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The MassHealth Waiver: 2009-2011...and Beyond

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Executive Summary

On December 22, 2008, the Centers for Medicare and Medicaid Services (CMS) approved Massachusetts' request to renew the MassHealth Section 1115 Research and Demonstration Waiver (Waiver) for an additional three years, through the end of state fiscal year (SFY) 2011. The Waiver, which has been in place since 1997, authorizes critical federal funding for several health coverage programs for low-income individuals and for the Commonwealth's safety net health system for uninsured residents. It is the programmatic and financial underpinning of the Commonwealth's landmark 2006 health care reform law (Chapter 58 of the Acts of 2006), helping to move Massachusetts toward its goal of near-universal coverage. Through the Waiver, over 1 million low-income children, families and individuals receive coverage through MassHealth and Commonwealth Care, the subsidized premium assistance program for low-income adults created by Chapter 58.

The terms of the new Waiver agreement fully fund Chapter 58's coverage expansions and explicitly tie the Waiver to Massachusetts' broader health care reform effort, as shown in the statement of the Commonwealth's goals under the Waiver:

- Achieving near-universal health coverage for all citizens of the Commonwealth
- Continuing the redirection of spending from uncompensated care to insurance coverage
- Demonstrating successful cost-containment by reducing the rate of spending growth in the Medicaid budget for eligible populations
- Increasing access to and improving the quality of care for Demonstration enrollees.

History of the MassHealth 1115 Waiver and Impetus for the 2006 Reform

The Commonwealth implemented the MassHealth program on July 1, 1997. The original Waiver, which operated from SFYs 1998-2002, enabled the state to: (1) expand Medicaid coverage to 300,000 children and adults not otherwise eligible for Medicaid; (2) require most beneficiaries to enroll in a managed care plan; and (3) simplify the Medicaid application process and eligibility rules. The Waiver also authorized the State to pay enhanced financial support in the form of supplemental payments to the newly-created managed care organizations (MCOs) operated by the State's two largest safety net institutions, Boston City Hospital (now Boston Medical Center) and Cambridge City Hospital (now Cambridge Health Alliance).

In return for this flexibility, the State was required to demonstrate "budget neutrality": that federal expenditures under the Waiver program would not exceed what federal expenditures would have been in the absence of the Waiver program. Demonstrating budget neutrality involves complex calculations and negotiations with CMS, and was a major focus in developing the terms of the present Waiver agreement.

After a routine three-year extension for SFYs 2003-2005, the Waiver was extended in 2005 for an additional three years (SFYs 2006-2008), this time with significant changes to the terms and conditions of the Waiver agreement. The new agreement changed how certain components of the

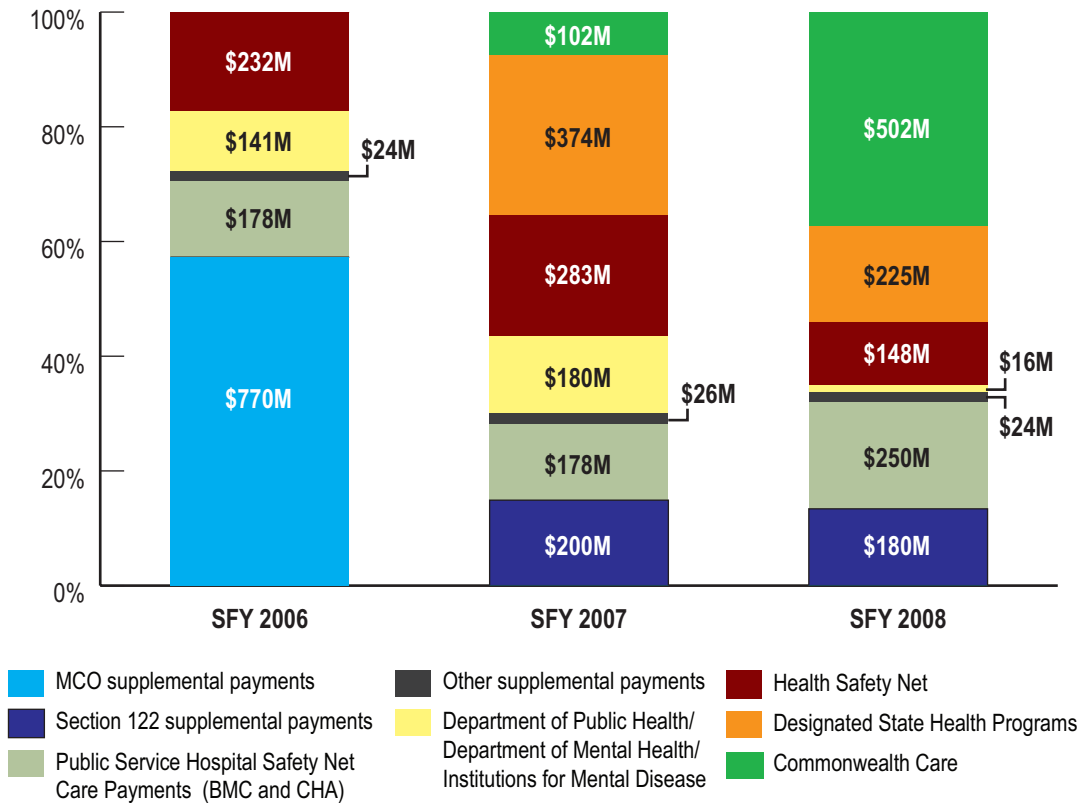
Waiver were financed and incorporated the framework for the comprehensive health care reform plan that State leaders were in the process of developing.

The State's 2006 health care reform effort resulted from a convergence of events, but one served as an immediate impetus for reform. Based on changes to federal Medicaid rules in 2002 and 2003, CMS informed the State that as of the end of the first Waiver extension (SFY 2005) it would no longer be permitted to make the MCO supplemental payments to the two safety net systems that it had been making since 1997. State leaders, already in the process of developing a comprehensive reform plan, persuaded CMS to keep the federal dollars associated with these payments—\$385 million in 2005—in Massachusetts' health care system by committing to use the money to expand insurance coverage for low-income, previously uninsured individuals. This commitment gave rise to the concept of the Waiver's Safety Net Care Pool (SNCP).

The SNCP combined the funding of the former MCO supplemental payments with funding from the State's disproportionate share hospital (DSH) program, which had been used primarily to subsidize the State's Health Safety Net (HSN) (formerly the Uncompensated Care Pool). The SNCP was capped at \$1.34 billion for each of the three years of the Waiver agreement, to be used to reduce the number of uninsured in Massachusetts and ensure access to care for the remaining uninsured individuals who seek care from safety net health care providers. The underlying principle of the SNCP was that as more people became insured through new health reform options, the funds needed for uncompensated care necessarily would decline. The Waiver agreement allowed a one year transition (SFY 2006) during which the MCO supplemental payments continued. During that time, the State developed its coverage model and identified a number of state-funded health programs, called Designated State Health Programs (DSHP), for which CMS agreed to provide federal Medicaid matching dollars equal to what it had been providing for the MCO supplemental payments.

Commonwealth Care, a centerpiece of the State's health reform law, is the coverage model envisioned by the 2005 Waiver agreement and is one of several components of the Waiver's SNCP. Chapter 58 also created new supplemental payments—known as "Section 122" payments—for the two providers that previously received the MCO supplemental payments. The Section 122 payments were authorized for three years starting in SFY 2007, and are another part of the SNCP, along with Commonwealth Care, the Designated State Health Programs, the Health Safety Net, state expenditures at hospitals operated by the Departments of Mental Health and Public Health (DMH and DPH), and several other supplemental payments to safety net providers.

Safety Net Care Pool Uses, SFYs 2006–2008
(Total = \$1.3 billion)



As the State prepared to renew the Waiver for the three year period beginning July 1, 2008 (SFY 2009), the overarching challenge was to demonstrate to CMS that the Waiver program, which now funded a growing Commonwealth Care program, would remain budget neutral to the federal government. Though the State still was able to demonstrate budget neutrality after incorporating into the calculation Chapter 58’s new spending items, the task was becoming increasingly difficult. An additional challenge was the existing structure of the Waiver’s SNCP. The annual SNCP cap of \$1.34 billion that governed the Waiver in SFYs 2006-2008 would not be sufficient to accommodate projected spending for Commonwealth Care, the HSN, and various other safety net spending items in SFYs 2009-2011.

A major goal of the 2008 Waiver renewal negotiation was to ensure that the budget neutrality calculation would accommodate a spending model that included a fully funded Commonwealth Care program at existing eligibility levels and sufficient support for a residual safety net system for the uninsured. For both the state and federal governments, the Waiver negotiation was one piece of a much bigger story and vision—that of a successful comprehensive health care reform plan in Massachusetts and a model of near-universal coverage for the states and the nation.

Outcomes of the 2008 Waiver Negotiations: Sustaining Health Care Reform for the Future

As expected, the major news in the Waiver extension is not programmatic but financial. The Commonwealth received the budget neutrality room it needed, flexibility around the SNCP, and continued authority to claim federal reimbursement for the Designated State Health Programs. The federal government obtained from the State a commitment to cost containment, a SNCP structure that ensures continued movement of funds from support for uninsured people to coverage for those people, and an extension of its partnership in Massachusetts' health care initiative.

Budget Neutrality. The Waiver agreement set a budget neutrality limit of \$21.2 billion for the three year extension period. Under current spending projections, MassHealth will spend to a level that will leave approximately \$13 million in budget neutrality "cushion" at the end of the three years, which leaves little room for variation or further expansion of the Waiver program. The cushion is the gap between the projections of what federal expenditures would be under the Waiver program and what federal expenditures would have been in the absence of the Waiver program. The impact of the SFY 2009 "9c" cuts and the spending blueprint contained in the Governor's SFY 2010 budget is not reflected in this \$13 million figure, so the extent to which they have altered the budget neutrality cushion is not yet known. In general, though, reduced spending relative to the trends in the Waiver agreement will create more room under the budget neutrality cap.

To ensure budget neutrality during this Waiver extension period, the Waiver agreement expands the "without waiver" spending base on which budget neutrality is calculated by counting certain members of Commonwealth Care and MassHealth Essential, who could be categorically eligible for traditional Medicaid absent the Waiver, as part of "without waiver" expenditures. Spending for the affected Commonwealth Care populations also no longer counts against the Waiver's SNCP cap. The Waiver agreement also adds to the "without waiver" base the hospital and physician rate increases mandated by Chapter 58, which were not contemplated in historical trend rates or the President's budget trend rates, but likely would have occurred without a Waiver program in place.

The Waiver agreement incorporates efforts to slow Waiver spending growth. As prescribed by Chapter 58, the agreement ends the Section 122 payments to Boston Medical Center and Cambridge Health Alliance after SFY 2009. It also commits the Commonwealth to a baseline level of cost savings (\$210 million over the three-year period). The SFY 2009 "9c" cuts and savings targets built into the Governor's SFY 2010 budget may already exceed the baseline savings target.

Safety Net Care Pool. The SNCP retains a cap in the Waiver extension, but it is higher and more flexible than what was in place before. At the same time, CMS is more prescriptive in how portions of the SNCP may be spent, and will be more closely monitoring overall use of the SNCP. The new Waiver agreement establishes a three-year aggregate SNCP cap of \$4.6 billion. The increase in funds from the previous Waiver period that is potentially available for coverage is over \$1 billion, because spending for Commonwealth Care parents and Commonwealth Care 19- and 20-year-olds (roughly \$582 million) no longer count against the SNCP cap. Projected spending for Commonwealth Care

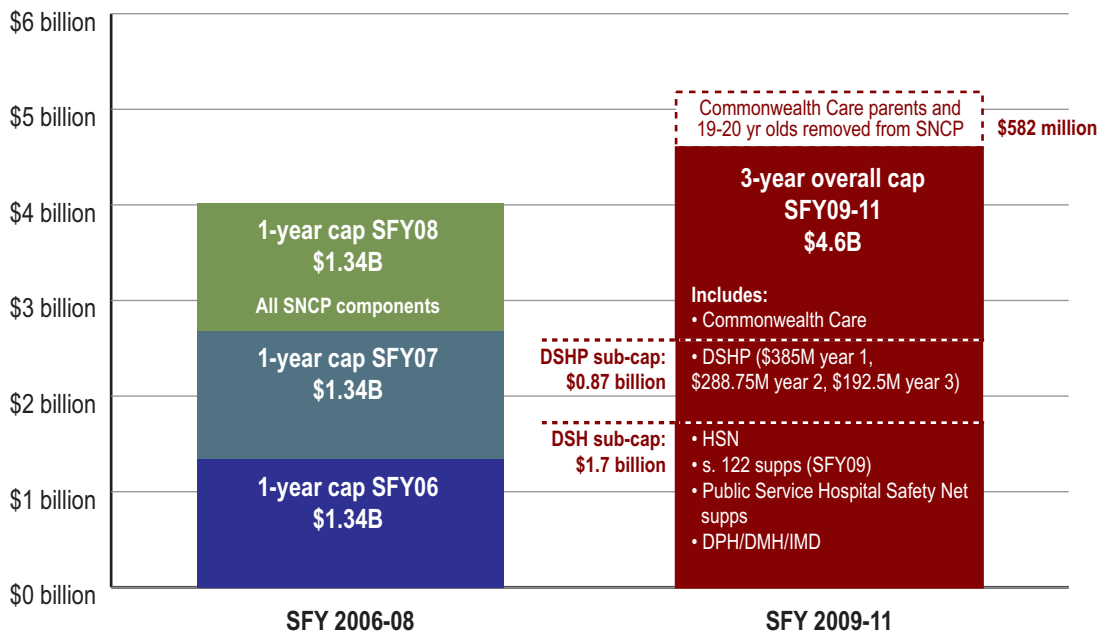
is fully accommodated under the cap; to accomplish this, though, there are limits on the spending for the other elements of the SNCP, in the form of two “sub-caps.”

One sub-cap is a \$1.7 billion limit on all components of the SNCP except Commonwealth Care and the Designated State Health Programs (DSHP). This includes hospital supplemental payments, the HSN, payments to institutions for mental diseases (IMDs) and to DMH and DPH hospitals. Current projections indicate that the Commonwealth’s spending under this sub-cap is roughly \$200 million below the limit.

The second sub-cap is for the DSHP. CMS is phasing down support for these programs, indicating a view that this was intended only as a transitional financing mechanism for the Waiver. The State may claim federal reimbursement for up to 100 percent of the DSHP amount (\$385 million) in SFY 2009, 75 percent in SFY 2010, and 50 percent in SFY 2011.

If Commonwealth Care spending turns out to be lower than projected, those saving can be used to claim more federal reimbursement for other elements of the SNCP, subject to the sub-caps. If there are savings elsewhere in the Waiver program, they may be used to increase the SNCP cap, but only for use by Commonwealth Care.

Safety Net Care Pool Caps, Then and Now



Implications for MassHealth and Health Reform through SFY 2011, and beyond

The continuing success of the MassHealth Waiver and of health care reform depends, in part, on the Commonwealth’s success in keeping the costs of its programs within the tight budget neutrality constraints that are part of the new Waiver extension. At the moment, these constraints seem less

rigid because of the SFY 2009 “9c” cuts and the spending proposal in the Governor’s SFY 2010 budget.

Recent budget cuts likely have produced savings exceeding the baseline spending level built into the budget neutrality estimate, savings that disproportionately affect provider payments. Though it appears now that spending will not exceed the budget neutrality limit, circumstances may change and the Commonwealth must continue to actively monitor its spending. If readjustments were needed, program administrators could consider other tools in addition to the tightening of provider payments that already has been employed, such as limiting the number of members in the Waiver programs through various means. This would presumably be a last resort, as it undermines the primary goal of the Waiver and of health care reform.

The reconstituted SNCP favors funding for coverage, and seems to have adequate room to fully support Commonwealth Care for the three years of the extension, though some uncertainty remains about Commonwealth Care projections for SFYs 2010 (as the budget is not final) and 2011 and, therefore, for the other elements of the SNCP.

All of these challenges are being played out against a background of worsening conditions in the state’s economy, which may have other important ramifications. Beyond 2011, the State will have to continue to be vigilant about cost containment and may have to identify new sources of its share of program costs if CMS phases out federal reimbursement for DSHP. National policy developments will affect Massachusetts as well, with health reform high on the agenda of the Obama Administration and Congress. How any national reforms that emerge are designed to fit with state programs will likely have a great influence on how Massachusetts’ programs will look in the future.

I. Introduction

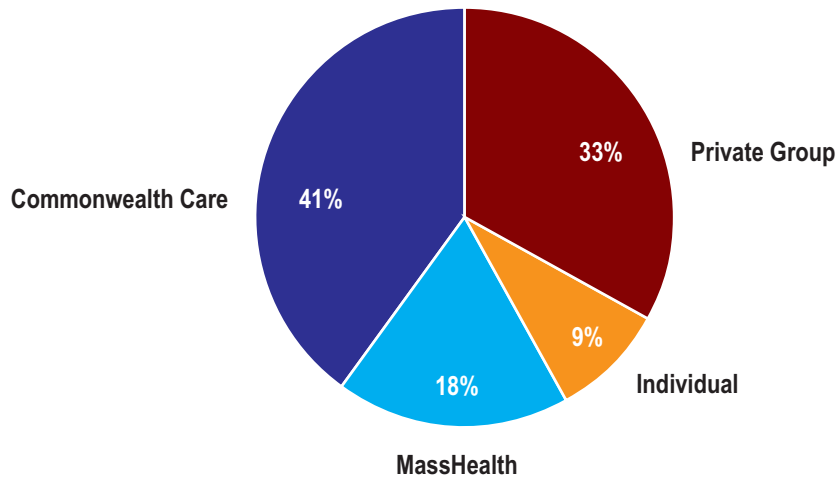
On December 22, 2008, the Centers for Medicare and Medicaid Services (CMS) approved Massachusetts' request to renew the MassHealth Section 1115 Research and Demonstration Waiver (Waiver) for an additional three years, through state fiscal year (SFY) 2011.¹ The Waiver authorizes critical federal funding for several health coverage programs for low-income individuals and for the Commonwealth's safety net health system for uninsured residents. The Waiver has been in place since July of 1997, and is the programmatic and financial underpinning of the Commonwealth's landmark 2006 health care reform law. Chapter 58 of the Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care*, was designed to ensure access to affordable health insurance coverage for nearly all state residents. Through the Waiver, over 1 million low-income children, families and individuals receive MassHealth coverage and an additional 163,000 individuals are enrolled in Commonwealth Care, the subsidized premium assistance program for low-income adults created by Chapter 58.

The new Waiver agreement has significant implications for the long-term sustainability of the Commonwealth's effort to make available affordable coverage to its residents. The Waiver directly affects the scope of the initiative's publicly-funded coverage expansions and the continued level of federal financial support for these key components of the comprehensive reform plan. To date, the reform law has been enormously successful. In just two years, approximately 442,000 previously uninsured individuals have obtained health insurance coverage through MassHealth, Commonwealth Care and other private insurance plans.² (See Figure 1.)

1 Because the Waiver was operating under temporary extensions from July 1, 2008 through December 22, 2008, while the parties negotiated the renewal, the new Waiver extension period is from December 22, 2008 through June 30, 2011. The budget neutrality and Safety Net Care Pool (SNCP) sections, however, are effective from July 1, 2008 through June 30, 2011. This earlier effective date does not present any substantive issues, and is used to remain consistent with the three-year renewal period ending with the June 2011 expiration date.

2 Massachusetts Division of Health Care Finance and Policy. *Health Care in Massachusetts: Key Indicators Report, November 2008*.

Figure 1: Newly Insured in Massachusetts, by Type of Insurance
June 30, 2006–June 30, 2008
(N = 442,000)



Recent data indicate that the number of uninsured Massachusetts residents has dropped by nearly three-quarters since the reform law was implemented and that public coverage is not substituting for or “crowding out” existing private coverage.³ Additionally, use of the state’s Health Safety Net (HSN)⁴ declined by 36% in the first six months of HSN year 2008 (beginning October 1, 2007) compared to the same period the year before; HSN payments declined by 38% over the same time period.⁵ All of the key stakeholders who came together to develop and pass Chapter 58—government, health plans, providers, consumer groups and business—remain fully committed to the reform effort.

The Challenge of Costs

Despite these dramatic successes, challenges regarding the long-term financial sustainability of the health coverage initiative remain. Per capita health care spending and health insurance

3 Long, Sharon. “On the Road to Universal Coverage: Impacts of Reform in Massachusetts at One Year,” *Health Affairs*, 27, No. 4 (2008).

4 Prior to October 1, 2007, the State’s free care pool was called the Uncompensated Care Pool. Chapter 58 changed its name to the Health Safety Net (HSN) and reformed its payment and eligibility policies. Throughout this document, the free care pool is referred to as the Health Safety Net or HSN.

5 Massachusetts Division of Health Care Finance and Policy. *Health Care in Massachusetts: Key Indicators Report*, November 2008.

premium increases in Massachusetts continue to be significantly higher than the national average.⁶ Additionally, enrollment in Commonwealth Care initially grew much faster than originally projected, although it has remained fairly level over the past year. Continuation of historical trends in the cost of health care threatens the ability of the Commonwealth and employers to continue subsidizing health insurance at a sufficient level to keep it affordable for many residents.

Architects of the reform plan laid the groundwork for serious debate and focused attention on health care cost containment in Chapter 58 by creating the Health Care Quality and Cost Council (HCQCC), expanding funding for health information technology (HIT), mandating increased transparency of price and quality data, and establishing value-based purchasing initiatives in Medicaid. On August 10, 2008, the Commonwealth reinforced its commitment to “Phase II” of health care reform by enacting Chapter 305 of the Acts of 2008, *An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care*. Chapter 305 strengthens the role of the HCQCC, formalizes and expands the state’s investment in HIT, requires extensive additional reporting and public disclosure of cost and quality data from payers and providers, and adopts numerous strategies to improve access to primary care.

The Next Chapter

The terms of the new Waiver agreement reflect the State’s focus on cost control and quality improvement, while fully funding Chapter 58’s coverage expansions, including projected Commonwealth Care spending. The new Waiver commits the Commonwealth to health care cost containment goals for MassHealth and Commonwealth Care, and compels the Commonwealth to continue to redirect spending from uncompensated care to insurance coverage by prioritizing Commonwealth Care spending in the Waiver’s Safety Net Care Pool (SNCP). The basic programmatic features of the previous Waiver agreement do not change—all eligibility and benefit levels are preserved. However, the Waiver’s financing structure, particularly that of the SNCP, is altered significantly to support the above-mentioned goals.

This issue brief will provide a history of the MassHealth Waiver, highlight the key concepts of the basic Waiver agreement, describe the issues at stake in and the outcomes of the most recent negotiations between the Commonwealth and CMS to renew the Waiver, and assess the implications of the new Waiver agreement on major stakeholders, including the Commonwealth, consumers, health plans and providers.

6 Health Expenditure Data: Health Expenditures by State of Residence, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released September 2007; available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/res-us.pdf> (accessed February 10, 2009); Premium Data: RWJF/NORC/BCBSMA Foundation, Survey of Massachusetts Employers, 2007; available at http://www.bcbsmafoundation.org/foundationroot/en_US/documents/EmployerSurveyChartpack.pdf (accessed February 10, 2009).

II. History of the MassHealth 1115 Waiver and Impetus for the 2006 Reform

The Original Waiver: July 1, 1997–June 30, 2002

In 1997, Massachusetts implemented a Section 1115 Waiver program, called MassHealth, to operate a large portion of its Medicaid program in a manner that differs from what is allowed under traditional Title XIX federal Medicaid rules.⁷ States apply for Waivers to the Centers for Medicare and Medicaid Services (CMS)—the federal Medicaid oversight agency—to test innovative strategies for delivering or financing care in a more cost effective way for some or all of their Medicaid population. Typically, States use Waivers to streamline eligibility rules, cover populations or services that they could not cover under Title XIX without a Waiver, or utilize different delivery systems than otherwise would be allowed under Title XIX.

Massachusetts filed its Waiver request in 1994, obtained federal approval in 1995 and state legislative approval in 1996. After a year of significant program redesign and creation of a first-in-the-nation automated eligibility process, MassHealth opened enrollment on July 1, 1997. Massachusetts' Waiver covers most non-institutionalized Medicaid enrollees under age 65, and excludes the approximately 100,000 children covered through the State Children's Health Insurance Program (SCHIP).⁸ The term "MassHealth," however, often is used to refer to all Medicaid and SCHIP enrollees in Massachusetts.

With this Waiver authority, the State: (1) expanded Medicaid coverage to an additional 300,000 low-income children and adults not otherwise financially or categorically eligible for Medicaid (some of whom the State had previously covered at full State cost); (2) required most beneficiaries to enroll in a managed care plan; and (3) simplified the Medicaid application process and financial eligibility rules. In return for this flexibility, CMS required the State to demonstrate that federal expenditures under the Waiver program would not exceed what federal expenditures would have been in the absence of the Waiver program. This "budget neutrality" demonstration (see text box), required of all States requesting Section 1115 Waivers, entails complex, technical and theoretical data projections and often intense negotiations with CMS.

⁷ Section 1115 and Title XIX refer to provisions in the federal Social Security Act.

⁸ SCHIP is authorized under Title XXI of the federal Social Security Act.

CMS, then called the Health Care Financing Administration, initially approved the Waiver for a five-year period (SFYs 1998-2002). Under the key terms of the agreement, the State:

- Expanded Medicaid coverage to more people by increasing income eligibility limits for existing eligibility categories to include more infants, children, parents, pregnant women and disabled individuals in the program;
- Expanded Medicaid coverage to more people by creating new eligibility categories for populations not otherwise eligible for Medicaid, including individuals receiving unemployment compensation benefits (Medical Security Plan), long-term unemployed adults who no longer qualify for unemployment compensation benefits (MassHealth Basic and Essential), individuals with HIV (MassHealth Family Assistance-HIV), and low-income workers employed by certain small businesses (MassHealth Family Assistance Premium Assistance and the Insurance Partnership)⁹;
- Required most children and families to enroll in a managed care plan, either the state-operated Primary Care Clinician (PCC) Plan or a private managed care organization (MCO); and
- Significantly enhanced the application and eligibility determination processes by eliminating face-to-face interviews and asset test requirements, and refining how income is counted.

By the end of the first Waiver period, total enrollment in the MassHealth Waiver program was 860,000.

The planned transition of Medicaid enrollees from a fee-for-service delivery system to managed care raised concerns for the Commonwealth about enrollees' continued access to care and the stability of safety net providers. The State's two largest public safety net providers—Boston City

Calculating Budget Neutrality

In general, the State first determines the Waiver spending limit (also called the budget neutrality ceiling or cap) by projecting what it would have spent on populations who could have been covered under traditional Medicaid in the absence of the Waiver. To do so, the State and CMS identify a base year off of which it will build these "without Waiver" spending projections. The base year typically is the most recent year with complete program data. Then, using a trend rate based either on historical program costs and enrollment or on the underlying Medicaid growth rate in the President's federal budget proposal (whichever is lower), the State projects program spending without a Waiver over five years (and then subsequent three-year periods if extending an existing Waiver). Typically, the base year remains the same regardless of the number of Waiver renewals, as it represents the last year in which the State had true "without waiver" expenditures.

The State then projects what it expects to spend on the Waiver-covered populations, including any new expansion of population groups or services not normally eligible for coverage under Medicaid, with the Waiver. These "with Waiver" spending projections must be less than or equal to the "without Waiver" spending projections to meet the budget neutrality test. If they are lower, the State has a budget neutrality "cushion." The State typically creates cushion by adopting policies or implementing programs under the Waiver that deliver care more cost effectively. To be able to cover new populations or services not traditionally authorized by Title XIX, the State must create sufficient savings or cushion to absorb the expansion costs.

Budget neutrality often is described as an "art rather than a science." Any budget neutrality calculation is the result of State-specific negotiations with CMS, which can exercise broad discretion in testing and approving a State's demonstration of budget neutrality. This primarily is because of the theoretical nature of the calculation; over time, base year/trend calculations may no longer represent the true "without waiver" scenario, and CMS may, in certain cases, make corresponding adjustments. Additionally, as actual Waiver expenditures for both "without waiver" and "with waiver" populations are realized, the cushion varies and the State's projection of the cushion in future years must be updated regularly.

⁹ Through the Insurance Partnership, the State also provides subsidies to the qualified small businesses that employ the low-income workers.

Hospital (now Boston Medical Center) and Cambridge City Hospital (now Cambridge Health Alliance)—were concerned that the shift to managed care would disrupt care for their Medicaid patients who might seek treatment elsewhere once enrolled in a health plan. These hospitals also were concerned that this shift could threaten their financial stability if the rates that health plans paid them were significantly lower than Medicaid fee-for-service rates.¹⁰

To address these concerns, the State supported the creation of managed care plans by these two safety net providers, and obtained authority in the Waiver to pay enhanced financial support to their newly-created managed care organizations (MCOs). These “MCO supplemental payments” were in addition to the standard capitation payments that all participating Medicaid MCOs received for their members. The non-federal financial share of these supplemental payments was funded not by the state general fund, but by the localities (the cities of Boston and Cambridge) through an intergovernmental transfer (IGT), a state financing option permitted and defined by federal Medicaid regulations.

The First Extension: July 1, 2002–June 30, 2005

The Waiver was extended in 2002 for three years (SFYs 2003-2005) without any changes to the terms and conditions, as required by federal law.¹¹ For this period, the State only needed to assure CMS that the Waiver program would remain budget neutral to the federal government over the next three years. To do so, the State projected its expenditures for three more years under the Waiver compared to what the federal government would have spent in the absence of the Waiver, using a newly-negotiated trend rate applied to the three-year spending projections.¹²

The Second Extension: July 1, 2005–June 30, 2008

The Waiver was extended in 2005 for an additional three years (SFYs 2006-2008) with significant changes to the terms and conditions of the Waiver agreement. The basic components of the original Waiver agreement did not change and the Waiver continued to authorize expanded coverage, streamlined application and eligibility processes, and mandated managed care. The State again successfully demonstrated to CMS that the Waiver program would remain budget neutral to the federal government, after CMS conducted a comprehensive retrospective review of the budget

10 The pre-Waiver fee-for-service rates for these hospitals included adjustments that took into consideration the disproportionate number of Medicaid and low-income uninsured patient volume these public hospitals served.

11 The initial Waiver was approved under the authority of Section 1115(a) of the Social Security Act. Extensions of Section 1115(a) Waivers are authorized under Section 1115(e) of the Social Security Act and require the extensions to be on the same terms and conditions that applied to the Waiver before its extension.

12 This extension predated CMS policy regarding using the lower of the State’s historical spending or the underlying Medicaid trend in the President’s proposed budget. For this extension period, the State negotiated a per-member per-month (PMPM) trend rate for families at 7.71% and for disabled enrollees at 10.0%. The trend rates for the original five-year Waiver period were 7.71% for families and 5.83% for most disabled enrollees.

neutrality model to confirm the calculation.¹³ The new Waiver terms, however, changed how certain components of the Waiver were financed and incorporated the framework for the comprehensive health care reform plan that State leaders were in the process of developing.

The State's 2006 health care reform effort resulted from a convergence of events. These included a growing number of uninsured individuals after a period of decline, increasingly unaffordable private health insurance premiums, annual shortfalls in the HSN after a period with little or no shortfalls, and long-standing calls for universal coverage from consumer advocacy groups. Additionally, the Commonwealth had steadily built a strong foundation for comprehensive reform through nearly twenty years of incremental coverage expansions and service delivery innovations.

Finally, changes in federal Medicaid rules in 2002 and 2003 added new restrictions on how States may pay Medicaid MCOs and use IGTs to finance supplemental provider payments. In 2002, CMS implemented Medicaid managed care requirements of the Balanced Budget Act of 1997 that required capitation payments to Medicaid MCOs to be "actuarially sound" to be eligible for federal financial participation (FFP). In 2003, CMS initiated policy activities that narrowed the scope of the definition of permissible IGTs. These federal changes, combined with the upcoming deadline for securing another extension of federal support for the Waiver program, served as the final impetus for reform. These changes ultimately shaped the structure of the public coverage components of the health reform plan, which served as the building block for the broader universal coverage initiative.

Based on the changes in federal rules, CMS decided that, as of June 30, 2005 (the end of the first Waiver extension period), the State could no longer make the MCO supplemental payments to the two safety net systems that it had been making since 1997. CMS indicated its intent to withdraw its financial contribution to these payments—\$385 million in 2005—from Massachusetts' Waiver program. State leaders, already in the process of developing a comprehensive reform plan, persuaded CMS to keep these critical federal dollars in Massachusetts' health care system by committing to use the money to expand insurance coverage for low-income, previously uninsured individuals.

To meet this core commitment, the Waiver agreement for SFYs 2006-2008 established a Safety Net Care Pool (SNCP) dedicated to reducing the number of uninsured in Massachusetts and ensuring access to care for the remaining uninsured individuals who seek care from health care providers in the State. The SNCP combined the funding for the former MCO supplemental payments (\$770 million in total state and federal spending in 2005) with funding from the State's disproportionate share hospital (DSH) program (set at \$574.5 million in 2005), which had been used up to that point for several safety net payment purposes, including to subsidize the state's HSN. The total amount available for the designated purposes in the SNCP was \$1.34 billion for each year of the three-year Waiver period. This limit on SNCP spending is an additional fiscal constraint under the Waiver's overall budget neutrality cap. By combining these dollars and setting a cap on SNCP spending, the

¹³ For the second extension period, the State's PMPM trend rates were equal to those included in the President's budget proposal, which were 7.3% for families and 7.0% for disabled enrollees.

Waiver agreement set up a dynamic relationship between the dollars going to support uncompensated care, either through the HSN or through supplemental payments to safety net providers, and the dollars used for coverage. As more people became insured through new health reform options and the money was redirected to pay for coverage, funds required for uncompensated care would necessarily decline.

An important feature of the 2005 Waiver agreement was a one-year transition period (SFY 2006) during which the State could continue to make the MCO supplemental payments and fund the non-federal share of the payments through an IGT, as the State developed its coverage model. The Waiver required the State to end the MCO supplemental payments in SFY 2007 and identify a new source of state or local funds to continue to draw down the \$385 million in federal funds previously supporting the supplemental payments. As part of this effort, the State identified a number of fully state-funded health programs, called Designated State Health Programs (DSHP), for which CMS agreed to provide federal Medicaid matching dollars under the Waiver's SNCP.¹⁴ Examples of DSHP include home care services, universal immunization, and mental health programs administered by agencies within the State's Executive Office of Health and Human Services. Because the programs previously were funded entirely with state dollars, the ability to receive federal matching dollars for these programs freed up state dollars to help pay for new coverage programs under the Waiver.

With the framework for a public coverage expansion established, and agreement from the federal government to contribute to its costs, the task of developing a detailed public coverage model and fitting it into the broader universal coverage initiative would follow.

¹⁴ Massachusetts' federal Medicaid matching rate for most program expenditures is 50%, meaning that for every dollar the State spends, the federal government reimburses the State for half the cost.

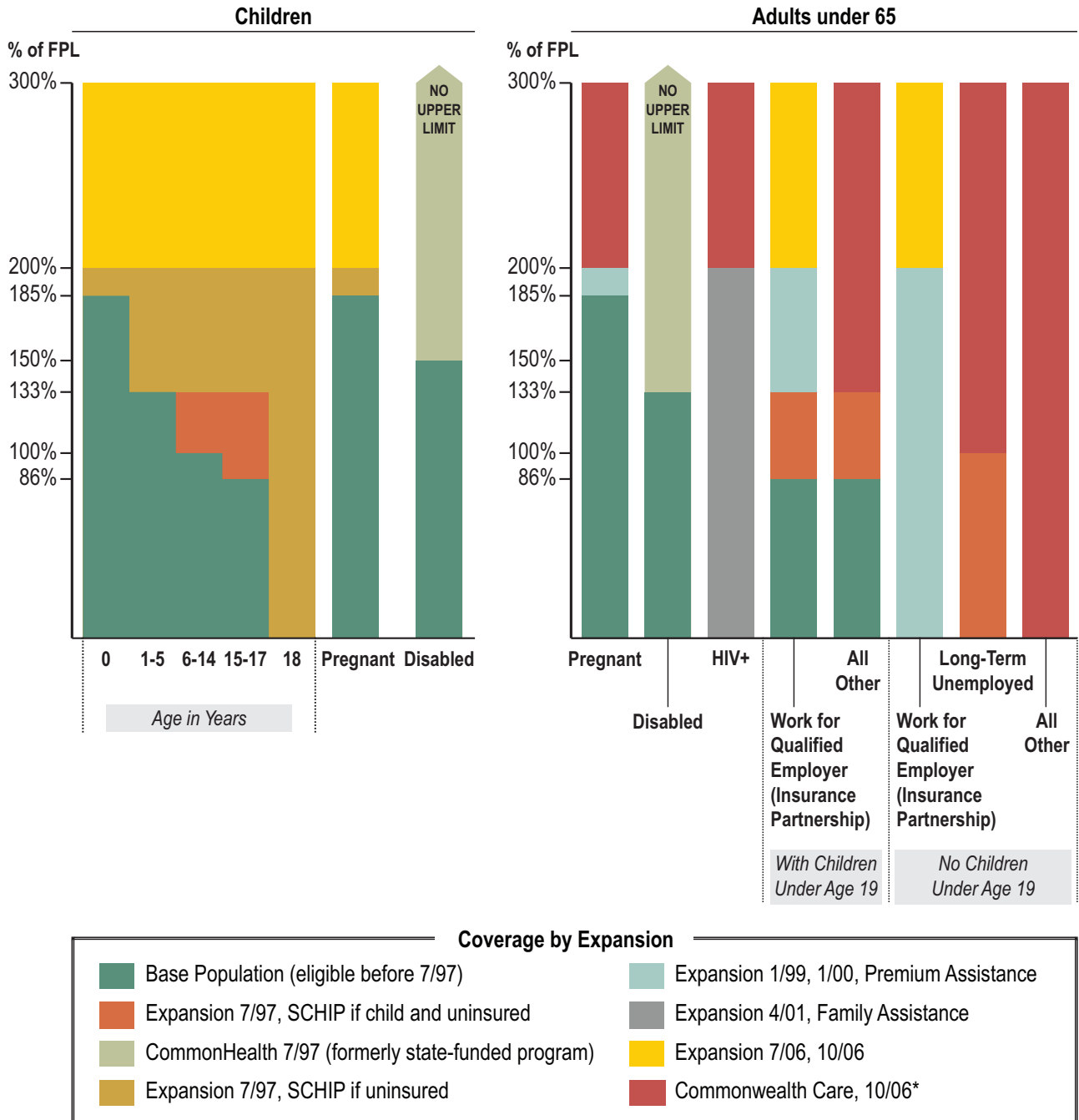
III. Implementation of Health Care Reform and Implications for the 2008 Waiver Renewal Negotiations

After the second Waiver extension was signed in January 2005, State leaders spent the next year developing, negotiating and passing a comprehensive health care reform plan that would provide access to affordable health coverage for nearly all state residents. Chapter 58 was enacted on April 12, 2006, and included a series of interrelated public and private initiatives to achieve this goal. The reform plan included public coverage expansions, private market reforms, the creation of a health insurance exchange to facilitate access to affordable private insurance products, a first-in-the-nation individual health insurance mandate and employer participation requirements. A hallmark of the reform plan was the creation of the publicly-subsidized Commonwealth Care premium assistance program to help low-income adults not eligible for MassHealth purchase affordable coverage from health plans.¹⁵ Commonwealth Care is the coverage model envisioned by the 2005 Waiver agreement and is one of several program components funded under the Waiver's SNCP.

In addition to creating Commonwealth Care, Chapter 58 expanded eligibility for several existing MassHealth coverage programs. Chapter 58 also mandated substantial Medicaid rate increases for hospitals and physicians, required coverage of certain Medicaid services, and reformed the payment and eligibility policies for the HSN. With Chapter 58's coverage expansions in place, the Waiver provides access to affordable, publicly-funded health insurance coverage for most individuals in Massachusetts with income below 300 percent of the federal poverty level (FPL). (See Figure 2.)

¹⁵ For the first three years of the program (SFYs 2007-2009), Chapter 58 specifies that the four existing Medicaid MCOs will participate in Commonwealth Care on an exclusive basis. For SFY 2010, the Commonwealth has opened the Commonwealth Care procurement to other private plans.

Figure 2: MassHealth Eligibility Overview

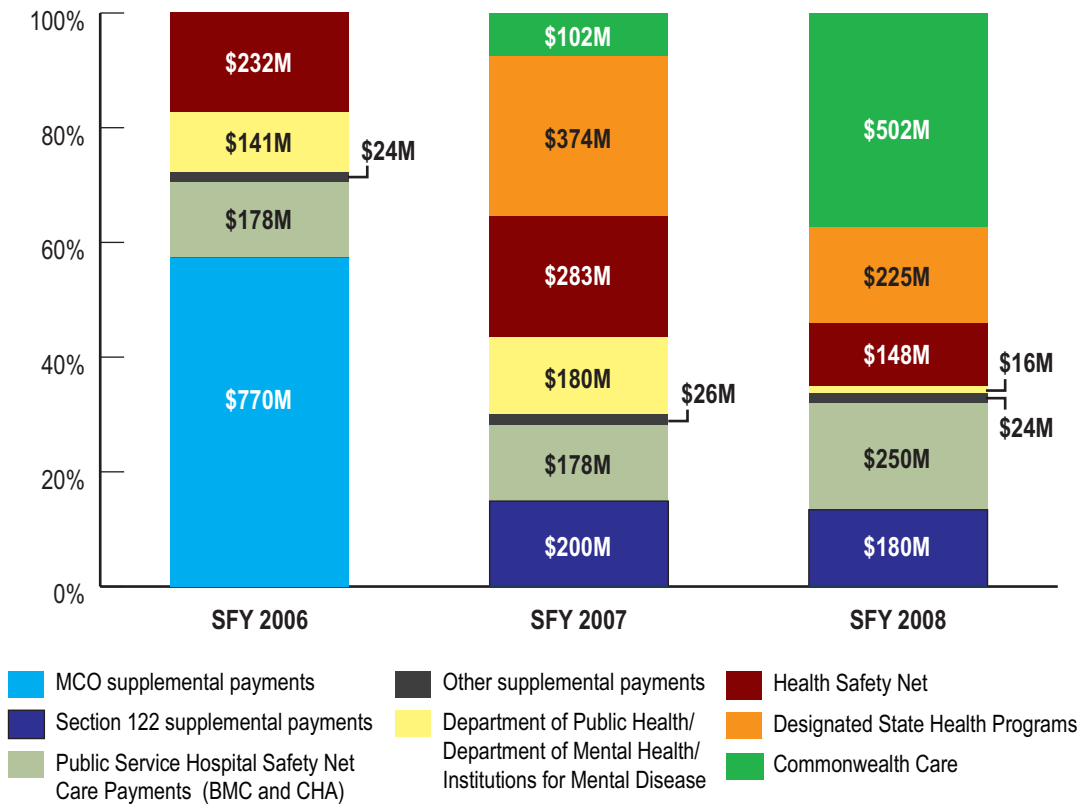


Adapted from material developed by MassHealth and the Massachusetts Medicaid Policy Institute.

Chapter 58 also created new supplemental payments for the two providers that previously received the MCO supplemental payments. These “Section 122” payments were authorized for three years, starting in SFY 2007. The Section 122 payments are part of the Waiver’s SNCP, along with Commonwealth Care, the Designated State Health Programs, the HSN, expenditures for hospitals

operated by the State's Departments of Mental Health and Public Health, and several other supplemental payments to safety net providers.¹⁶ (See Figure 3.)

Figure 3: Safety Net Care Pool Uses, SFYs 2006–2008
(Total = \$1.3 billion)

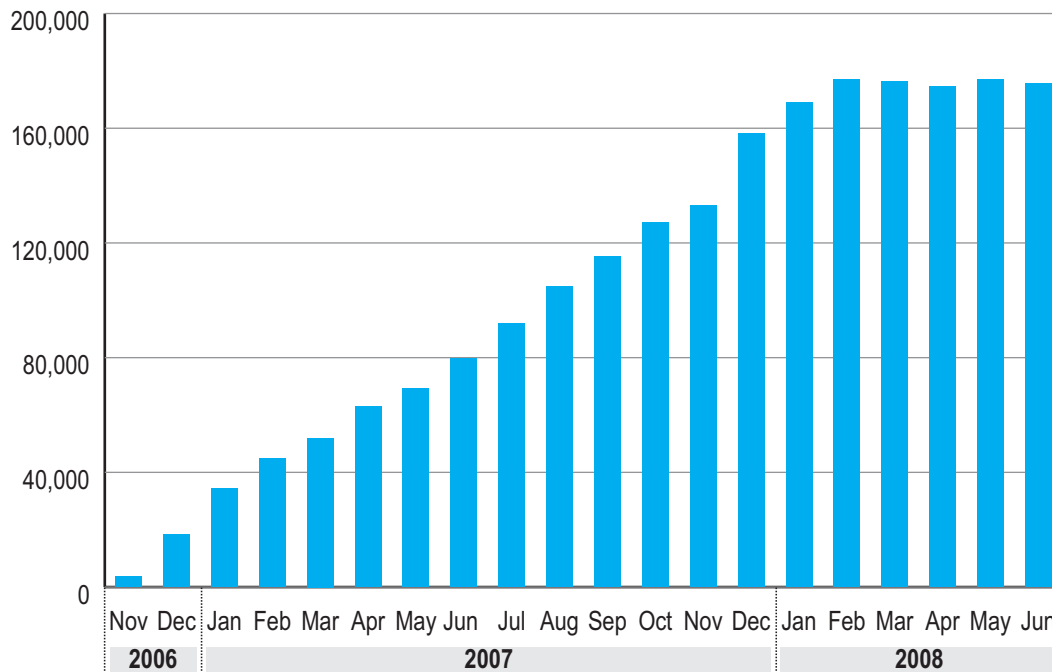


The State amended the Waiver in July of 2006 (the beginning of SFY 2007) to incorporate these changes and update the budget neutrality calculation to reflect the impact of the changes on projected Waiver spending through SFY 2008, the end of the second Waiver extension period. The State was able to demonstrate to CMS that the Waiver program would remain budget neutral with the new coverage and benefit expansions and additional Waiver spending resulting from Chapter 58, but the task was becoming increasingly difficult. The available budget neutrality cushion, mostly created early in the Waiver, was rapidly depleting. In fact, by SFY 2004, the State began to spend more under the Waiver on an annual basis than it projected it would have otherwise spent in the absence of the Waiver. Budget neutrality, however, is measured in the aggregate over the life of the Waiver (versus on a year-to-year basis), and the State projected to remain budget neutral over the first 11 years of the Waiver (SFYs 1998 through 2008).

¹⁶ These supplemental payments primarily include payments to Boston Medical Center and Cambridge Health Alliance.

Within six months of amending the Waiver, the State had implemented Chapter 58's MassHealth eligibility and benefit expansions, Medicaid provider rate increases, Section 122 payments, and the Commonwealth Care program. Waiver program spending increased accordingly. For Commonwealth Care, enrollment and actual spending in the first year of the program was significantly higher than originally projected due to the rapid early success in enrolling eligible individuals. (See Figure 4.) This enrollment success was due, in part, to the automatic conversion into Commonwealth Care of thousands of eligible individuals who previously had been using the HSN and, in part, due to a massive outreach and education campaign about the program and the soon-to-be implemented individual health insurance mandate and its enforcement penalties. Despite the rapid growth in Commonwealth Care, the State remained under the Waiver's budget neutrality ceiling due to the annual SNCP cap, which restricted the State's ability to expand claiming for Commonwealth Care without corresponding reductions in other claims for federal reimbursement in the SNCP.¹⁷

**Figure 4: Commonwealth Care Enrollment
(November 2006–June 2008)**



In the fall of 2007, the State prepared to renew the Waiver for an additional three-year period (SFYs 2009-2011), and began to develop the SFY 2009 budget. Commonwealth Care spending projections became the major focus of attention. The State originally projected to spend \$869 million

¹⁷ To absorb this increased Commonwealth Care spending, the State decreased federal claiming in SFY 2008 for DSHP spending and spending for the hospitals operated by the Departments of Mental Health and Public Health.

on Commonwealth Care in SFY 2009¹⁸, but by the spring of 2008 it began to question whether this would be sufficient to cover projected program costs. Midway through SFY 2009, however, Commonwealth Care enrollment appears to have stabilized, and actual spending may be slightly below what the State originally projected.

With respect to the Waiver renewal, the overarching challenge for the State was to demonstrate to CMS that the Waiver program, which now funded a growing Commonwealth Care program, would remain budget neutral to the federal government for another three years. Continued federal financial contribution to fully funded MassHealth and Commonwealth Care programs is critical to the success of the overall health care reform initiative. Because the remaining budget neutrality cushion going into the Waiver renewal period was nominal, the State would need to reduce Waiver spending, create new Waiver savings, or both, to demonstrate budget neutrality. This would entail renegotiating with CMS the Waiver's budget neutrality construct in a way that generated sufficient budget neutrality room to absorb all projected Demonstration spending, including Commonwealth Care. The Commonwealth's December 2007 Waiver renewal application, therefore, proposed a suite of solutions for doing so.¹⁹

An additional challenge was the existing structure of the Waiver's SNCP. The annual SNCP cap of \$1.34 billion (set for SFYs 2006–2008) would not be sufficient to accommodate projected spending for Commonwealth Care, the HSN, and various safety net care spending items for SFYs 2009–2011. The Commonwealth proposed to eliminate the SNCP sub-cap of the Waiver's overall budget neutrality cap to fully account for these projected expenditures.

Going into the 2008 Waiver negotiations, federal health officials declared their continued support for Massachusetts' health care reform experiment and their desire for successful Waiver negotiations. However, CMS had serious concerns about the State's ability to demonstrate continued Waiver budget neutrality and to generate its share of the projected Waiver program costs, particularly because CMS had expressed its intent to phase out federal reimbursement for DSHP as it viewed the financing mechanism as transitional. CMS also questioned whether the State had sufficiently redirected its spending from subsidizing providers of uncompensated care (either through the HSN or supplemental payments to safety-net providers) to subsidizing insurance coverage for individuals, as envisioned in the 2005 Waiver agreement. Of particular concern to CMS was the creation of new supplemental payments to safety net providers (the Section 122 payments) in SFY 2007. CMS also was concerned about precedent. Massachusetts' reform model, including its Waiver

18 This figure represents total Commonwealth Care expenditures, including capitation payments (minus enrollee contributions) and administrative expenditures. This entire amount is not claimed against the Waiver's SNCP cap, however, as expenditures for certain Commonwealth Care enrollees are not eligible for federal reimbursement under the Waiver and administrative expenditures are excluded from the Waiver's budget neutrality calculation altogether.

19 Massachusetts Executive Office of Health and Human Services, Office of Medicaid. Section 1115 Demonstration Project Extension Request, Health Care Reform Sustainability, December 21, 2007 (available at www.mass.gov/masshealth).

financing component, has been touted by many in the local and national press as a potential model for other States and the nation. With other States looking to the federal government for financial contributions for their reform efforts, CMS and federal budget officials wanted to ensure that federal Medicaid dollars were being used efficiently and for the primary purpose of reducing the number of uninsured.

With this backdrop, the State and CMS entered negotiations to renew the Waiver in 2008. Unlike previous Waiver extensions and amendments, the technical negotiations focused almost exclusively on Waiver financing rather than programmatic changes. The goal of this Waiver negotiation was to ensure that the Waiver would remain budget neutral to the federal government for another three years, based on a spending model that included a fully funded Commonwealth Care program at existing eligibility levels and sufficient support for a residual safety net system for the uninsured. For both the state and federal governments, however, a successful Waiver negotiation was one piece of a much bigger story and vision—that of a successful comprehensive health care reform plan in Massachusetts and a model of near-universal coverage for the states and the nation.

IV. Outcomes of the 2008 Waiver Negotiations

On September 30, 2008 the Patrick Administration announced it had reached an agreement in principle with CMS on terms to extend the Waiver through the end of SFY 2011. The press release announcing the agreement stated that the agreement “fully preserves existing eligibility and benefit levels as well as federal matching funds for all programs, including Commonwealth Care at 300% of the federal poverty level.”²⁰ The final Waiver agreement, approved on December 22, 2008, confirms this and explicitly ties the Waiver to the broader health care reform effort, as shown in the statement of the Commonwealth’s goals under the Waiver:

- Achieving near-universal health care coverage for all citizens of the Commonwealth
- Continuing the redirection of spending from uncompensated care to insurance coverage
- Demonstrating successful cost-containment by reducing the rate of spending growth in the Medicaid budget for eligible populations
- Increasing access to and improving the quality of care for Demonstration enrollees.

The Waiver agreement changes very little about the core MassHealth eligibility and benefit levels. One significant exception is that, beginning on July 1, 2009, CommonHealth members will be required to enroll in managed care, either the Primary Care Clinician (PCC) Plan or one of the Medicaid MCOs.²¹ This previously had been an option for CommonHealth members, who, unlike families, were also free to choose a fee-for-service arrangement.

As expected, the major news in the Waiver extension is not programmatic but financial. The Commonwealth and CMS mutually sought to preserve the coverage achievements of the Commonwealth’s health care reform initiative, while also focusing the negotiation on their own unique goals. The Commonwealth received the budget neutrality room it needed to continue operating MassHealth and Commonwealth Care at projected levels for SFYs 2009-2011, flexibility around and an increase in the spending level of the Safety Net Care Pool, and continued authority to claim federal reimbursement for DSHP at significant levels. The federal government obtained from the State a commitment to control the growth in Waiver spending, parameters for the use of the Safety Net Care Pool that ensure continued movement of funds from supporting care for uninsured people to paying for insurance coverage, and an extension of the partnership in Massachusetts’ closely watched, so far successful health care reform initiative. Details of these points, and their implications for the various stakeholders involved in MassHealth and health reform, follow.

²⁰ “Governor Patrick Announces \$21.2 Billion Medicaid Waiver Agreement.” Press release, September 30, 2008. http://www.mass.gov/?pageID=gov3pressrelease&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=MassHealth&sid=Eeohhs2&cb=pressrelease&f=093008_waiver&csid=Agov3, accessed November 12, 2008

²¹ CommonHealth is a MassHealth program for children with disabilities and working and non-working adults with disabilities.

Budget Neutrality

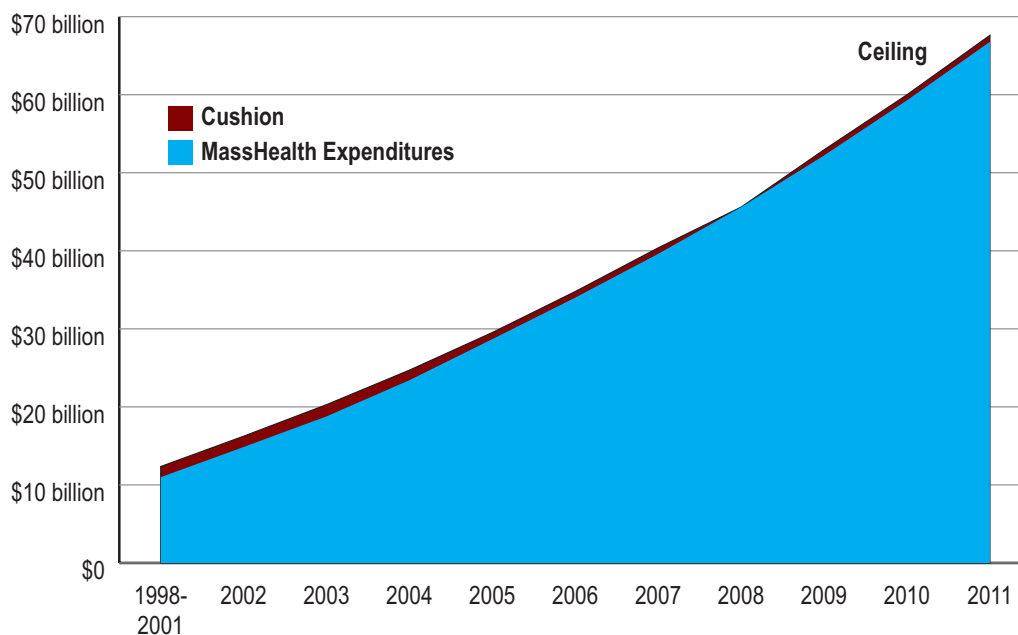
In a very real sense, the future of health care reform in Massachusetts depends on the arcana and art of the budget neutrality negotiation. By setting a limit on the amount of Waiver spending for which the Commonwealth can expect full federal financial participation, budget neutrality regulates what federal funds will be available over the next three years to support Commonwealth Care, the MassHealth expansion populations, the HSN, and other elements of reform.

The Waiver agreement set a budget neutrality limit of \$21.2 billion for the three year extension period.²² Under the approved program rules and spending projections, MassHealth will spend to a level that will leave about \$13 million in cushion at the end of the three years.²³ This cushion leaves little room for variation or further expansion of the “with waiver” part of the program. Remembering that budget neutrality is measured over the entire 14-year period of the Waiver, the projected \$13 million cushion represents just 0.02 percent of the roughly \$67 billion in program spending over that period. (See Figure 5.)

22 As noted earlier, budget neutrality is measured over the entire span of the Waiver, which began in SFY 1998. In general, the new Waiver agreement simply adds \$21.2 billion to the total spending eligible for federal support over the 14 years (by the end of SFY 2011) of the Waiver program. During the Waiver negotiations, however, CMS and the Commonwealth identified a disagreement about how the budget neutrality calculation should have been constructed for the first 11 years of the Waiver (through SFY 2008). The parties decided to resolve the disagreement by agreeing to craft the new budget neutrality agreement starting from a cushion of zero; i.e., “with no deficit or savings carried over” to the SFY 2009-2011 extension period.

23 The spending limit is based on actual expenditures through SFY 2007 and the MassHealth budget forecast as of February 2008. This calculation, therefore, does not include the impact of Governor Patrick’s “9c” cuts that were implemented in SFY 2009 or the spending blueprint contained in the Governor’s proposed SFY 2010 budget. The calculation builds in caseload growth of 1.4% in SFY 2009 and 1.8% in SFYs 2010 and 2011. It assumes a per capita cost trend from the President’s budget of 6.95% per year for non-disabled children and adults, and 6.86% for people with disabilities and women in the breast and cervical cancer treatment program. The budget neutrality cushion is affected by actual cost increases relative to the target trend for both the with-waiver and without-waiver populations, and by enrollment growth relative to trend only for the with-waiver population.

Figure 5: Projected Budget Neutrality Cushion (SFYs 1998–2011)



Based on the approved calculation, the Waiver is balanced on this razor’s edge of budget neutrality. Because key elements of health reform depend on financing through the Waiver, it was critical that the Commonwealth find enough cushion under the budget neutrality ceiling to be able to maintain existing levels of eligibility and benefits. The cushion is a function of the “without waiver” spending base (a larger base raises the cap, which increases the cushion) and projected spending in the demonstration (spending below projected trend increases the cushion).

Key features of the Waiver agreement reflect the Commonwealth’s and CMS’s determined efforts to ensure the accuracy of the budget neutrality calculation and, in doing so, to keep the continued full funding of health care reform from violating budget neutrality. For example, the agreement adds to the “without waiver” spending base certain Waiver expansion populations who could be categorically eligible for traditional Medicaid.

In the 2006 Waiver amendment negotiations, CMS permitted the Commonwealth to move CommonHealth members into the “without Waiver” spending estimates, which balanced the actual spending in the Waiver program, resulting in CommonHealth spending not using up budget neutrality cushion. This was justified because, subsequent to the creation and implementation of CommonHealth in Massachusetts, federal policy changes allowed working adults with disabilities to be covered under Medicaid as a categorical population, at state option but without a Waiver.

The current extension expands the base further by counting certain members of Commonwealth Care and MassHealth Essential, who could be categorically eligible for traditional Medicaid absent the Waiver programs, as part of the “without waiver” expenditures. These include parents of Medicaid-eligible children enrolled in Commonwealth Care, and 19- and 20-year-olds in Commonwealth Care

and MassHealth Essential who otherwise meet MassHealth eligibility standards. One implication of this change is that the Commonwealth cannot cap enrollment or maintain waiting lists for these populations. Additionally, spending for these Commonwealth Care populations no longer counts against the Waiver's SNCP cap.

The Waiver agreement also adds to the "without waiver" spending base certain spending items, not contemplated in historical trend rates or the President's budget trend rates, that likely would have occurred without a Waiver program in place. Specifically, the Waiver agreement incorporates into the spending base Chapter 58's legislatively-mandated hospital and physician rate increases.

Another way the Waiver agreement creates budget neutrality room is through cost containment initiatives. In its proposal to extend the Waiver, MassHealth committed to slowing the growth of spending in the Waiver program by 1 percent from the budgeted growth rate in SFY 2010 and another 1 percent in SFY 2011. This target translates into a baseline of \$210 million in savings over the three-year Waiver period. The final Waiver agreement incorporates this savings target and contains a provision by which savings in excess of this target may be used to increase the SNCP cap, but only to support Commonwealth Care expenditures if they exceed current projections.

The Waiver agreement does not describe any specific cost containment initiatives that will be implemented to achieve the baseline savings target (or savings in excess of the target), only the process by which the Commonwealth must seek approval for an initiative and apply the savings to the SNCP. The State's Waiver proposal to CMS and Governor Patrick's SFY 2010 budget proposal reveal potential areas for savings, however, including:

- ensuring fair and efficient hospital and MCO rates and eliminating earmarks for specific providers;
- comprehensive care management for high-cost utilizers;
- expanded pharmacy management; and
- enhanced program integrity efforts.

While the State is actively engaged in developing cost containment initiatives, any savings from these initiatives likely would not be realized until towards the end of the renewal period. It should be noted that the SFY 2009 "9c" cuts and savings targets built into the Governor's SFY 2010 budget likely already exceed the baseline savings target that is built into the budget neutrality calculation.

The Waiver agreement also ends the Section 122 payments to Boston Medical Center and Cambridge Health Alliance after SFY 2009, as prescribed by Chapter 58, opening up more budget

neutrality room for coverage expansion. This supplemental payment totaled \$160 million in SFY 2009. Through a new SNCP structure, the Waiver also restricts the possibility of their reinstatement, and increases the transparency around all supplemental payments to these two providers.

Budget neutrality is a constantly moving target. The Commonwealth must report on any significant financial developments as part of its quarterly operations report, and must submit a corrective action plan to CMS if spending exceeds the cumulative budget neutrality limit by a specified percentage at the end of each fiscal year (though enforcement of budget neutrality—the return of federal money spent above the cap—would not occur until the end of the extension period). Budget neutrality can be affected by spending increases or reductions that are not currently part of the calculation. New EPSDT²⁴ spending resulting from the *Rosie D. v. Romney* settlement,²⁵ for example, will be added to the spending cap and to actual demonstration spending in equal amounts after CMS approves a methodology to track these new expenditures. This will have a neutral effect on the cushion. In contrast, State budget cuts may result in more budget neutrality cushion; further reductions in supplemental payments to hospitals, for example, are decreases in Waiver spending that are not reflected in the current budget neutrality calculation. The sensitivity of budget neutrality means that whenever any new policy, court decision or spending proposal in the health care arena is vetted, its effect on budget neutrality must be considered and could determine its ultimate fate.

Safety Net Care Pool

The Safety Net Care Pool (SNCP) comprises specific categories of Waiver spending and is subject to a subordinate spending limit within the overall budget neutrality constraint. The SNCP is the public financing core of Chapter 58's coverage expansions. In the previous Waiver extension, the SNCP was capped at \$1.34 billion per year, an amount that was expected to fund Commonwealth Care subsidies and the HSN, as well as supplemental hospital payments, Designated State Health Programs, and some other smaller expenses. In SFY 2008, the SNCP cap became a real constraint: the State was not able to claim federal reimbursement for about \$300 million in state spending on Designated State Health Programs and State hospitals because spending on Commonwealth Care and other requirements (such as hospital supplemental payments) consumed a larger portion of the allotted SNCP spending room than originally projected.

With Commonwealth Care enrollment growing beyond original projections, it was critical that the SFY 2009-2011 Waiver extension either remove or increase the SNCP cap to ensure full federal reimbursement for all SNCP programs. The agreement achieves this, though it depends on a continuing decline in spending from the HSN and phasing out other parts of SNCP spending, with

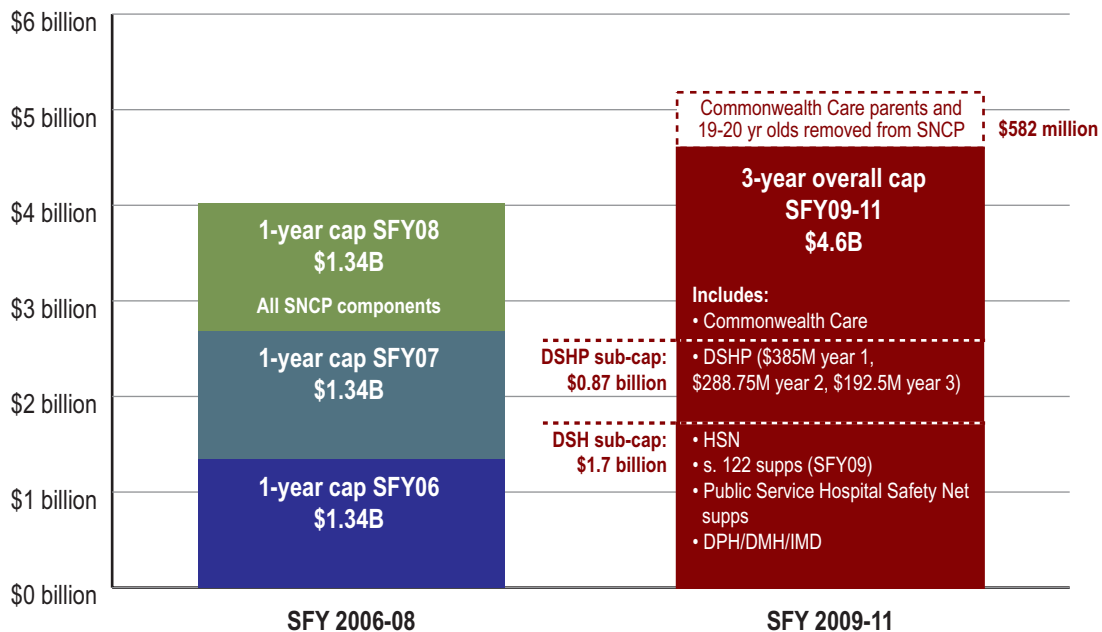
24 Early and Periodic Screening, Diagnosis and Treatment service, which are mandatory services for all “without waiver” Medicaid children.

25 *Rosie D. v. Romney* is a class action lawsuit filed in 2001 in federal district court alleging that the State had violated Medicaid's EPSDT requirement. In the 2006 decision, the Court found that Medicaid-eligible children with serious emotional disturbances in Massachusetts were not receiving appropriate EPSDT services (particularly mental health screenings, service coordination, and home-based treatment services).

the overall effect of using the SNCP funding primarily for coverage, as was originally intended. The SNCP retains a cap, but it is higher and more flexible than what was in place before. At the same time, CMS is more prescriptive in how portions of the SNCP may be spent, and will be more closely monitoring overall use of the SNCP.

The new Waiver agreement establishes a three-year aggregate SNCP cap, compared to the annual SNCP cap of the previous Waiver period. (See Figure 6.) Aggregate spending from the SNCP may not exceed \$4.6 billion over the three years of the extension. Nominally, this is an increase of \$0.6 billion over the cumulative three-year cap of about \$4 billion (\$1.34 billion per year) from SFYs 2006-2008. Effectively, though, the increase in funds potentially available for coverage is over \$1 billion because spending for Commonwealth Care parents and Commonwealth Care 19- and 20-year-olds no longer count against the SNCP cap. This increases SNCP spending room by an additional \$582 million over the three years.

Figure 6 : Safety Net Care Pool Caps, Then and Now



Projected spending for Commonwealth Care for SFY 2009 (\$570 million²⁶) is fully accommodated under the SNCP cap. The Commonwealth believes the three-year cumulative cap and the flexibility allowed in the SNCP also will accommodate Commonwealth Care spending in SFYs 2010 and 2011,

²⁶ This figure represents only Commonwealth Care spending that is claimed under the SNCP. This figure does not include Commonwealth Care administrative expenditures, expenditures for Commonwealth Care enrollees who are not eligible for federal reimbursement, and expenditures for Commonwealth Care parents and Commonwealth Care 19- and 20-year-olds who no longer count against the SNCP cap.

projected under the SNCP scenario in the Waiver agreement to be \$1.8 billion for the two years.²⁷ In order to achieve this, though, there are limits on the spending for the other elements of the SNCP.

There are two “sub-caps” within the overall SNCP cap. One source of the SNCP’s funds is the State’s annual allotment of Medicaid disproportionate share hospital (DSH) dollars, which has stood at \$574.5 million (state and federal) for several years. There is some chance that this amount may increase during the extension period²⁸, but, for now, three years of this allotment—about \$1.7 billion—represents the limit of spending on all components of the SNCP except Commonwealth Care and the Designated State Health Programs. This sub-cap applies to hospital supplemental payments,²⁹ the HSN, payments to institutions for mental diseases (IMD), and to hospitals run by the State Departments of Public Health and Mental Health. Current projections indicate that the Commonwealth’s spending under this sub-cap is roughly \$200 million below the limit.

The second sub-cap relates to the Designated State Health Programs (DSHP). CMS agreed to continue to match spending for the DSHP on a limited basis. These payments previously were authorized for up to \$385 million per year. In the new extension, CMS is phasing down support for these programs, reinforcing its view that they were intended only as a transitional source of funds for the Waiver, but not phasing them out entirely as was originally expected. If budget neutrality and the SNCP cap permit, the State may claim federal reimbursement for up to 100 percent of the DSHP amount (\$385 million) in SFY 2009, 75 percent (\$288.8 million) in SFY 2010, and 50 percent (\$192.5 million) in SFY 2011.

Under current budget neutrality estimates, the SNCP has enough room to claim federal reimbursement for DSHP for the full authorized amounts of \$385 million in SFY 2009 and \$288.8 million in SFY 2010, but only \$70 million in SFY 2011. If spending is not up to projections in other parts of the SNCP, however, claiming for DSHP in SFY 2011 could go as high as the fully authorized amount of \$192.5 million due to the flexible three-year aggregate SNCP cap.

With these restrictions, Commonwealth Care should be sufficiently funded under the three-year SNCP cap (See Figure 7). If Commonwealth Care spending turns out to be lower than projected, those savings can be used to claim more federal reimbursement for other authorized SNCP purposes,

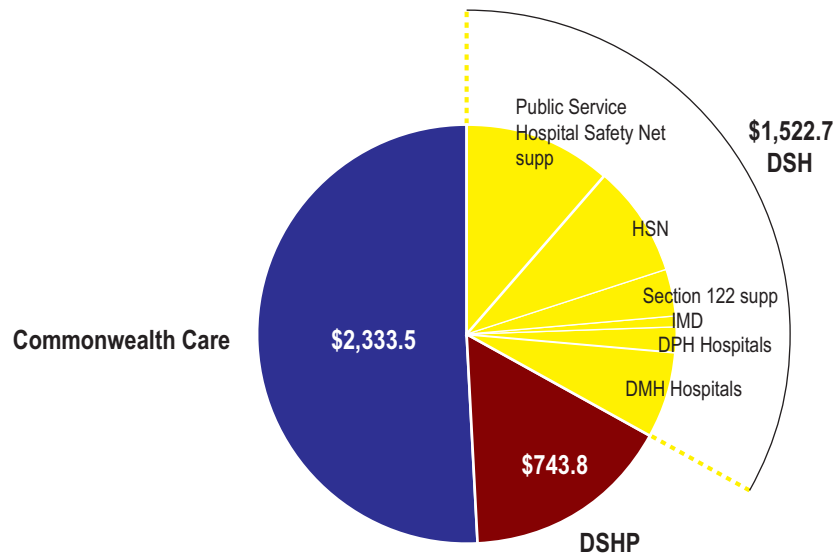
27 The new Waiver agreement continues the authority from the 2005 Waiver agreement to utilize up to 10 percent of the aggregate SNCP cap over the three-year extension period for infrastructure and capacity building to “support the improvement or continuation of health care services that benefit the uninsured, underinsured and SNCP populations.”

28 A provision in the Medicare Modernization Act of 2003 (MMA) temporarily increased States’ federal DSH allotments starting in federal fiscal year 2004. Based on a specified methodology in the provision, the calculation for determining States’ DSH allotments ultimately will revert to the traditional DSH allotment formula required prior to the MMA provision. This could happen during the SFYs 2009-2011 renewal period.

29 This includes the \$160 million in “Section 122” hospital supplemental payments to Boston Medical Center (BMC) and Cambridge Health Alliance (CHA) in SFY 2009, and the Public Service Hospital Safety Net Care Payments (e.g., the SNCP components of the Medical Assistance Trust Fund) to BMC (\$52 million) and CHA (\$125.5 of a total \$148 million) for each of SFYs 2009-2011.

subject to the two sub-cap limits. If there are savings elsewhere in the Waiver program (beyond the \$210 million in baseline savings), they may be used to increase the SNCP cap, but only for Commonwealth Care.

**Figure 7: Projected Safety Net Care Pool Spending, SFYs 2009–2011
(\$ millions)**



V. Implications for MassHealth and Health Care Reform through 2011

The continuing success of the MassHealth Waiver and of health care reform depends, in part, on the Commonwealth's success in keeping the costs of its programs within the tight budget neutrality constraints that are part of the new Waiver extension. At the moment, these constraints seem less rigid because of the SFY 2009 "9c" cuts, which scale back MassHealth Waiver spending primarily for providers, and the spending blueprint contained in the Governor's proposed SFY 2010 budget. The impact of these budget developments is not reflected in the budget neutrality calculation discussed in this document, so the extent to which they have altered the budget neutrality cushion is not yet known. In general, though, reduced spending relative to the trends in the Waiver agreement will create more room under the budget neutrality cap illustrated in Figure 5.

Who will bear the burden of cost containment and budget neutrality?

As previously mentioned, the Waiver agreement assumes that explicit cost containment initiatives will realize a "baseline" level of savings that is built into the budget neutrality estimates that resulted in a \$13 million cushion. To date, the budget cuts likely have produced savings in excess of this target and have disproportionately affected provider payments. The risk in this strategy is that it could affect members' access to service, or the quality of services they receive if plans and providers are not adequately compensated.

Beyond achieving the baseline savings required by the Waiver agreement, the Commonwealth must actively manage and monitor its spending to ensure that it does not exceed the budget neutrality spending limit during this three-year extension period. Current projections and the State budget situation suggest this will not happen. The margin for error is small, though, and economic circumstances may change.

If readjustment were needed, program administrators have additional tools at their disposal in addition to the tightening of provider payments that already has been employed. These involve limiting the number of members in the Waiver programs, though this would presumably be a last resort, as it undermines the primary goal of the Waiver and of health care reform. The Commonwealth could impose an enrollment cap on Waiver programs, as the Waiver authorizes the Commonwealth to do. Alternatively, it could make administrative changes that would effectively reduce the number of members over time, such as increasing the frequency of eligibility redeterminations or relaxing the standards for granting an exemption from the mandate to have health insurance coverage.

The previous Waiver extension listed a hierarchy of cuts in spending and eligibility that the Commonwealth would undertake in the event of violating budget neutrality. The new extension does require corrective action in such an event, but it does not spell out the specific actions that would be considered, or their order of priority, which provides a great degree of policy flexibility to the State if budget neutrality were to become an issue.

What will be the effect of the restructured SNCP?

The reconstituted SNCP favors funding for coverage, and seems to have adequate funding to fully support Commonwealth Care for the three years of the extension. Though the three-year aggregate SNCP cap provides significant flexibility to program administrators, particularly with respect to being able to fully fund Commonwealth Care in SFY 2009, there is still some uncertainty about SFYs 2010 and 2011.³⁰ The Commonwealth Care spending that is eligible to be claimed in the SNCP must fit within the remaining room under the SNCP cap, so this uncertainty also means uncertainty for the other elements of the SNCP.

A second challenge is the hard cap on funding for providers, particularly those safety net providers that care for a disproportionate share of low-income and uninsured people. The “DSH sub-cap,” about \$1.7 billion over three years (unless the Commonwealth’s federal DSH allotment increases), must cover hospital supplemental payments and the HSN, as well as payments to institutions for mental disease and state hospitals run by the Departments of Public Health and Mental Health. While there is no imminent threat of hitting the DSH sub-cap based on current projections, this depends on maintaining or increasing levels of coverage and continuing to reduce demand on the HSN.

How might general economic conditions affect the Waiver?

As noted above, the challenges of the Waiver are being played out against a background of worsening conditions in the state’s economy, which may have other important ramifications. Most immediately, increasing unemployment will reduce the level of employer-sponsored insurance, and many of the newly uninsured will enroll in Waiver programs—MassHealth, Commonwealth Care, the Medical Security Plan—or in some cases will place new demands on the HSN.³¹ To the extent that economy-driven new enrollment exceeds current State spending projections, particularly for the “with waiver” populations³², this could present the Commonwealth with additional management challenges. This interconnectedness between the financial viability of the public programs operating under the Waiver and the robustness of private sector coverage reflects the “shared responsibility” philosophy of the health care reform law, as well as the general counter-cyclical purpose of safety net programs like Medicaid. With potentially little room to absorb additional enrollment, however, continued worsening of the economy might present the Commonwealth with some difficult decisions to stay under the budget neutrality cap.

30 The Commonwealth Care spending projections contained in Governor Patrick’s SFY 2010 budget proposal fit within all applicable limits.

31 A recent analysis found that a percentage point increase in the national unemployment rate translates to one million more Medicaid members and 1.1 million more uninsured. (S. Dorn, B. Garrett, J. Holahan, and A. Williams, “Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses.” Kaiser Commission on Medicaid and the Uninsured, April 2008.)

32 The State is “held harmless” for enrollment growth in the “without waiver” base populations.

VI. Outstanding Issues for 2011 and Beyond

The Waiver is now extended through June 30, 2011, but it is not too early to start looking ahead to the end of this Waiver period and the future of the programs the Waiver supports. After what will be 14 years, it may strain common sense to continue to think of MassHealth as a “demonstration” program, but the current federal rules provide no alternative. Assuming this continues to be the case, the ongoing challenge for the Commonwealth will be financial. Programs will have to continue to demonstrate budget neutrality, which will require vigilance in cost containment. In addition, the Commonwealth most likely will have to identify new sources to fund its share of program costs. This is because one significant source of state funds—the Designated State Health Programs, which this year will leverage \$385 million in federal match—is diminishing as part of the current Waiver agreement, and could shrink further or disappear in the next extension, given that CMS views it as a temporary mechanism.

Another development we can anticipate is that, as Commonwealth Care gets firmly established, enrollment will stabilize and projections will become less uncertain. (It should even be possible to project effects on enrollment of the decline in employer-sponsored coverage resulting from the economic recession.) This should help program planning and budget neutrality estimates, and will enable program administrators to focus more effort on controlling per member costs in MassHealth and Commonwealth Care.

National policy developments naturally will affect Massachusetts as well. The Obama Administration appears to have health reform as one of its priorities, but how that will affect existing state initiatives remains to be seen. National reform efforts could proceed rapidly, potentially affecting Massachusetts health reform even during the current Waiver term. Will CMS under the Obama Administration continue to negotiate individual Waiver agreements with states, or will it try to align states with emerging national policies? Massachusetts would seem to be better situated than many states because some of the more prominent national reform plans draw heavily on the Massachusetts model. Where Massachusetts has perhaps committed more resources into its own approach to universal coverage than any other state, however, any superseding national program could require changes to its structure and impede its success. But the devil, as always, is in the details, and how any national reforms that emerge are designed to fit with state programs will likely have a great influence on how Massachusetts’ programs will look in the future.



This document was prepared by the Center for Health Law and Economics, University of Massachusetts Medical School for the Massachusetts Medicaid Policy Institute and the Massachusetts Health Policy Forum.

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