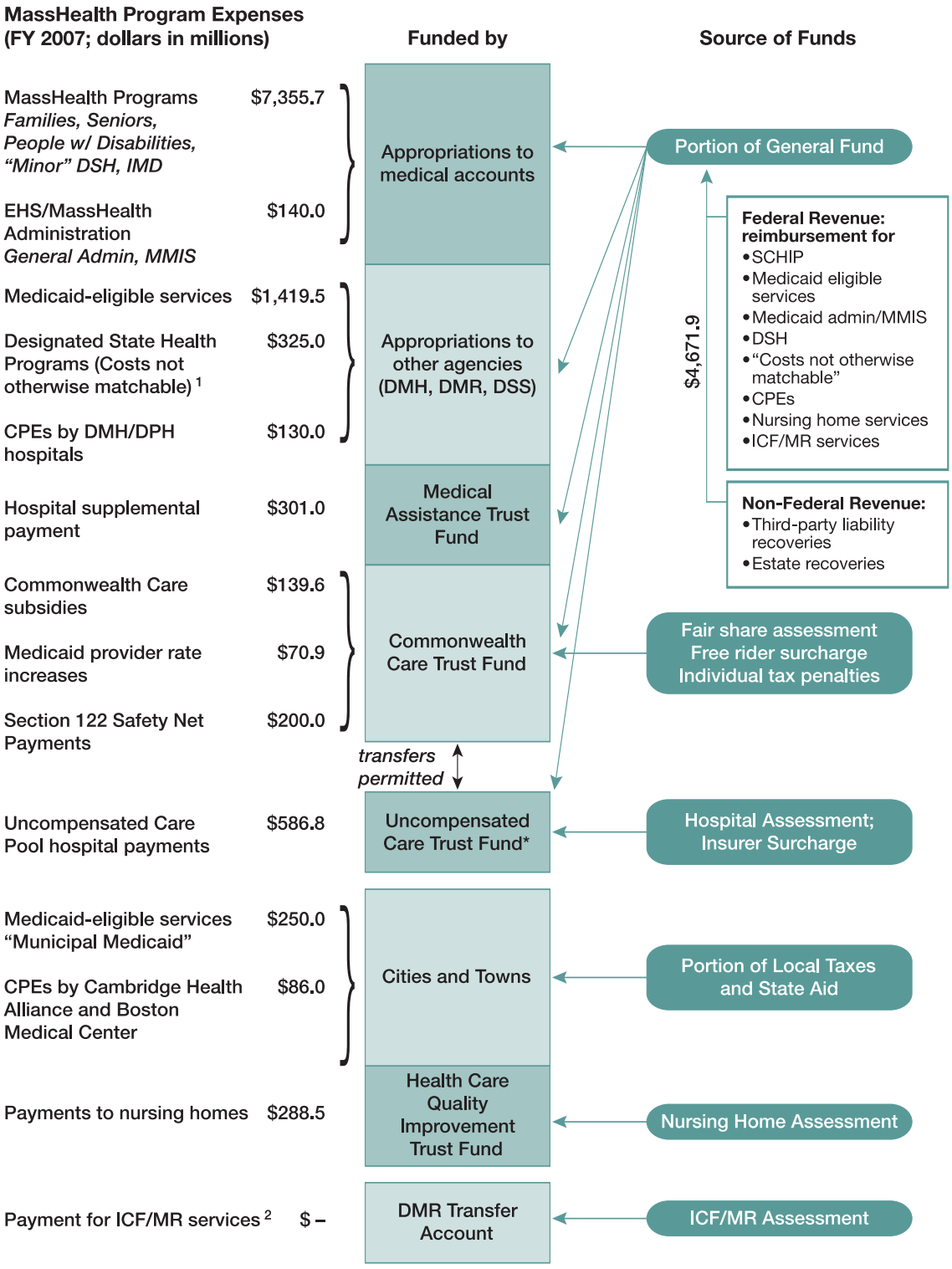
Conclusion: Medicaid in Context

Though it is the state's largest source of federal dollars, Medicaid consumes a large portion of state revenues and competes for finite resources with other worthy needs. In considering Medicaid among other spending priorities, it is important to remember the key role that it plays in the lives of nearly twenty percent of the residents of the state, including the most frail and vulnerable.

Medicaid is the program that delivers on the State's commitment to provide equal access to health care. It is the program to which policymakers have turned to meet basic health needs, address special populations, and sponsor innovation and creativity in program design and purchasing. Medicaid is the most cost-effective way to provide health care services for many populations. It has low administrative costs, demonstrated effectiveness in purchasing, and unequaled success in reaching and enrolling those in need.

While the growth in Medicaid spending is significant, most of it has been powered by planned expansions in caseload and benefits. Massachusetts has set a goal of replacing costly and inefficient episodic use of hospital care by the uninsured with a comprehensive system of health care coverage, subsidized for the low income population. Medicaid is a large part of this vision, and intelligent use of its potential offers the best opportunity for the State to achieve it.

Appendix A: MassHealth Funds Flows



[1] CHC and Demonstration payments from UCP Fund are also considered DSHP payments.
[2] Awaiting CMS approval for these payments.
*To be replaced by Health Safety Net Trust Fund in October 2007.
Source: EOHHS

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