

# **The Facts on MassHealth: What It Is. Why It Works.**

**Josh Greenberg  
Health Care For All  
30 Winter Street, Suite 1010  
Boston, MA 02108**

**March 28, 2002**

Also available on the Web at [www.hcfama.org/masshealthreport.html](http://www.hcfama.org/masshealthreport.html)

## **Executive Summary**

### ➤ ***MassHealth Provides Vital Care for Massachusetts Residents***

MassHealth is the Medicaid program, which provides **health coverage for 1,000,000 Massachusetts residents**. One in four children (and one in six residents overall) in the Commonwealth receive their medical insurance through MassHealth. MassHealth provides coverage to a broad range of people, including children, low-income parents, the disabled, and seniors.

In 1996 and 1997, the state received a federal waiver to expand Medicaid coverage, using funding from a dedicated tobacco tax and federal matching funds. As a result, the number of MassHealth members increased, allowing coverage for more of our neediest populations. Today, approximately 108,000 additional children are insured, as are 88,000 low-income parents and 87,000 disabled/ chronically unemployed adults (see chart, page 4). **To date, coverage for nearly 300,000 citizens of the Commonwealth has been provided with no additional contribution from the General Fund.**

### ➤ ***MassHealth Generates Billions of Dollars in Federal Revenues***

The MassHealth program receives Federal Financial Participation (FFP) for qualified expenditures. The availability of FFP has made the MassHealth program a valuable mechanism for increasing state revenues for the Commonwealth. **MassHealth receives fifty cents in federal reimbursement for every dollar the state expends on MassHealth.** The federal State Child Health Insurance Program (SCHIP) provides an enhanced match rate for certain children. In these cases, MassHealth receives sixty-five cents in reimbursement for every dollar expended.

### ➤ ***The Expansion Programs Have Been Funded without General Fund Contributions***

The expansions of 1996/97 have been funded without additional General Fund contributions. A vital financing source for the expansions has been the twenty-five cent per package tobacco tax. These funds are deposited in a separate state account, the Children's and Seniors' Assistance Fund (CSAF). Another key source of funding for expansion has been the FFP related to expanded services, which has been re-deposited in the CSAF. Funding from the Uncompensated Care Pool has been diverted to the CSAF as more people become insured. Lastly, funding for a small segment of welfare recipients previously served by Emergency Aid to the Elderly, Disabled and Children, was also moved into the expanded programs.

### ➤ ***MassHealth Cost Increases are Largely Due to Medical Inflation***

Recent MassHealth cost increases are attributable to two primary, separate causes:

- Medical inflation primarily in nursing home, pharmaceutical, community-based long term care and hospital expenditures.
- Caseload increases largely in the expansion populations. **These have been budget neutral to the General Fund because caseload and tobacco tax predictions have been accurate.**

➤ ***Cutting MassHealth Hurts the Economy and Destabilizes the Health Care System***

Because the federal government reimburses more than one-half of MassHealth costs, every dollar cut from the state budget will reduce federal revenues unnecessarily.

If coverage is lost, recipients would be forced to rely more on other state-funded services, such as the Uncompensated Care Pool, further reducing savings.

Cutting MassHealth means cutting jobs. The health service sector is the single largest employment sector in Massachusetts, accounting for 10% of all employees in the Commonwealth. Health care ranks as the #1 employer in nine counties and as the #2 employer in three more counties (see graphic, page 13).

➤ ***Recommendations to Save Costs and Stabilize Funding***

**Approve “Health Now!” (S. 1703).**

We recommend passing this legislation, which would raise tobacco taxes and dedicate the funding to the Children’s and Seniors’ Assistance Fund. The “Health Now!” Proposal would stabilize funding for the expansion programs, maintaining critical health coverage to hundreds of thousands of our neediest residents.

**Maximize Federal Revenue.**

While many major revenue maximization strategies have already been implemented, further projects should be shifted out of the Division of Medical Assistance’s jurisdiction and into an Executive Branch office (either the Health and Human Services or Administration and Finance). This would minimize inter-agency disputes and assure a comprehensive perspective on budget issues.

**Avoid Preventable Hospitalization.**

Targeted initiatives should be encouraged to decrease preventable hospitalizations. Diverting “stuck kids” (those in psychiatric beds but ready for discharge and receiving hospital-level care) into community-based services is one possibility. The Minigrants program also has proven effective in linking people to community providers.

**Control Pharmaceutical Costs.**

With pharmacy costs growing at an unsustainable rate, a variety of measures, some in progress, should be taken to restrain cost increases in this area. Such measures include bringing the cost of the Pharmacy Advantage program under Mass Health for low-income seniors, and exploring whether or not fair prices are being paid for pharmaceuticals.

**Support Targeted Fraud and Overpayment Initiatives.**

Overpayment and fraud hurt all citizens. The legislative task force and the Attorney General should be supported in their pursuit of stopping these practices, but should assure that providers are not harassed.

**Instituting Copayments and Broad Cuts in Eligibility and Services Won’t Work.**

Both strategies are simplistic solutions unlikely to achieve their stated objective of saving money. Copays and eligibility cuts undermine patients’ ability to get preventive care, leading to higher costs elsewhere. Both would also signal an unnecessary retreat from our moral commitment to serving the health care needs of the most vulnerable.

## **I. Introduction**

The Commonwealth is currently in the midst of a significant, deep budget crisis. As state leaders look to trim costs and enhance revenues, the Massachusetts Medicaid program (known as MassHealth) has garnered a lot of attention.

House Speaker Thomas Finneran has appointed a Medicaid working group to make recommendations about cost saving measures. This is a welcome opportunity to examine the program in detail, and to propose strategies for ensuring its future.

There is a great deal at stake. MassHealth insures one in four children, and one in six residents of the Commonwealth. It pays for the nursing home costs of the vast majority of institutionalized elders. As a program, it has worked well. We have experienced significant reductions in the number of uninsured residents of the Commonwealth as a result of our efforts. Massachusetts is seen as a national leader, and rightfully so.

This paper is intended to provide basic information about, and offer analysis of, the MassHealth program, including:

- A brief overview of the MassHealth program, including coverage categories. MassHealth is a well-designed program. The expansions made in 1996/97 were well considered, and had strong policy and financial rationales;
- An introduction to the financing mechanisms utilized for each program component. MassHealth is a good financial deal for the state. The availability of federal funds makes cutting the program a poor choice from a fiscal perspective;
- A breakdown of cost increases in terms of caseload growth and medical inflation. The reasons for cost increases vary between caseload segments and between services. Policymakers must be strategic in seeking to rein in costs;
- An estimate of the likely economic impact of cutting eligibility or services. Through the federal matching funds available, MassHealth provides substantial economic benefits to the state, which is critical because health services is the leading employment sector statewide;
- Suggested measures to control costs and ensure program stability. Changes can be made to the MassHealth program that will control costs and stabilize funding. However, some reforms are likely to do more harm than good.

This paper was prepared by Health Care For All. In general, the MassHealth Defense Coalition is supportive of the views and recommendations contained in the report, but not every member necessarily embraces every point it contains.

Blaming the MassHealth program for the Commonwealth’s budget problems is far too simplistic, and will likely produce recommendations that don’t achieve their objectives. We hope that a more comprehensive look at MassHealth will generate a better-tailored response, one that protects our most vulnerable residents and ensures a healthy future.

**II. Overview of the MassHealth Program**

In Massachusetts, the Medicaid Program is referred to as MassHealth. Medicaid is a state-federal partnership. Under federal law, if the state operates a Medicaid program consistent with federal standards, it is eligible to receive federal matching funds for the costs of its program. Some federal standards are *mandatory*, i.e. a state must provide certain services to certain categories of people. Other standards are *optional*, i.e. a state can choose to provide services to additional people; if it does provide these services it will receive matching funds for them.<sup>1</sup> Finally, states can ask the federal government for a *waiver* from some requirements; waivers allow states to reallocate dollars to which they are entitled in order to expand coverage, test creative strategies and tailor their health care programs to local conditions.

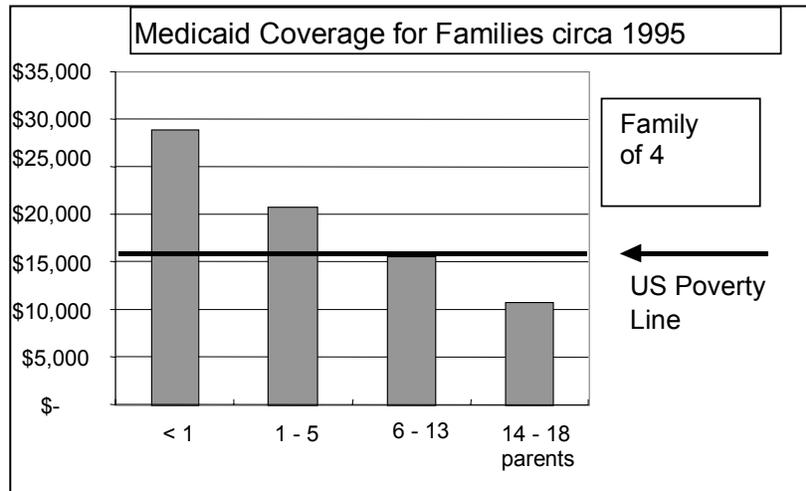
Massachusetts, like the majority of other states, currently operates much of its Medicaid program through a "waiver" from the federal government (elders and institutionalized recipients continue to receive Medicaid coverage under non-waiver rules). The federal waiver is a "living document" in the sense that it has been modified numerous times since it was first approved in 1996. The federal waiver is the document that defines the coverage expansions, financing arrangements, and service delivery structure for the MassHealth program. Understanding the waiver is critical to understanding the costs and benefits of the Medicaid program in Massachusetts.

**A. Medicaid Coverage in Massachusetts Before and After Expansion**

Family Coverage

Prior to 1996, Massachusetts operated a more traditional Medicaid program. While the Commonwealth provided coverage to children, parents, disabled people, and the elderly, it often did so in an uncoordinated and disruptive manner.

Family coverage provides a good example of this phenomenon. In the early 1990s, our Medicaid program's coverage standards were largely governed by federal requirements. As a result, eligibility for



children and their parents depended upon two primary factors, including the income level of the family and the age of the family member. Younger children were eligible at higher federal poverty levels, while the income threshold for older children and parents remained tied to the standard governing the Aid to Families with Dependent Children (AFDC) program.

<sup>1</sup> Once a state chooses to provide an optional service, there are some limits on how it may seek to restrict the benefit. Medicaid programs must provide services in an "amount, duration and scope" sufficient to achieve their intended purposes.

The impact of tying Medicaid eligibility to a combination of age and income level could be seen in individual families. In the same family, some children could have coverage while others were uninsured. Younger children lost coverage as they aged, frequently disrupting continuity of care. This was especially problematic for children with chronic conditions like asthma.

#### Disabled Coverage

There were different reasons for the changes made to coverage for individuals with severe disabilities. Prior to the expansions, coverage for those eligible on the basis of disability was fragmented in several programs. The programs utilized alternative, complicated eligibility determinations that were difficult for the state to administer and for recipients to understand. Traditionally, there were three separate program categories serving disabled residents, all of which were substantially altered and streamlined by the expansion legislation:

- Medicaid disabled coverage provided insurance to low-income residents who met Social Security Administration disability standards. It utilized a “net income test” in which gross income was totaled, and then a complex series of deductions and income disregards were applied. This program was simplified by raising the income standard to 133% of the Federal Poverty Line (FPL) but using a gross income test with no deductions. The result is a program that is easier to administer, easier to understand, and is unlikely to have increased coverage<sup>2</sup>;
- Medicaid “spend down” coverage was designed to insure “medically needy” residents who were over-income for regular disabled coverage, but otherwise met disability standards. Eligibility for this group had to be recalculated every six months. Recipients often cycled in and out of coverage, disrupting continuity of care and reducing the efficacy of treatment. The administrative costs were substantial. This program was eliminated and replaced by an expansion to the CommonHealth program (see below);
- The CommonHealth program was a 100% state-funded mechanism for providing coverage to working disabled adults and disabled children. There were no income limits in the program. CommonHealth utilized a sliding scale premium structure to recoup program costs from higher-income enrollees. The expansion legislation made several changes. First, it created a new category of CommonHealth recipient: non-working disabled adults. These recipients qualify by meeting a one-time six-month spend down. Subsequently, they are charged a sliding scale premium based on income. Second, the full CommonHealth program was included under the federal waiver, allowing the state to reduce costs by accessing federal funds for these enrollees.

#### MassHealth Basic

The creation of the MassHealth Basic program was the third major change in the 1996/97 legislation. MassHealth Basic provides a less comprehensive package of benefits to chronically unemployed individuals. Many of these residents were previously served by the EAEDC Program at state cost (there were no federal funds available). Others tended to use the Uncompensated Care Pool or hospital emergency departments for care. The MassHealth Basic Program was designed to provide ongoing coverage in

---

<sup>2</sup> A net income of 100% FPL is roughly equivalent to a gross income of 133% FPL.

less expensive settings. It also allowed the Commonwealth to collect federal payments for this coverage group.

The following table summarizes the changes made in eligibility and the approximate number of additional MassHealth members added as a result of the 1996/97 expansions.

**Children’s and Seniors Assistance Fund Programs**

<b>Coverage Group</b>	<b>Before Expansions</b>	<b>Now</b>	<b>Approximate Number Covered</b>
Children	Children’s coverage depended on a combination of the age of the child and the family’s income.	All children are covered up to 200% of the FPL (\$29,260 per year for a family of three).	107,800 additional children
Parents	Parents were covered up to 133% of the AFDC payment rate (less than 100% FPL).	All parents are now covered up to 133% of the FPL (\$19,458 for a family of three).  If the family has access to employer-based coverage and is below 200% FPL, the MassHealth Premium Assistance program will pay for a family policy (thus providing coverage to the parents as well as the children).	88,400 additional parents
Disabled adults	Disabled adults were covered up to 100% of the FPL.	Disabled adults are covered up to 133% of the FPL (\$11,425 for an individual) under the MassHealth Standard program, and have access to the CommonHealth program if they are over income.	40,500 adults with disabilities
Chronically unemployed adults who do not meet a specific disability definition	No coverage. Could use the Uncompensated Care Pool or other safety net programs funded with state dollars.	These adults are now covered up to 133% of the FPL under the MassHealth Basic program.	46,474 adults

**B. Financing of the MassHealth Program**

As noted in the introduction, the MassHealth program receives federal financial participation (FFP) for qualified expenditures. In general, the MassHealth Program receives fifty cents in reimbursement for every dollar expended. This "match rate" is applicable to most MassHealth expenses, including services provided to the majority of

children, adults, and elderly people in the Commonwealth. However, the federal State Child Health Insurance Program (SCHIP) program provides an enhanced match rate for those children covered by SCHIP; in this case, MassHealth receives sixty-five cents in reimbursement for every dollar expended.<sup>3</sup> Total federal revenues for FY2002 are projected to be \$2.9 billion.

State funds used for matching purposes can come from a variety of sources. The General Fund has historically been used to provide the state share of the Medicaid program. However, it is also possible to use dedicated funding streams (e.g. dedicated taxes or tobacco settlement funds) for Medicaid matching purposes.<sup>4</sup>

The availability of FFP has made the MassHealth program an attractive mechanism for increasing federal revenues for the Commonwealth. Services previously paid for by "state only" dollars have been incorporated into the Medicaid program in order to receive the federal matching funds. An example of this type of effort is the increasing use of the Medicaid program to cover mental health costs for Massachusetts residents. This stratagem produces a two-fold effect. On one hand, the overall cost of the Medicaid program increases as additional services or benefits are incorporated under its financing umbrella. On the other hand, the state receives a cost-offset in federal reimbursement for these services that can be used for any purpose. This dynamic has had a profound impact on the MassHealth Program and contributes substantially to its increasing share of the state budget.

<b>Health Coverage Programs Now Included under Masshealth</b>	<b>Additional Revenues Collected Through Federal Reimbursement</b>
<ul style="list-style-type: none"> <li>• EAEDC health coverage for low-income residents</li> <li>• CommonHealth program for people with disabilities</li> <li>• Medical Security Plan for people collecting unemployment insurance</li> <li>• Prescription Advantage program (in process)</li> </ul> <p><i>NB: these programs were previously funded with “state only” dollars. They are now included in MassHealth line items in the state budget, but net cost is reduced due to federal matching funds.</i></p>	<ul style="list-style-type: none"> <li>• Medical care provided to special education students in a school-based setting</li> <li>• Home and community based services waivers for mentally retarded (DMR), elders (EOEA), and traumatic brain injury (MRC)</li> <li>• Care provided in public hospitals (DPH, DMH, and DMR state schools)</li> <li>• Case management services</li> <li>• Residential rehabilitation services</li> <li>• Distressed hospital payments</li> <li>• Enhanced matching funds for CMS-approved IT projects (e.g. HIPAA)</li> </ul>

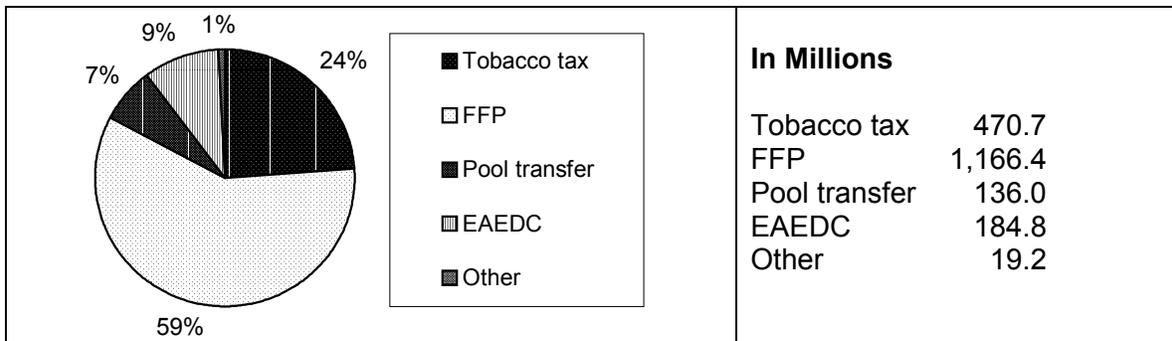
The expansions of 1996/97 created a new financial arrangement for the MassHealth program. The enabling legislation created the Children's and Seniors' Assistance Fund (CSAF) as a mechanism for tracking expansion-related revenues and expenditures. All revenues and expenditures for the expansion programs have been funneled through the

<sup>3</sup> SCHIP allowed states to either expand their Medicaid programs to cover children at income levels above federal Medicaid requirements, or to enact separate state health insurance programs for children. With federal permission, Massachusetts has implemented a blended program, combining the two approaches.

<sup>4</sup> A specific example of this strategy is the federal matching funds available for expenditures made by the Medical Security Plan (MSP). The MSP provides health coverage to unemployed residents. It is funded by an employer tax, currently set at \$16.80 per employee per year. Thus, an employer tax is used to provide the state share for funding in this case.

CSAF. The expansions have been financed from four key sources. First, the legislature passed a twenty-five cent per package tobacco tax as a major source of new funding. Second, all FFP related to expansion expenditures have been redeposited in the CSAF (typically Medicaid FFP is returned to the General Fund). This includes federal matching dollars available through both the Medicaid and SCHIP funding streams. Third, the expansion legislation anticipated that transfers would be made from the Uncompensated Care Pool to the CSAF. The rationale for these transfers was that increased insurance coverage would result in diminished Pool utilization. Lastly, the legislature moved health care costs for a small segment of welfare recipients – those receiving Emergency Aid to the Elderly, Disabled and Children – into the expansion programs. As a result, a transfer is made each year from the General Fund to the CSAF to cover these expenses.

To date, we have provided coverage for 300,000 people with no additional contribution from the General Fund. The CSAF expenditures were budgeted over a five-year period in order to account for the predictable impact of caseload growth over time. The legislature understood that the program would gradually enroll additional members over time. Thus, in the early years of the expansions revenues significantly exceeded expenditures, while in the out years expenses were expected to outstrip revenues. The legislature expected that over the five-year period the two sides of the balance sheet would line up; i.e. that the programs created would be budget neutral to the state General Fund. This requirement is commonly referred to as **“state budget neutrality.”**<sup>5</sup>



**III. Understanding MassHealth Expenditure Increases**

The MassHealth budget has been growing at a significant rate, **but until FY02 General Fund contributions to the MassHealth program have not.**

	FY98	FY99	FY00	FY01	FY02
Total State Budget (in Millions)	\$18,069.0	\$19,045.0	\$20,416.0	\$22,110.0	\$23,017.0
Medicaid Spending Less Expansion Costs	\$3,568.1	\$3,777.2	\$3,986.0	\$4,311.4	\$4,927.7
General Fund Spending as a Percent of State Budget	19.75%	19.83%	19.52%	19.50%	21.41%

**not.** In fact, General Fund contributions to the MassHealth Program as a percentage of overall state budget expenditures have remained fairly flat from FY1998-2002.<sup>6</sup> Indeed, the FY98-01 data show a slight decline in this ratio. There is an increase for FY02 that

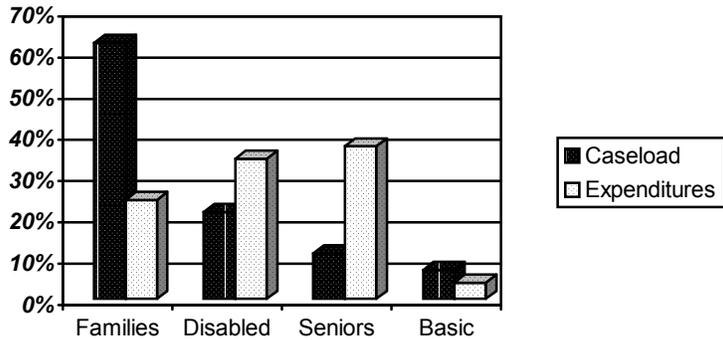
<sup>5</sup> There is also a “federal budget neutrality” requirement for all programs seeking approval for federal waivers. Under this requirement, a waiver cannot cost the federal government more than it would have paid without the waiver. The actual negotiation involves complicated discussions about medical inflation rates and the relevant base cost of the program.

<sup>6</sup> For this calculation, we used state budget projections from the Massachusetts Taxpayers Foundation; see Massachusetts Taxpayers Foundation. *State Budget '02: Heading For a Crash*. Boston: January 2002 (available at [www.masstaxpayers.org](http://www.masstaxpayers.org)).

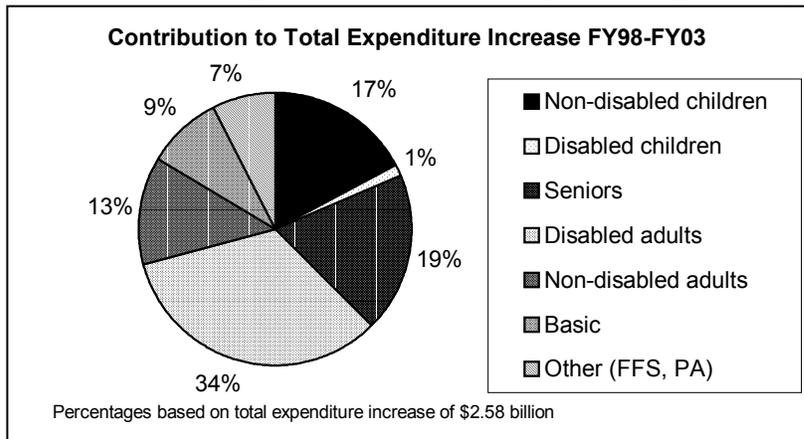
may be explained by several factors, primarily recession-related caseload increases combined with slower overall budget growth.

Total expenditure increases originate from a combination of caseload growth and medical inflation. The more people on the program, the more it costs. Similarly, even if enrollment stays flat, expenditures can rise due to increases in service costs. Within the MassHealth Program, these dynamics are specific to individual sub-populations of recipients. For some sub-populations, like elders and people with disabilities, service costs are a more significant factor because these groups are relatively high users of medical services. For other, relatively inexpensive sub-populations like children and parents, enrollment growth may contribute more to overall cost increases.

The following chart illustrates the relative balance of caseload and expenditures for four different population groups within the MassHealth program. While children and their parents make up nearly two-thirds (62%) of enrollment, they account for less than 25% of all expenditures. In contrast, elders comprise only 11% of the MassHealth population but contribute to over one-third of all costs (37%).



Thus, growth rates are inextricably linked with average per-member-per-month (PMPM) costs. The PMPM rate for elders is nearly 10 times that for children and parents (\$1,460 per elder vs. \$168 for non-disabled children and parents). Growth rates in program expenditures thus follow a predictable pattern: higher cost populations have been more responsible for overall expenditure growth on a per capita basis. Elders and adults and children with disabilities account for 54% of all expenditure growth during the past five years. The following chart summarizes expenditure growth by population since 1998.



## A. Growth in Enrollment

Since 1996, we have added approximately 300,000 people into the MassHealth program. This is one of the primary statistics cited in support of the claim that the program is a “budget buster”; it is therefore important to understand the causes of enrollment growth and whether these causes were anticipated or unexpected.

MassHealth enrollment growth can be influenced in three distinct ways. First, enrollment can grow because eligibility criteria are changed. The expansions of 1996/97 are an obvious example of this factor—making more people eligible resulted in additional people signing up for the program. Second, the economic environment can impact MassHealth enrollment because eligibility for all MassHealth programs is tied to people’s income levels. If incomes rise during good economic times, fewer people will be eligible for coverage. In contrast, during a recession, more people will become eligible. Recent growth in the MassHealth program is likely attributable to this cause, and should reverse itself upon an economic upturn.<sup>7</sup> Finally, MassHealth’s relationship to the broader health care system can impact enrollment. If employers drop coverage, more people may rely on public options for their insurance. From all indications, this factor (called crowd-out) has not been a significant contributing factor to caseload increases.<sup>8</sup>

The 1996/97 expansions have provided the most significant contributions to enrollment increases over this period, **but have been entirely funded by tobacco taxes, federal revenues, and contributions from the Uncompensated Care Pool.** About 300,000 people have been added to the MassHealth program. This level of new enrollment was anticipated by the original projections made in 1998; however, especially on the adult side, enrollment in individual components of the program has differed from projections.<sup>9</sup> Some of the new enrollees would have been eligible for coverage under the previous rules; however, their costs have been charged to the Children’s and Seniors’ Assistance Fund through an accounting formula.<sup>10</sup>

The CSAF is expected to run a deficit at the end of FY2002 of \$112M. The shortfall has resulted from the decision of the legislature not to make budgeted transfers from the Uncompensated Care Pool at the level anticipated by the original budget projections.<sup>11</sup> The expansions have, however, saved the Uncompensated Care Pool a great deal of money (probably \$100-150M per year), as shown by the following chart.

---

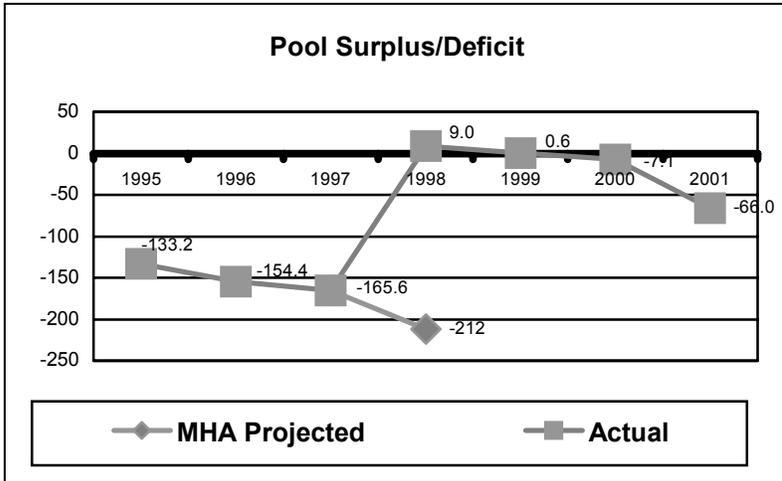
<sup>7</sup> Holohan, John. Rising Unemployment and Medicaid. Washington, DC: Urban Institute, September, 2001.

<sup>8</sup> Lutzky and Hill. Has the Jury Reached a Verdict? States Early Experiences with Crowd-out Under SCHIP. Washington, DC: Urban Institute, June 2001; Blumberg, Dubay and Norton. “Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis Using SIPP.” Journal of Health Economics 19 (2000).

<sup>9</sup> Massachusetts has enrolled fewer adults than anticipated in the insurance subsidy programs, and more than expected in MassHealth Basic and MassHealth Disabled/Commonhealth coverage.

<sup>10</sup> There are complicated arguments about the appropriateness of charging people to the CSAF who would have been eligible under old rules. On one hand, their costs would have been paid by the General Fund, and arguably should have been charged there. On the other hand, it is likely that the streamlining and marketing of the MassHealth Program encouraged some previously eligible people to apply for coverage who would not otherwise have done so (the “woodwork effect”).

<sup>11</sup> Expected Pool transfers have fallen short by \$128M (more than the overall deficit of \$112M). Predicted tobacco tax revenues have been extremely accurate over the five year period. Both enrollment and total cost have been slightly lower than anticipated.



In contrast, enrollment in traditional coverage programs (e.g. Medicaid coverage that was available prior to expansion) has remained flat. For example, the number of elders receiving coverage through MassHealth has been virtually unchanged over the past five years, averaging around 100,000 members.

In recent months, it is likely that the economic downturn has impacted caseloads significantly. DMA estimates that application volume has increased by about 15% since September 2001. However, it is likely that enrollment increases are more substantial than cost increases. Family coverage tends to be most sensitive to economic conditions, but is also the least expensive in terms of per-member-per-month costs.

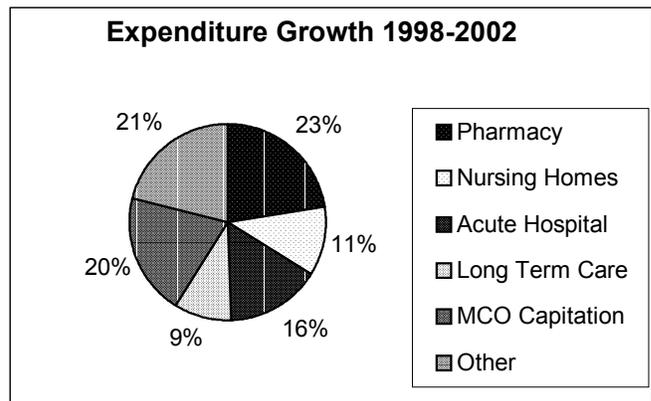
**B. Growth in Service Costs**

The second area to examine in terms of expenditure growth is specific services. Over the past five years (1998-2002), five areas have been responsible for much of the cost growth in the MassHealth program. These include pharmacy, managed care capitation, nursing home, services delivered at acute care hospitals (both inpatient and outpatient), and community-based long term care services.

Service Type	Change
Pharmacy	\$409.9M
Nursing homes	\$207.9M
Community long term care	\$171.2M
(Acute) hospital care	\$283.5M
MCO capitation	\$366.1M
Other	\$384.2M

The chart to the right provides a visual snapshot of the composition of service factors.

It is important to note that capitation payments for the managed care program account for 20% of the expenditure growth. The MassHealth program provides care to a significant percentage (about 16% or



145,000 members)<sup>12</sup> of the non-elderly population by contracting with four managed care organizations (MCOs).<sup>13</sup> To the extent that cost increases to MCO providers reflect inflation in the same service areas, the above chart understates the impact of these cost sectors.<sup>14</sup>

As with enrollment growth, it is important to understand the dynamics driving cost increases in specific service areas. As with cost growth generally, overall increases are the product of the base cost of the service in the initial year and the inflation rate for that service over the period in question. Thus, service areas that have high price tags to begin with can grow at relatively slow rates and still contribute significantly to overall cost inflation. In addition, specific services may be disproportionately utilized by a specific population, or may have internal dynamics which warrant further explanation. For this reason, the remaining four cost drivers outlined above will be considered in turn.

**Pharmacy** expenditures account for 16% of the overall MassHealth budget and are one of the fastest growing segments of the budget. Since 1998, pharmacy costs have increased by an average of 16.7% per year. This experience is consistent with overall trends in the health care marketplace. As might be expected, seniors and people with severe disabilities disproportionately utilize pharmacy benefits. Fully eighty-two percent (82%) of all pharmacy expenditures serve these two populations. Within pharmacy expenditures, the top three classes of medication are psychiatric drugs, cardiovascular drugs, and pain medications. Psychiatric medications account for fully one-third of all pharmacy costs, while the top three classes combined comprise nearly sixty percent (60%) of expenditures.

As an area of cost growth, pharmacy expenditures provide a logical area for savings. They are growing rapidly and are a significant component of the MassHealth budget. At the same time, this service is overwhelmingly utilized by particularly vulnerable segments of the MassHealth population. Moreover, the top three expenditure classes typify the problems with controlling pharmacy costs generally – if cost controls lead to inadequate access or poorer quality care, substitution of more expensive services (in this case hospitalization) will result.

**Nursing home** expenditures paid by MassHealth have increased substantially since 1998, but the growth rate in nursing home costs has averaged only four percent (4%) per year. The increase in expenditures here results from the fact that nursing home services are relatively expensive to provide. The base cost of nursing home care in 1998 was \$1.27B out of a \$3.73B overall Medicaid budget, or just over one-third of overall expenditures. Over the past five years, nursing home costs as a percentage of the overall MassHealth budget have actually declined. Nursing homes primarily serve elders, with almost 90% of all MassHealth nursing home benefits provided to older residents of the Commonwealth. There are approximately 37,000 elders on MassHealth residing in nursing homes.

---

<sup>12</sup> Division of Medical Assistance. [MassHealth 1115 Demonstration Project Annual Report SFY2000](http://www.state.ma.us/dma/researchers/res_pdf/1115_2000-demoAR.pdf). Boston: 2001 (available at [http://www.state.ma.us/dma/researchers/res\\_pdf/1115\\_2000-demoAR.pdf](http://www.state.ma.us/dma/researchers/res_pdf/1115_2000-demoAR.pdf)).

<sup>13</sup> Neighborhood Health Plan, the Boston HealthNet Plan, Network Health and Fallon Community Health Plan currently participate in the program.

<sup>14</sup> For example, assuming that the MCOs have experienced inflation in pharmacy costs at the same rate as the rest of the MassHealth program, pharmacy cost increases would account for 28% of overall cost increases. Excluding MCO costs, overall increases have been \$1,456.7M, of which pharmacy accounts for \$409.9M ( $\$409.9M / \$1,456.7M = 28.1\%$ ).

Unlike pharmacy benefits, nursing home costs cannot be easily controlled through reducing rates of payment. Nursing home providers complain that MassHealth currently pays them on average \$10 to \$15 a day less than the actual cost of care, and bankruptcies and facility closures have escalated in recent years.<sup>15</sup> Any cost savings would therefore need to be achieved through the increased provision of lower-cost alternatives in the community. This has begun to occur with the development of programs within the Executive Office of Elder Affairs that provide intensive services to elders at risk of institutionalization, and through the growth of alternative housing and care programs such as assisted living. However, this strategy is easier to state in theory than implement in practice. Elders that have already been placed in nursing homes confront significant barriers to returning to community settings. In the first place, elders in nursing homes tend to be the frailest and most medically needy members of their age groups. Because of the way in which eligibility criteria are structured for nursing home care, they would confront significant financial hurdles even if lower-cost, quality care were available in the community.<sup>16</sup> In addition, there is no guarantee that the provision of home-based care to severely incapacitated elders will save money, given the level of care they may require. Finally, elders in nursing homes have often severed ties with existing community resources (e.g. they have lost their previous housing), making return to the community a complex task requiring significant coordination of a broad range of social services.

A more promising alternative would be to expand the provision of diversionary programs to try to prevent or delay elders' entry into nursing homes where high quality community-based services are available. This would require the creation of additional capacity of community-based long-term care options, and targeted identification of elders in danger of nursing home placement.<sup>17</sup>

**Community-based long-term care expenditures** are largely made on behalf of adults and children with disabilities. The caseload growth for adults with disabilities is driving a significant percentage of the cost increase in this area. The kinds of services provided – personal care attendants, visiting nurses, etc. – keep recipients with chronic health conditions from requiring more expensive and less appropriate services. Indeed, these services have been identified by the Supreme Court in the *Olmstead* case as essential to allow the provision of care in the most “integrated” setting, a requirement of the Americans with Disabilities Act.

Lastly, **hospital costs** have increased significantly over the past five years. These increases in part reflect how the delivery system in Massachusetts is structured and

---

<sup>15</sup> Massachusetts Health Care Task Force. Draft Final Report. Boston: January 25, 2002 (available at [www.state.ma.us/healthcare/index.htm](http://www.state.ma.us/healthcare/index.htm)).

<sup>16</sup> The community income eligibility level for MassHealth is 100% of the FPL. Nursing home income eligibility is based on the monthly cost of care, with elders paying most of their income to the nursing home and MassHealth paying the balance. In addition, we require elders to “spend down” their assets in order to qualify for care, leaving them with few financial resources to draw upon. Moreover, elders with community-based spouses might lose eligibility for coverage because of the way income is “deemed” in the MassHealth program. Elders who live in the community must count a portion of their spouse’s income as available to them when determining whether they qualify for MassHealth coverage. When they are institutionalized, this income is not counted. Consequently, some elders would lose eligibility for coverage were they moved from nursing homes to the community.

<sup>17</sup> Alecxih, Lisa Marie, et al. Estimated Cost Savings from the Use of Home and Community-Based Alternatives to Nursing Facilities in Three States. Washington, DC: AARP Public Policy Institute, 1996.

financed.<sup>18</sup> First, relative to the rest of the country, Massachusetts is over-reliant on acute care hospitals as the place where medical services are delivered for outpatient care. Second, our cost structure for hospital care is relatively expensive due to the disproportionate use of academic teaching hospitals by Massachusetts residents. Third, hospitals have experienced cost pressures from both private payors (through managed care contracting) and Medicare (as the result of the federal Balanced Budget Act). The consequence has been increased attention paid to Medicaid rates and billing.

At the same time, hospital rates have not increased substantially over the past five years. Unlike some of the other services, hospital usage tends to be more evenly distributed across the MassHealth population. As a result, the expansions are more responsible for overall increases in the hospital budget (but these costs have been paid for without General Fund contributions). The issues are complicated and contentious, and are not likely to be resolved in the short term through changes to the MassHealth program.

#### **IV. The Economic Impact of Cuts to the MassHealth Program**

Cutting costs from the MassHealth program can frequently result in adverse consequences, including negative economic impacts. Health care is the single most important employment sector in the Commonwealth. Thus, overall cuts to health care services can reverberate throughout the broader economy. In a nutshell, reduced health care spending directly translates into job loss.

A quick review of health care’s place in the Massachusetts economy is in order. Health services are the single most important employment sector in the state. According to

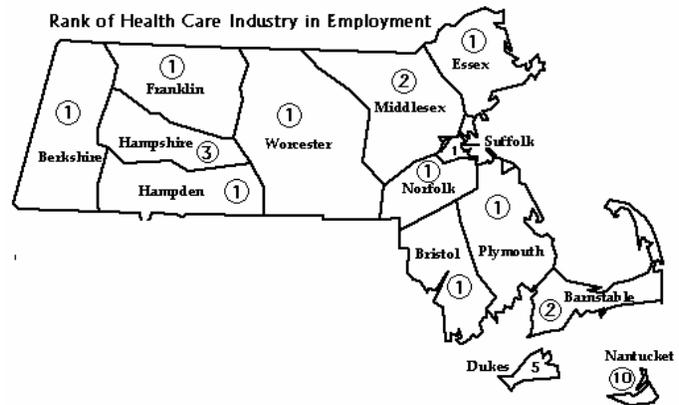
<b>County</b>	<b>Employees</b>	<b>% Workforce</b>
Barnstable	9,949	10.4%
Berkshire	6,842	11.1%
Bristol	22,529	9.0%
Dukes	535	7.5%
Essex	31,482	8.9%
Franklin	2,199	6.0%
Hampden	25,204	12.0%
Hampshire	4,304	5.4%
Middlesex	61,830	7.7%
Nantucket	221	5.3%
Norfolk	30,976	8.9%
Plymouth	16,654	7.0%
Suffolk	80,175	24.5%
Worcester	37,290	10.5%

---

<sup>18</sup> The “Lewin Report” on Medicaid hospital issues provides an overview of many of these issues. [http://www.mhalink.org/News/Newsdir/News01/Lewin\\_Contents.htm](http://www.mhalink.org/News/Newsdir/News01/Lewin_Contents.htm). In addition, the Blue Ribbon Commission’s consideration of the report raised significant questions. See, <http://www.state.ma.us/healthcare/pages/pdf/lewreport.pdf>

## “The Facts on MassHealth”

1998 data, 341,000 people in Massachusetts are employed in health services out of a total working population of 3,414,000, fully 10% of the total employed population. They are distributed throughout the state. Health care ranks as the most important employment sector in Suffolk, Essex, Norfolk, Bristol, Plymouth, Worcester, Franklin, Hampden and Berkshire counties; it ranks second in Middlesex, Barnstable and Dukes counties.



As evident from earlier discussion, MassHealth has its own form of “fiscal math.” Cutting Medicaid dollars poses three inter-related problems to the health care sector and the economy more broadly:

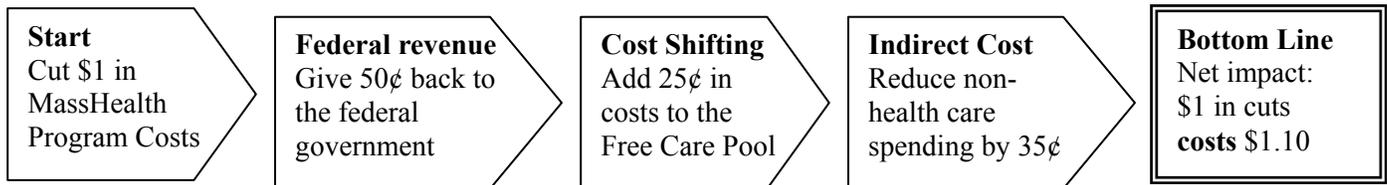
- Cuts in MassHealth result in less federal revenue available to the state. This is a direct reduction in funds flowing overwhelmingly from out of state into Massachusetts<sup>19</sup>;
- Cuts in MassHealth will result in increased demand on the Uncompensated Care Pool, which covers hospital costs for the uninsured.<sup>20</sup> The Pool has a fixed amount of funds available, including a capped amount of federal dollars. Thus, any unreimbursed increase in demand on the Pool amounts to a net economic drain because health providers will have to deliver additional services with the same overall funding. Alternatively, uncompensated care costs will be shifted to private insurers and employers raising health insurance premiums;
- The loss of federal revenue is amplified because the federal dollars are no longer available to circulate through the state economy. Fewer federal dollars results in diminished in-state expenditures by health workers and health providers. In addition, recipients who lose eligibility or benefits as the result of cuts will have less available disposable income to make non-health related purchases. Researchers at the University of South Carolina have estimated the “indirect” economic impact of reductions in federal Medicaid funds to be an additional 70% of the total reduction.<sup>21</sup>

<sup>19</sup> This idea should be distinguished from state budget cuts. State dollars are “redistributive.” Cutting them will impact services, but the net economic impact to the state will be minimal because they come largely from in-state sources. In contrast, the federal funding leveraged through the Medicaid program is “free money.”

<sup>20</sup> Approximately 25% of all health care costs in Massachusetts are attributable to hospital charges; thus a \$1 cut is likely to lead to 25¢ in additional Pool charges.

<sup>21</sup> Division of Research, Moore School of Business. Economic Impact of Medicaid on South Carolina. Columbia: University of South Carolina, 2001.

The first three items listed have relatively predictable price tags given the current structure of federal and state financing mechanisms. The following graphic illustrates the dilemma:



## **V. Proposed Solutions: What Works and What Doesn't**

As evident from the prior discussion, finding cost savings in the MassHealth Program will be a complex process, where careful consideration must be given to the cost ramifications of any proposed changes. In many cases, the cure will be worse than the disease. In others, cost controls will require careful planning and a long-term commitment to implementation that are unlikely to result in short-term savings. Below is a brief analysis of possible strategies.

### **A. Approve the Health Now! Tobacco Tax Proposal**

The legislature has been considering a proposal known as “Health Now!” sponsored by Representative Kaprielian and Senators Montigny, Melconian, and Moore that would raise tobacco taxes and dedicate the funding to the Children’s and Seniors Assistance Fund. The Health Now! proposal would stabilize funding for the expansion programs for several years, providing critical health coverage to hundreds of thousands of residents. A significant majority of Massachusetts residents support raising tobacco taxes if they are used to fund health care. The legislature should pass this bill, and earmark the proceeds to the CSAF, where they can leverage federal funds. The legislature should act quickly – each day that they wait, the Commonwealth loses over \$500,000 in additional revenue. Moreover, other revenue sources should be found to support the non-expansion components of the MassHealth program.

### **B. Control Pharmaceutical Costs**

Pharmacy costs are growing at an unsustainable rate. There are a variety of measures, some already in progress, that should serve to restrain cost increases in this area. The legislature should be careful, however, to assure that cost-control measures do not backfire. Medications are essential to treatment for many chronic diseases; measures that are based purely on cost, and do not take into account efficacy, are likely to be unsuccessful.

With respect to pharmacy costs:

- Cost savings from the Division of Medical Assistance’s (DMA’s) shift to generic medications should be given time to accrue. This past fall, the MassHealth program made significant changes to its prescription drug program, and placed prior approval requirements on the use of brand name medications if generic alternatives are available. The benefit from these cost controls has not yet accrued to DMA due to changes in the pharmacy vendor. Savings should be accounted for, while assuring

that these more restrictive policies have not had unintended health impacts on beneficiaries;

- DMA should implement bulk purchasing strategies, particularly in conjunction with other state agencies. While savings on the MassHealth side may be limited, the purchasing power of MassHealth may reduce costs for other agencies like the Department of Public Health and the Department of Mental Retardation;
- DMA should pursue a federal waiver to bring the costs of the Pharmacy Advantage program under MassHealth for low-income seniors and individuals with disabilities. Savings in state funds from this strategy should be understood to originate with the MassHealth program (and thus be seen as one way MassHealth is helping balance the state budget in difficult fiscal times), although doing so will ultimately increase the overall size of MassHealth;
- DMA should actively explore whether it is paying fair prices for pharmaceuticals. Currently, DMA utilizes a formula which bases individual drug prices on the wholesale acquisition cost (WAC) of pharmacies plus 10%. The Inspector General of the United States Department of Health and Human Services found that these prices are manipulated by pharmaceutical companies, and tend to overstate acquisition costs.<sup>22</sup> We recommend uniformly decreasing costs by a small percentage (perhaps to WAC + 7.5%) across the board. However, in order to protect small pharmacies from undue impact of such a change, state policymakers should explore the creation of a small pharmacy purchasing cooperative which would enable these businesses to compete fairly with larger pharmacy chains;
- DMA should aggressively educate physicians and other prescribers about the medical efficacy and cost of medications in order to counter the marketing strategies of pharmaceutical companies.

The legislature should be cautious in embracing all cost controls, however. DMA is planning to use a more restrictive formulary, where certain “tiers” of medications are preferred over others. Prior approval processes would attempt to prevent the use of non-preferred medications. This process should be explored but should carefully analyzed before being implemented. First, a careful assessment of efficacy should be undertaken, and should involve experts from outside DMA. This structure must save money throughout the MassHealth program (not just in pharmacy costs), and cannot have unanticipated cost consequences.<sup>23</sup> Second, certain classes of medications should be exempted from the proposed formulary, including psychiatric drugs, cancer medications, medications used to treat HIV disease, etc. Third, the prior approval process should assure deference to the clinical judgment of the treating physician. DMA could then encourage the use of medications that work better and cost less in terms of overall (not simply medication) costs. Patients who needed medications not included on

---

<sup>22</sup> Department of Health and Human Services, Office of the Inspector General. Medicaid Pharmacy – Actual Acquisition Cost of Brand Name Prescription Drug Products. Washington, DC: August 10, 2001.

<sup>23</sup> As one telling example of the problem, the cost of AIDS drugs for patients newly enrolled in the Community Medical Alliance Program increases on average after enrollment by about \$400 per month. However, other medical costs decrease on average by more than this amount. Good pharmaceutical management combined with the use of “cutting edge” drug treatments actually saves money. Personal communication with Robert Master, M.D.

the preferred formulary would need sufficient, simple mechanisms to assure continued access to these pharmaceuticals.

### **C. Encourage Care in Less Expensive Settings**

Copayments are often seen as an obvious means to direct people to more appropriate settings, but there are other mechanisms that achieve the same effect in a more targeted and less disruptive manner. Using the example of outpatient departments (OPDs) is helpful. As noted above, Massachusetts disproportionately provides care in relatively expensive outpatient settings rather than community settings (such as health centers and physician offices). Assuming it makes sense to shift people from OPDs to these community settings, the threshold problem is the availability (both in terms of proximity and capacity) of alternatives. It makes far more sense to create economic incentives for *providers* to see MassHealth patients in these settings – e.g. by enhancing rates of payment for providers when they see patients outside OPDs.

Patient behavior is better influenced by enhanced member education initiatives. One strategy would be to redirect and/or enhance the current Minigrants funding for community outreach organizations to assist members with finding cost-effective care settings. The community organizations could also assist patients in accessing and maintaining regular preventive care. Similarly, many elders enter nursing homes as private paying clients only to “spend down” to Medicaid eligibility within a few months. By offering voluntary screening and counseling to these individuals, some could access home and community-based services delaying or eliminating their need for more costly nursing home care. The legislature should explore this and other options to expand access to home and community-based long term care as a means of reducing nursing home costs.

### **D. Enhance Revenue Maximization Efforts**

As is clear from the previous discussion, MassHealth has actually provided substantial economic benefit to the Commonwealth by shifting costs to the federal government. While many major revenue maximization strategies have already been implemented, there are likely areas for additional efforts. In order to facilitate this process, further projects should be shifted out of DMA’s jurisdiction and into an Executive Branch office (either EOHHS or A&F). This would assure a comprehensive perspective on budget issues, and would minimize inter-agency disputes. Through the establishment of an advisory committee of knowledgeable parties from outside state government, DMA could create a structure that tapped expertise in a more formal way.

### **E. Avoid Preventable Hospitalization**

Hospital care is expensive and often preventable. DMA should be encouraged to undertake targeted initiatives to decrease preventable hospitalizations. Several ideas should be explored:

- “Stuck kids” in psychiatric beds have received a lot of attention over the past several years. These children are ready for discharge, but are receiving hospital-level care for lack of alternative placements. The solution lies in both diverting youth likely to need hospitalization to intensive community-based services, and creating step-down levels of service once they are discharged. The House I budget proposal includes \$2M for inter-agency implementation of such intensive services in six cities

statewide. The idea is based on the success of the MHSPY Program in Cambridge/Somerville and the Worcester Communities of Care Program. Under MHSPY (which serves acutely ill children) average costs of care have declined from \$100,000 per year to about \$40,000 per year per child.<sup>24</sup> This is one area where greater spending in the short term may lead to significant savings and improved care down the road;

- DMA should reorient service delivery for people with disabilities to maximize community-based care and minimize hospitalizations. The Community Medical Alliance Program (CMA), a managed care plan that serves MassHealth recipients with very severe disabilities, has demonstrated substantial cost savings through reorganizing care. CMA’s approach uses a case capitation rate that is adjusted to reflect the level of disability of the consumer (e.g. it is higher than the traditional MassHealth capitation rate but lower than what these consumers tend to “cost” the program on a fee-for-service basis). Care is then reorganized using a strong case management system, with well-organized and integrated service delivery. On average, CMA has decreased costs for the care of these patients by 10-25%. The model could be expanded to serve a population with less acute disabilities, including pediatric cases. This strategy is currently being piloted in Springfield with good results; serving a group of 800 patients, average yearly days of hospitalization have decreased from 1150 days/1000 patients to 722 days/1000 patients;
- The Minigrants program has proven an effective mechanism for enrolling individuals statewide into MassHealth. Given the current budget crisis, some of its emphasis should be redirected towards assisting with member education activities. In particular, the Minigrants are ideally suited to linking members with community providers in a cost-effective way.

#### **F. Support Targeted Fraud and Overpayment Initiatives**

It is difficult to know the exact extent of fraud and overpayment. The GAO estimated that overpayment amounted to about 8% of the Medicare fee-for-service program and that no state is maximizing available federal matching funds for Medicaid fraud control.<sup>25</sup> However, the extent to which Medicaid parallels the Medicare experience is unknown. Also, improving payment accuracy might reveal significant underpayment. Finally, fraud is difficult to detect and thus, difficult to estimate.

To the extent that fraud does occur, it hurts everyone. Therefore we believe that the fraud and overpayment efforts of the legislative task force and the Attorney General’s Office should be supported, and the cost effectiveness of enhancing fraud control efforts should be explored. An important caveat is that reasonable efforts to recover improper payments should not be confused with a license to engage in provider harassment. An

---

<sup>24</sup> Master, Robert. "Massachusetts Medicaid and the Community Medical Alliance: A New Approach to Contracting and Care Delivery for Medicaid-Eligible Populations with AIDS and Severe Physical Disability." *The American Journal of Managed Care* 4 (June 25, 1998); Master, Robert, and Eng, Catherine. "Integrating Acute And Long-Term Care for High-Cost Populations." *Health Affairs* 20 (November/December 2001).

<sup>25</sup> General Accounting Office. *Medicaid: State Efforts to Control Improper Payments Vary*. Washington, DC: July 11, 2001. See also, General Accounting Office. *Medicare Improper Payments: Challenges for Measuring Potential Fraud and Abuse Remain*. Washington, DC: July 12, 2000.

overly punitive or bureaucratic approach risks damaging access by driving providers out of the program.

### **G. Avoid Broad Cuts in Eligibility or Services**

These cuts are unlikely to result in cost savings. They will destabilize the health care system and will result in very low-income residents going without essential care or utilizing more expensive services. Because of the federal matching system, Massachusetts will forego significant federal funding, and will drive people into the Uncompensated Care Pool. Loss of state and federal revenue will weaken an already fragile health care delivery system which will reduce the ability of the system to care for everyone (both MassHealth members and the general population). Similarly, increased reliance by the newly uninsured on emergency rooms would exacerbate existing problems with overcrowding and diversions, to the detriment of all. As detailed, the economic impact is significant. In addition, when specific services are eliminated, they are often replaced by more expensive, less tailored alternatives. We should avoid dismantling a program that works well and provides critical services to a million Massachusetts residents.

### **H. Increasing Copayments Will Not Work**

Increasing copayments to MassHealth recipients seems like a simple mechanism for controlling costs, but it is a bad idea. There are two theoretical rationales for copayments:

- They discourage the use of unnecessary care;
- They are a mechanism that creates beneficiary-level economic incentives to use more appropriate and cost effective types of care.

The problem with the first rationale (“copayments discourage the use of unnecessary care”) is that it is not well targeted. While some people may overutilize services, far more consumers utilize services appropriately. Many studies have found that copayments serve to deny people necessary services. This problem is heightened in a Medicaid population. Even modest increases in copayments have been shown to result in adverse outcomes for low-income people, and have actually cost states more money.<sup>26</sup> In addition, they disproportionately impact the sickest individuals who tend to use the most services and thus incur the most copayments.

Insofar as copayments are collected by providers, they should also be seen as an indirect rate reduction – when people don’t pay them the provider absorbs the cost. They are a particularly inefficient means to accomplish this doubtful end, and lead to more administrative work for overburdened providers.

With respect to creating incentives, we have proposed several preferable strategies in Section C, above.

---

<sup>26</sup> Newhouse, et al. “Copayments and the Demand for Medical Care: the California Medicaid Experience.” *Bell Journal of Economics* (Spring 1978). See also, Stuart and Zacker. “Who Bears the Burden of Medicaid Drug Copayment Policies.” *Health Affairs* (March-April, 1999.)

## **VI. Conclusion**

The MassHealth program is an important part of the health care system and critical to the health care needs of our most vulnerable citizens. The legislature can make reforms that achieve dual purposes: long-term stability of the program and improved health outcomes for consumers. Passing the tobacco tax, gaining federal reimbursement for the Prescription Advantage program, and reducing pharmacy costs are short-term strategies that will help stabilize MassHealth. Over the next year, DMA should pursue additional strategies that seek to control costs and improve care, including coordination of care for people with disabilities and development of incentives to seek care in lower cost community-based care settings. The Commonwealth should assure that it is cost-conscious in purchasing care by minimizing inappropriate overpayments and negotiating reduced pharmacy prices. The legislature should not make choices likely to constrain economic growth, lead to job loss, or to have unintended negative cost consequences. At a time of difficult fiscal choices, the Commonwealth must reaffirm its commitment to the health care needs of our residents, not eviscerate its successes.