WebMemo
Published by The Heritage Foundation
No. 1979
July 2, 2008

Health Care Reform in Massachusetts: Medicaid Waiver Renewal Will Set a Precedent

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Federal and state officials are currently negotiating the terms and conditions for a renewal of the commonwealth's Medicaid 1115 demonstration "waiver." The current waiver extension expired on June 30, but federal officials agreed to a further two-week extension (until July 14) to allow additional time to complete the negotiations.[1] The last renewal of this long-standing waiver in 2005 was the catalyst for Massachusetts adopting a package of major health reform measures in 2006.

One of the major reform elements was an agreement between state and federal officials as to how Massachusetts would redirect federal Medicaid funds previously flowing to "safety net" institutions. The 2006 amendments to the waiver made Massachusetts one of the first states in the nation to attempt a large-scale shift in public health care funding away from subsidizing health care providers for delivering care to the uninsured and instead subsidizing the purchase of health insurance coverage for the low-income uninsured. This fundamental policy shift—from subsidizing institutions to subsidizing people—should not now be reversed or diluted in a new waiver extension. The outcome of these negotiations will not only affect health reform in Massachusetts; it will also set an important policy precedent for other states considering similar reform measures.

The State of Play. The 2006 legislation included a number of different elements and a three-year implementation schedule.[2] The two most significant pieces are a set of insurance market reforms and the public financing reforms embodied in the 2006 Medicaid waiver amendments. The results of the first two years of implementation have been broadly positive. To date, approximately 350,000 Massachusetts residents,[3] or roughly half the state's estimated uninsured population, have obtained coverage, and there has been a significant decline in taxpayer subsidized "free care" in hospital emergency rooms and community health centers.[4]

However, Massachusetts's new Commonwealth Care program for subsidizing health coverage is now projecting cost overruns of $153 million for state fiscal year 2008 and $144 million for FY 2009.[5] The overruns are attributable to greater-than-expected (and faster-than-expected) enrollment in the program, which is targeted to lower-income, previously uninsured adults.

Even so, the additional enrollment and associated costs do not pose a significant challenge to the long-term success of the reforms for two reasons. First, they are the result not of flawed reform design but of flawed estimates arising from the imprecision of the available data on the uninsured population. Second, the waiver design gives state officials all the authority and funding they need to make

This paper, in its entirety, can be found at:
www.heritage.org/Research/HealthCare/wm1979.cfm

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
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any necessary adjustments. Furthermore, and contrary to what some commentators have implied, the Commonwealth Care program is not structured as an entitlement, with enrollment and spending on autopilot.

Consequently, any supposed "fiscal crisis" with the Massachusetts health reform experiment is principally political in nature and is best addressed by state and federal officials rebuffing attempts by health care providers to undermine the basic reform design or to evade the consequences of reform.

Background on the Waiver. In 1994, Massachusetts submitted a request to the Clinton Administration for a Section 1115 Medicaid waiver for a five-year demonstration project.[6] A Section 1115 waiver gives a state regulatory relief from one or more specified federal requirements or restrictions on how federal Medicaid dollars can be spent as part of a demonstration in delivering services or providing coverage in a manner that would not otherwise be allowed under federal Medicaid rules. The waivers, however, are subject to "budget neutrality" requirements that set maximum amounts a state can spend while still securing federal matching funds. The principle of budget neutrality is that the cost to the federal government can be no greater with the waiver than without it.

With federal approval in 1995, and state legislative action to implement it in 1997, Massachusetts's demonstration was put in place and was later renewed through 2005 without any significant changes. The original waiver expanded Medicaid coverage and also shifted from a system of direct payment to providers to one of enrolling most Medicaid beneficiaries in managed care organizations (MCOs), as a number of other states were also doing at that time. However, the state's two largest safety-net hospital systems—Boston Medical Center and Cambridge Health Alliance—were concerned that the shift to managed care would result in Medicaid patients being treated elsewhere. To address that concern, each of the hospital systems created their own Medicaid MCOs, and the state agreed to give them annual "MCO supplemental payments" on top of their capitation payments for the Medicaid beneficiaries enrolled in their MCOs. In addition, like other safety-net providers, the two hospitals systems were already getting "dispropor-

1. "State Leaders say Waiver Talks are Going Well but aren't Done Yet," NPR, June 20, 2008, at *http://www.wbur.org/weblogs/commonhealth/?p=509* (June 30, 2008).
2. Commonwealth of Massachusetts, "Chapter 58 of the Acts of 2006," at *http://www.mass.gov/legis/laws/seslaw06/sl060058.htm* (June 30, 2008).
3. Massachusetts Health Connector, "Health Connector Facts and Figures," June 2008, at *http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/Current/Week%2520Beginning%2520March%25209%252C%25202008/Facts%2520and%2520Figures%25203%252008.doc* (June 30, 2008); Sharon K. Long, "On the Road To Universal Coverage: Impacts of Reform In Massachusetts At One Year," *Health Affairs*, June 3 2008.
4. Of the 350,000 newly insured, about 110,000, or one-third, obtained unsubsidized private insurance, 176,000 qualified for Commonwealth Care subsidized coverage, and 64,000 were already eligible for "MassHealth," the state's Medicaid and SCHIP program. According to the Commonwealth Connector, uncompensated care dropped by 16 percent in the first year of health care reform, and anticipated savings of $240 million are reflected in the current budget. See *ibid*.
5. *Ibid*. The budget projections for Commonwealth Care at enactment were $475 million in FY 2008 and $725 million in FY 2009. The current cost projections are $625 million in FY 2008 and $869 million in FY 2009. Another official document from April of this year stated that the estimate of $869 million in FY 2009 is based on an enrollment projection of 225,000 individuals, but it also indicated that enrollment could reach 255,000 by the end of FY 2009, resulting in total Commonwealth Care spending of $1.082 billion. However, the state has not made public the capitation rate assumption underlying that estimate, which may have been higher or lower than the actual rates agreed to in the just completed contract renewal negotiations. See Commonwealth of Massachusetts, "Information Sheet," April 16, 2008, p. A-28, at *http://www.dacbond.com/GetContent?dctm_r_object_id=0900bbc7800c82b4* (June 30, 2008).
6. For details on the Massachusetts MassHealth 1115 Waiver, see *http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=dual,%20data&filterValue=Massachusetts&filterByDID=2&sortByDID=2&sortOrder=ascending&itemID=CMS042959&intNumPerPage=10*.

tionate share hospital" (DSH) payments, and the state then further provided the two systems with special "hospital supplemental payments." These last two forms of extra payment were to defray costs incurred in providing uncompensated care to the uninsured or treating Medicaid patients at low reimbursement rates.

According to the Government Accountability Office, by 2006 Massachusetts was distributing through all its various supplemental payments $1.6 billion a year in federal and state Medicaid funds.[7] In 2005, the MCO supplemental payments alone amounted to $770 million, of which $385 million were federal matching funds. In effect, the state was subsidizing institutions, not patients. As Professor Jonathan Gruber, a prominent MIT economist closely involved in the state's reform efforts, put it, "The federal government was essentially supplementing the expansion of these inner city hospitals."[8]

Simultaneously, in 2003 the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid, began to devote more effort to systematically eliminating, or at least restricting, a number of financial abuses that had crept into the Medicaid program. CMS particularly focused on instances where state governments, often in agreement with health care providers, had devised ways to favorably "game" federal reimbursement rules. In some cases, the abuses enabled a state to effectively obtain more federal funding for its Medicaid program than it was otherwise entitled to under the applicable federal matching rate percentage. Other cases consisted of arrangements whereby certain providers received Medicaid payments that exceeded their actual costs for providing medical services. As a consequence, over 30 states—including Massachusetts, which had engaged in both practices—were eventually faced with reductions in federal Medicaid funding.

The Reform Policy. Faced with the impending loss of federal matching funds, then-Governor Mitt Romney negotiated an agreement with CMS for keeping and using the "at risk" federal funding. Massachusetts identified additional state-only spending that would qualify for the same federal matching funds and the state agreed to shift subsidies away from safety-net providers, instead using those funds, along with monies from the state's existing uncompensated care pool, to subsidize the purchase of insurance coverage for low-income uninsured individuals. In April 2006, Massachusetts put in place provisions needed to fulfill its new agreement with CMS.

The Current Waiver. The centerpiece of the current waiver was a new funding arrangement called the Safety Net Care Pool (SNCP). The state's previous DSH allotment ($574.5 million) was combined with the MCO supplemental payments ($770 million) to give the SNCP an annual budget of $1.34 billion per year, half of which was federal money, and that figure was set as a budget neutrality sub-cap over the length of the waiver. It was agreed that most of this funding would be used to subsidize health insurance coverage for low-income uninsured adults, but the state was also allowed to use the money to offset any residual uncompensated care costs and to fund some other small, targeted health improvement programs.

For the 2006 state fiscal year the waiver allowed the SNCP to make payments to Boston Medical Center and Cambridge Health Alliance in the same manner as before. However, this was to be a transitional arrangement. For SFY 2007 onward, those dollars—coupled with the savings from reductions in uncompensated care costs—were to be redirected into subsidies for patients to purchase insurance through the new Commonwealth Care program.

Thus, the basic principle embodied in the waiver was that as the share of funding going to subsidize coverage for the low-income uninsured grew, the share going to offset hospital uncompensated care costs would decline. The agreement recognized that it would take several years for this shift to occur, and that even if successful, it was likely that hospi-

7. U.S. Government Accountability Office, *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, GAO-08-614, May 2008, at *http://www.gao.gov/new.items/d08614.pdf* (July 2, 2008).
8. Jonathan Gruber, "The Massachusetts Health Care Revolution: A Local Start for Universal Access," Hastings Center Report, September-October 2006, p. 16, at *http://econ-www.mit.edu/files/978* (June 30, 2008).

tals would still incur some residual uncompensated care costs. Consequently, the state was allowed, after paying for the new insurance subsidies, to apply any remaining funds to offsetting any residual uncompensated care costs.

Furthermore, the enabling legislation stipulated that for the first three years of the program only already existing Medicaid MCOs would be permitted to offer coverage to Commonwealth Care enrollees.[9] It was thought that this would give Boston Medical Center and Cambridge Health Alliance, which had become dependent on direct subsidies but also operated Medicaid MCOs, a way to adjust to the new market in which more of their revenues would come from treating insured patients, before allowing other insurers to compete for subsidized Commonwealth Care enrollees. In addition, under the reform legislation, the state included substantial rate increases to health care providers in order to further ease this transition.

The Unresolved Problem. However, as the Massachusetts legislature was finishing work on the 2006 legislation, it inserted new supplemental payment provisions for Boston Medical Center and Cambridge Health Alliance, which became known as "Section 122 payments."[10] These payments—which were authorized for three years starting at $200 million for FY 2007, declining by $20 million each year—essentially guaranteed to the recipient institutions a portion of their previous direct funding and effectively gave those payments preference over payments for subsidized coverage.

Had initial enrollment in Commonwealth Care come in at or below projected levels, these Section 122 payments would likely not have created a financing issue. But with enrollment running higher than expected, the state has already obligated elsewhere hundreds of millions of dollars that it should otherwise have available to meet the added cost of providing subsidized coverage to more individuals. In FY 2008, Section 122 payments come to $180 million, while Commonwealth Care overruns are $153 million. These payments are just one place where the state can cover this budget shortfall.

Furthermore, a recent report by the Massachusetts Hospital Association found that the number of uncompensated care hospital visits appears to be declining at a rate that is virtually identical to the take-up rate for the new subsidized coverage.[11] This not only indicates that the reforms seem to be working as intended but also that the state should be able to fund higher than planned Commonwealth Care enrollment out of lower than planned spending on uncompensated care. Yet, state payments for uncompensated care do not seem to have decreased as much as these trends suggest they should have.

One explanation may be that some hospitals are attempting to compensate for providing less uncompensated care by charging the state higher rates for the uncompensated care they still provide. Indeed, in FY 2007, these institutions could not substantiate $102 million in Section 122 payments that exceeded the hospitals' costs but were below what they charged the state. While the state paid the hospitals, the federal government rightfully deferred its $51 million matching payment to the state. This issue is now a pending legal matter.[12]

So if there is a state budget problem, it is not the result of increased enrollment in Commonwealth Care but rather of the state failing to fully comply with the basic waiver agreement to shift subsidies from health care providers to individuals needing assistance in buying health insurance.

What Federal Officials Should Do. Federal officials should insist on maintaining in any waiver extension not only basic budget neutrality but also all of the spending sub-caps set in the 2006 waiver amendment.

9. Commonwealth of Massachusetts, "Chapter 58 of the Acts of 2006," Section 123, at *http://www.mass.gov/legis/laws/seslaw06/sl060058.htm* (June 30, 2008).
10. See *ibid.*, Section 122.
11. "Hospital Uncompensated Care Trends & Health Care Reform," Massachusetts Hospital Association, February 13, 2008, at *http://www.mhalink.org/public/news/2008/attach/08-02-07%20FREECAREANALYSIS.doc* (June 30, 2008).
12. Commonwealth of Massachusetts, "Information Sheet."

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1. *Insist on budget neutrality.* The waiver process is a valuable tool for supporting state experimentation in developing better solutions. That tool, however, works only if the federal government insists on "budget neutrality." For federal policymakers, the essential point is that they must remain firm in insisting that state lawmakers, in Massachusetts as well as other states, confront and manage the results of their experiments. Without the firm constraint of federal budget neutrality and all spending sub-caps, any waiver project would simply become a mechanism for states to shift more costs onto federal taxpayers.
2. *Maintain spending sub-caps.* In its waiver renewal request earlier this year, the state proposed eliminating the SNCP sub-cap.[13] Federal officials should not agree to this arrangement. The concept behind creating the SNCP sub-cap was that a fixed amount of existing funds could be pooled together and redirected to subsidize insurance coverage for the low-income uninsured. The supplemental payments should continue to be subject to the sub-cap and should eventually decline to zero. Any change in that arrangement would not only undermine the successes to date of Massachusetts's health reform effort but also set a bad precedent for other states. If state lawmakers insist on perpetuating direct subsidies to politically favored health care providers, then they should be forced to do so exclusively out of state tax revenues and justify such payments to their constituents.

What State Officials Can Do. Massachusetts officials have a number of options for addressing their emerging budget problem in ways that are fully consistent with the objectives, principles and specific terms of the 2006 waiver agreement. State officials can:

- *Eliminate Section 122 payments.* These special payment arrangements should not have been included in the reform legislation in the first place. The more enrollment in Commonwealth Care exceeds projections, the less affordable, necessary or justifiable these payments become. If spending threatens to exceed the SNCP sub-cap, jeopardizing the state's compliance with budget neutrality, then these payments should be the first to go, as agreed upon in the waiver's corrective action plan.[14] Furthermore, regardless of how and when state officials terminate these payments, reimbursement should not exceed the actual cost of delivering health care services.
- *Eliminate all other hospital supplemental payments.* It is reasonable and prudent for states to plan for some residual hospital uncompensated care costs. However, it is not reasonable to disproportionately compensate some hospitals for those costs at the expense of others with the same costs. Instead, state officials should direct all claims for residual uncompensated care to the Health Safety Net (formerly known as the Uncompensated Care Pool) within the SNCP fund. That way, safety-net care providers will all be treated equally, and reimbursement will not exceed the actual cost of delivering health care services.
- *Make Commonwealth Care more affordable.* Massachusetts officials have the power to make any adjustments needed to continue operating the Commonwealth Care program within existing budget neutrality constraints. For example, the state could reduce program costs by modifying the Commonwealth Care benefit design and reducing the number of mandated benefits. The state could also increase enrollee cost sharing in the program or reduce the level of subsidies, or both. Another option is to limit enrollment by reducing the income threshold for eligibility.

13. Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid, Section 1115 Demonstration Project Extension Request: Health Care Reform Sustainability," Submitted December 21, 2007, at *http://www.mass.gov/Eeohhs2/docs/eohhs/cms_waiver_2007/cms_waiver_2007.1/ma_1115_demonstration_extension-proposal.pdf* (June 30, 2008).
14. See Health and Human Services, Centers for Medicare and Medicaid Services, Expenditure Authority, Attachment C, p.31, at *http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/Massachusetts%20MassHealth%20Current%20Approval%20Documents.pdf* (June 30, 2008).

Indeed, the Commonwealth Connector Board debated several options before agreeing on the eventual particulars of the program. It would not take much for the board to go back and reconsider some of the earlier options and possibly consider some new ones as well. Alternatively, the state could leave the program design unchanged and fund any additional expenses out of reduced hospital subsidies or even other state spending.

- *End restrictions on private plan competition in Commonwealth Care.* The enabling legislation gave existing Medicaid MCOs three years of exclusivity in enrolling individuals who qualify for Commonwealth Care. That was a political move intended to give Boston Medical Center and Cambridge Health Alliance an opportunity to replace the direct subsidies they would lose under the reforms with capitation payments for covering the uninsured patients they had been treating. What was at best a debatable political compromise becomes a philosophically unjustifiable restriction on market competition and consumer freedom of choice if hospitals are allowed to continue receiving earmarked, direct subsidies.[15] The cost of Commonwealth Care subsidy payments is projected to increase by 9.4 percent, whereas premiums in the unsubsidized Commonwealth Choice program are projected to grow by an average of only 5 percent.[16] Thus, if Commonwealth Care were opened to competition and enrollees were able to receive a direct subsidy toward the plan of their choice through the Connector, Massachusetts could slow the trend of its health care spending. Indeed, a move toward direct subsidies to patients is consistent with the waiver's basic design and would deliver the important added benefits associated with increased transparency and accountability.

Setting a Precedent. The core principle of the Massachusetts demonstration is an experiment in shifting from targeting government funds to health care providers to redirecting those funds to patients to help them buy insurance. The policy precedent set by the Massachusetts experiment is particularly important, and the terms of any waiver renewal will either confirm or undermine an important policy shift that should also occur in the rest of the country.

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15. Commonwealth of Massachusetts, "Chapter 58 of the Acts of 2006," Section 123, at *http://www.mass.gov/legis/laws/seslaw06/sl060058.htm* (June 30, 2008).
16. Massachusetts Health Connector, "Health Connector Facts and Figures," June 2008, at *http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/Current/Week%2520Beginning%2520March%25209%252C%25202008/Facts%2520and%2520Figures%25203%252008.doc* (June 30, 2008).