

Stabilizing MassHealth Funding: Options to Break the Recurring Cycle of Expansion and Contraction

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by Beth Waldman, Bailit Health Purchasing
Robert Seifert, Center for Health Law and Economics,
University of Massachusetts Medical School
Kate Nordahl, Massachusetts Medicaid Policy Institute

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About the Massachusetts Medicaid Policy Institute

The Massachusetts Medicaid Policy Institute (MMPI) — a program of the Blue Cross Blue Shield of Massachusetts Foundation — is an independent and nonpartisan source of information and analysis about the Massachusetts Medicaid program, “MassHealth.” MMPI’s mission is to promote the development of effective Medicaid policy solutions through research and policy analysis.

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The University of Massachusetts Medical School’s Center for Health Law and Economics is a sought-after partner among public agencies, non-profit organizations and foundations striving for health care system improvement and health policy analysis. CHLE’s collective expertise lies at the intersection of health law and health policy, and includes health law and economics, policy impact analysis, and structuring new policy, legal and financial frameworks.

About Bailit Health Purchasing

Bailit Health Purchasing, LLC is a health care consulting firm dedicated to working with public agencies and private purchasers to expand coverage and improve health care system performance for consumers, purchasers and taxpayers.

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Executive Summary

MassHealth provides health care coverage to a significant portion of Massachusetts' low-income residents. Since eligibility depends on an individual's income, demand for the program fluctuates with economic activity in the state. When times are good and employment is high, the eligible population declines. When state economic growth slows and people lose their jobs (and their employer-based health insurance coverage), the low-income population needing health care coverage from MassHealth grows. A major policy problem is that available funding for the program also depends on economic activity in the state as a whole. As the economy weakens, revenues available to cover the state share of the cost of MassHealth shrink, just as the need for coverage increases.

When this occurs, the Administration and the Legislature are forced to make difficult decisions to keep program spending within the state's means — decisions that are made more difficult because, being the state's Medicaid program, MassHealth is an entitlement program with joint state and federal funding. As such, it is required by federal law to cover certain populations and certain services, regardless of state funding limitations.

The imperative to cut when the economic downturn inevitably comes is further complicated by the reverse phenomenon. As economic conditions improve, the need for MassHealth coverage decreases, just as state revenues increase. When this has happened in the past, Massachusetts has not only reversed many of the cuts and program changes made in the previous downturn, but has also taken steps to expand MassHealth by raising the income-eligibility limit, covering new population groups, and expanding the services covered. All of this makes the inevitable cuts required during the next economic downturn even harder to achieve.

The volatility resulting from this boom and bust cycling of the MassHealth program has widespread negative impacts on the quality and continuity of care for MassHealth members and potential applicants, for Medicaid providers and managed care organizations, and for staffing at the Executive Office of Health and Human Services (EOHHS) and other state agencies involved in the Massachusetts health care sector. While enrollment volatility is mostly among adults and families — groups whose income eligibility is most sensitive to changing economic conditions — the cycle of programmatic cutbacks significantly affect seniors and people with disabilities because they remain eligible for many years and depend on the program to meet greater, more costly health care needs. Year-to-year fluctuations in resources restrict MassHealth's ability to effect long-term improvements in the effectiveness and efficiency of coverage for these groups of members.

This year, once again, the state is struggling to balance its books with respect to MassHealth, with the need to cut 7 percent of total program spending in state fiscal year (FY) 2012 alone.

This requires MassHealth to reduce spending by \$770 million — an unprecedented amount for the program to achieve within a single year. During the current economic downturn, the federal government raised its matching rates¹ for all states on the condition that no eligibility cuts would be made. Enhancing matching rates with these contingencies is indeed an effective federal approach to stabilizing the continuity of Medicaid enrollments when state revenues plummet. The loss of this stabilizing funding in FY 2012 was, in fact, a major factor in explaining why the need for spending reductions is so large this year.

The options to cut MassHealth program spending in the short term are limited to those that can be achieved within one state fiscal year, including:

- reducing eligibility by limiting populations the state has opted to make eligible to receive MassHealth²
- reducing the amount of time allowed for members to return annual eligibility redetermination paperwork, resulting in some MassHealth members having their coverage interrupted temporarily
- reducing benefits covered at state option (such as dental services)
- reducing provider payments (limited to *federally permitted* reimbursement rate freezes or cuts)
- improving service utilization management (e.g., introduction of new prior authorization requirements)

If MassHealth is unable to reach its targeted \$770 million spending reduction, cuts may be needed in other areas of the state budget as MassHealth spending crowds out other public investments such as education, transportation, and infrastructure.

MassHealth also has a longer-term focus on improving the program's efficiency and the quality of services its members receive. Initiatives aimed at these goals typically require a number of years to develop and implement, however. The long-term projects include care management and integration programs (e.g., care coordination for PCC Plan members, the Patient Centered Medical Home Initiative, integration of care and financing for dual eligible members), payment reforms (e.g., reduced payment for preventable hospital readmissions, bundled payment methods), and other incentives to reduce service costs (e.g., policies and contracts that reduce use of higher-cost sites and services in favor of lower-cost ones, funding primary care and community-based supports to reduce the need for more costly medical care). These projects require skilled and experienced staff resources and financial investments in the short term,

¹ Federal matching rates are formally referred to as Federal Medical Assistance Percentage (FMAP) rates.

² In recent years, Medicaid programs have been limited in their ability to modify eligibility for the program as enhanced federal funding has been conditioned on states' maintaining the eligibility standards a state had in place as of July 2009.

with better patient care and control of the program's costs as an expected payoff in the future. MassHealth's commitment to these initiatives acknowledges the importance of payment and delivery system reform to the future stability of the program, but the agency staff's ability to focus on these complex and longer-term projects is hampered by the need to solve immediate budget issues, reprocur dozens of major provider contracts, and maintain operations for a program that serves one in five residents of the state.

This paper discusses options within state government control for reducing the reactive swings in MassHealth funding and scope of services that come with each economic downturn. Of course, Medicaid is not the only portion of the state budget that is strained during difficult economic times. This paper advocates for the importance of a stabilizing mechanism specifically for MassHealth because of:

- its entitlement nature, which limits the state's spending discretion;
- its size, accounting for about 30 cents of every state budget dollar;
- the concurrent loss of federal Medicaid revenue resulting from any cuts made to the program;
- the impact of cuts on the health care sector, an economic engine of the state's economy; and
- the impact on a program that over 20 percent of state residents depend upon for their health care needs.

A stabilizing mechanism would also benefit other health and human service agencies, hospitals, other health care providers, and businesses that may otherwise be called on to absorb some of the consequences of decreasing Medicaid funds.

The timing is propitious for opening such a discussion. Not only is there the potential of a period of economic stability ahead, starting in 2014 there is also increased federal financing for Medicaid under the federal health care reform law, the Affordable Care Act (ACA). Policymakers could use this opportunity to end the cycle of expanding and retracting MassHealth based on annual budget fluctuations by developing a strategy to ensure the long-term stability of the program.

Any mechanism to stabilize MassHealth funding should uphold, at a minimum, the following cross-cutting principles to provide the greatest potential for success in meeting its ultimate goal. The mechanism should:

- improve MassHealth's ability to conduct long-term planning, including improved forecasting, and implement comprehensive program improvements and reforms;
- include a well thought-out governance structure that provides oversight and assigns clear accountability for the implementation and use of the mechanism;

- be transparent, providing clear and understandable information on the mechanism and its allowable use; and
- apply lessons learned from past experience by Massachusetts and other states with similar mechanisms meant to stabilize spending or dedicate funds.

We present three potential options for stabilizing mechanisms, which could be considered separately or in combination:

- **Establish a Medicaid Stabilization Fund:** This Fund could serve as a MassHealth- specific “rainy day fund.” A portion of additional federal money flowing to the state under the ACA, plus any appropriated but unexpended MassHealth dollars from a given fiscal year, could be retained in the Fund. In better economic times, a targeted amount could also be set aside and deposited in the Fund. The Fund would only be accessible to the program under specified adverse economic circumstances. Thus, it would not be available to provide for additional benefits or rate increases otherwise unaffordable in a fiscal year, absent a federally required mandate. *The use of a Medicaid Stabilization Fund would be limited to costs related directly to caseload increases and maintenance of effort relative to rates and benefits and, in limited circumstances, amounts may be spent on up-front investments required to implement initiatives that can reduce the overall costs of MassHealth or have been proven elsewhere to slow the rate of growth in Medicaid.* In addition, during better economic times, a minimum contribution to the Medicaid stabilization fund should be required before any eligibility or benefit expansions can be considered for the program.
- **Adopt Multi-year Budgeting for MassHealth:** MassHealth now makes its fiscal plans in an annual timeframe, making each year’s budget dependent on that year’s economic conditions and available revenues and limiting financial management options to only those that have spending impacts in a matter of months. A multi-year budget is currently the practice in over 20 other states. Adopting this practice for just the MassHealth program could allow MassHealth time to invest in improvements and infrastructures that would ultimately have a bigger impact on containment of costs. *Multi-year budgeting would provide MassHealth the necessary time to plan and implement program improvements and reforms that produce much greater returns on investments relative to the quality and costs of MassHealth services, but necessarily take longer to execute and require up-front investments.*³
- **Create a Public Authority:** Public authorities currently administer health coverage programs in Massachusetts, Maine, and Oklahoma. Converting administration of MassHealth from an executive branch agency to a public authority could allow more flexibility for longer-term financial arrangements and the program stability that comes with it. This stability, in turn, could

³ Care must be taken, of course, not to project such planning too far into the future and to keep a sharp eye out for any shortfalls in the cost-savings projected for such innovations in health care organization and delivery.

make possible more ambitious payment and delivery system reforms that, over time, could improve the management of the program and slow its cost trajectory.

Some policymakers have argued for states to be given more latitude in managing their Medicaid program budgets through “block grants.” This option is not explored here, as it cannot be adopted by the state without federal intervention.⁴

⁴ While block grants would allow states to make changes to the program outside federal rules, block grants could also expose the state to significant financial risk. As the state experiences economic downturns and the resulting increased need for Medicaid coverage, it is unclear if the formula for annual increases in block grant allotments would be able to keep up with such need. For an in-depth analysis of the implications of block grant proposals on Massachusetts and other state Medicaid programs see <http://www.kff.org/medicaid/upload/8173.pdf> and <http://www.kff.org/medicaid/upload/8185.pdf>.

1. Introduction

MassHealth provides health coverage to low-income Massachusetts residents. Given that the program's eligibility is based on an individual's economic situation, demand for the program increases when the economy is in a downturn or recession. At those times, there is also increased pressure on the program to reduce or constrain its spending based on the fiscal reality of the state's budget.

MassHealth is the state's Medicaid program. Medicaid is a state-administered health care program that is jointly funded by the state and federal governments, with the proportion of federal funding (the match rate)⁵ varying by state. The match rate for Massachusetts is about 50 percent. State participation in the program itself is voluntary, but once a state elects to operate a Medicaid program it must follow certain federal Medicaid program and financing rules. These include coverage of mandatory populations and benefits and, for certain providers, mandated cost-based reimbursement. Populations that MassHealth is required to cover under the federal Medicaid law, and the spending for mandatory services associated with those members, are considered entitlements. As such, the state is required to provide Medicaid coverage to those populations regardless of any economic or other state-specific considerations. Therefore, options to cut MassHealth spending are limited.

In addition, the state's own health reform law, which mandates coverage for individuals, and the federal health care reform law, the Affordable Care Act (ACA), which extends the Medicaid entitlement beginning in 2014 to low-income adults without dependent children, further limit the policy choices available to the state Administration and Legislature for reducing MassHealth spending.⁶

Medicaid is not the only portion of the state budget that is strained during difficult economic times; other agencies within health and human services and across state government face many of the same challenges that Medicaid does. Although the state's "Rainy Day Fund" provides some cushion for the Commonwealth during such times, this paper advocates for the importance of an additional mechanism to stabilize funding for MassHealth, specifically, because of:

- its entitlement nature, which limits the state's spending discretion;
- its size: about 30 cents of every state budget dollar;

⁵ The federal matching rate is formally known as the Federal Medical Assistance Percentage (FMAP) rate.

⁶ The Government Accountability Office recently recommended that Congress consider enacting a formula that would automatically raise states' federal match rates temporarily during national economic downturns. If enacted, such a formula would relieve some of the financial pressure resulting from Medicaid's countercyclical nature. (Medicaid: Prototype Formula Would Provide Automatic, Targeted Assistance to State during Economic Downturns. GAO-12-38, November 2011.)

- the concurrent loss of federal Medicaid revenue resulting from any cuts made to the program;⁷
- the impact of cuts on the health care sector, an economic engine of the state's economy; and
- the impact on a program that over 20 percent of state residents depend on for their health care needs.

A mechanism to stabilize funding for the MassHealth program would also benefit other health and human service agencies, hospitals, other health care providers, and businesses that may otherwise be called on to absorb some of the consequences of decreasing Medicaid funds, for example through increased demand for services or reduced payment rates.

This brief describes the revenue cycles over the last thirteen years and their impact on the MassHealth program. It then opens a conversation to explore three potential options to break this cycle of expansion and contraction, and allow for more stable operation of the program: 1) a MassHealth Stabilization Fund, 2) multi-year budgeting for MassHealth, and 3) creation of a public authority to administer MassHealth.

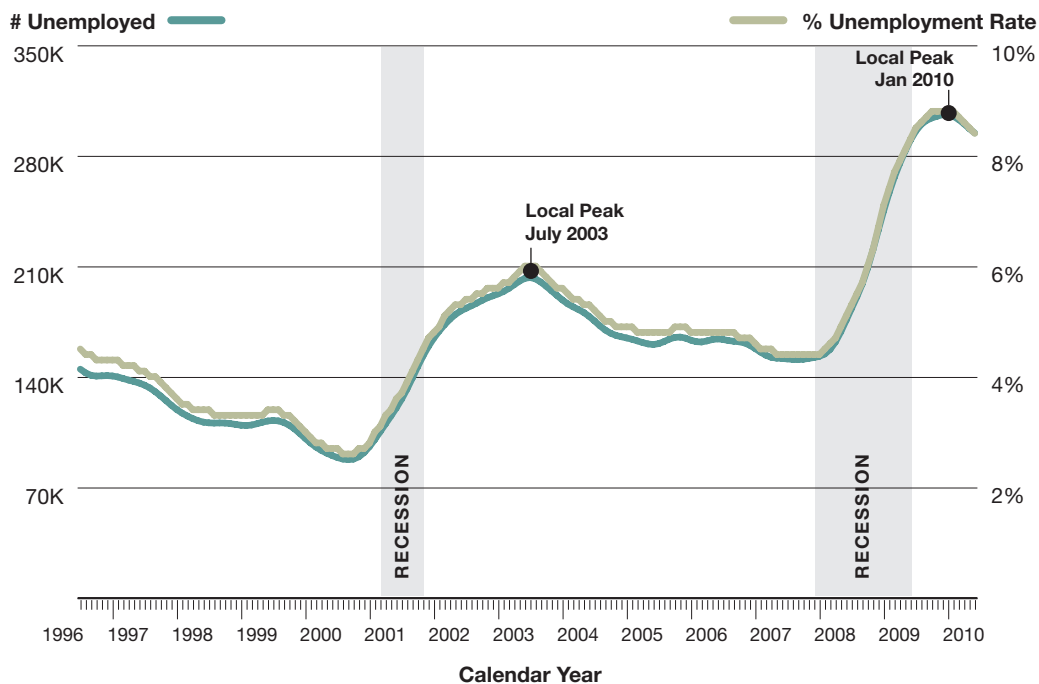
⁷ Because MassHealth is jointly funded by the federal and state governments, any cut to a Medicaid reimbursed service only brings the state 50 percent of the savings. In other words, for every \$1 cut in the MassHealth program, the state realizes only 50 cents of savings and loses 50 cents of federal revenue.

2. Economic Cycles Affecting MassHealth Financing

Public demand for MassHealth is sensitive to economic cycles. When the economy lags and unemployment rises, people who lose their employer-sponsored health insurance may turn to MassHealth as an alternative. At the same time, fewer work hours or lower paying jobs for those remaining employed means lower incomes, making some families financially eligible for MassHealth who were not eligible before. The following charts show the cyclical changes in economic conditions in Massachusetts and how those changes have affected the MassHealth program and the Commonwealth's ability to support it.

The official dates of the last two national recessions were March 2001 through November 2001 and December 2007 through June 2009.⁸ As Figure 1 shows, unemployment in Massachusetts began to increase at the start of those economic slowdowns and continued to rise after the national recessions had officially ended.

Figure 1. Unemployment in Massachusetts



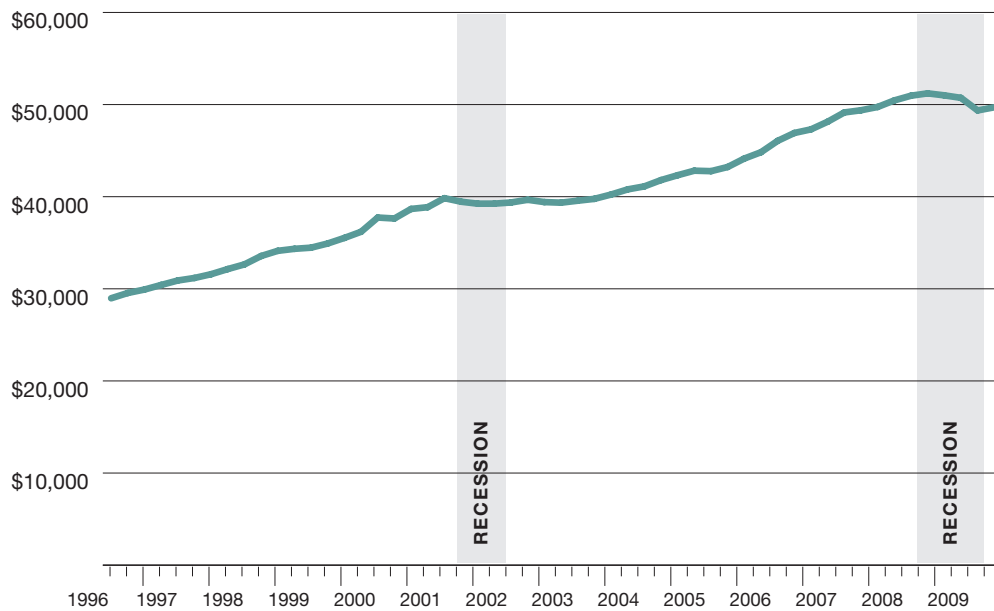
Source: Bureau of Labor statistics (unemployment data); National Bureau of Economic Research (recession dates)

Note: Natural population growth contributed minimally to the growth in the number of unemployed over this period. From 1997 through 2009, the population in Massachusetts grew 8.5 percent, less than 1 percent per year.

⁸ National Bureau of Economic Research.

Growth in personal income is an indicator of the strength of the economy. Figure 2 shows the trend in per capita personal income in Massachusetts. Personal income stagnated or fell during and just after the two recent periods of recession, while unemployment increased, suggesting that the population with lower incomes — those most likely to qualify for MassHealth — also grew. As we shall see, during both periods MassHealth enrollment increased as state tax revenues fell.

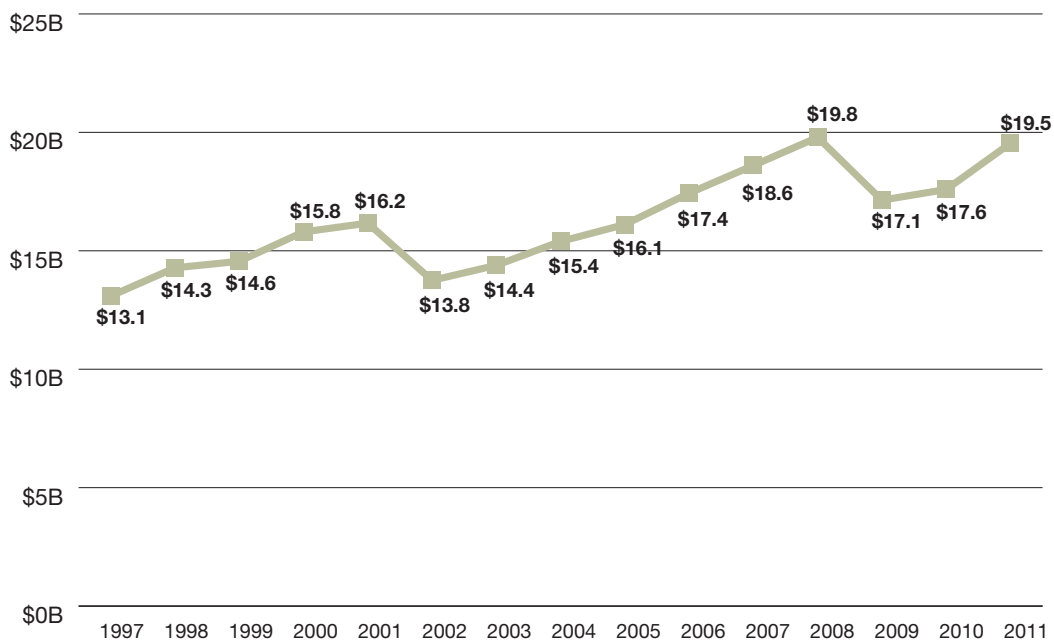
Figure 2. Massachusetts Personal Income Per Capita



Source: Bureau of Economic Analysis

State revenues from taxes and assessments are the primary source of funding for the state's share of MassHealth spending.⁹ These revenues fell significantly during the economic downturns, when (as shown below) demand for safety net programs such as MassHealth increased.¹⁰ In the case of the 2001 recession, it took several years for tax revenues to regain their pre-recession level. Tax revenues have still not recovered fully following the 2007-09 recession, as shown in Figure 3.

Figure 3. State Tax and Assessment Revenues



The state fiscal year begins July 1 of the previous calendar year (e.g. SFY 2010 is from July 1, 2009 through June 30, 2010). Taxes include Income, Sales and Use, Corporate, Motor Fuel, and other taxes from a variety of goods and services including: alcoholic beverages (where applicable), certain banking transactions, cigarettes, income from estates, and hotel or room occupancy tax. Assessments are Ongoing charges to groups of customers of state services. Figure for SFY 2011 may not be exactly comparable to other years.

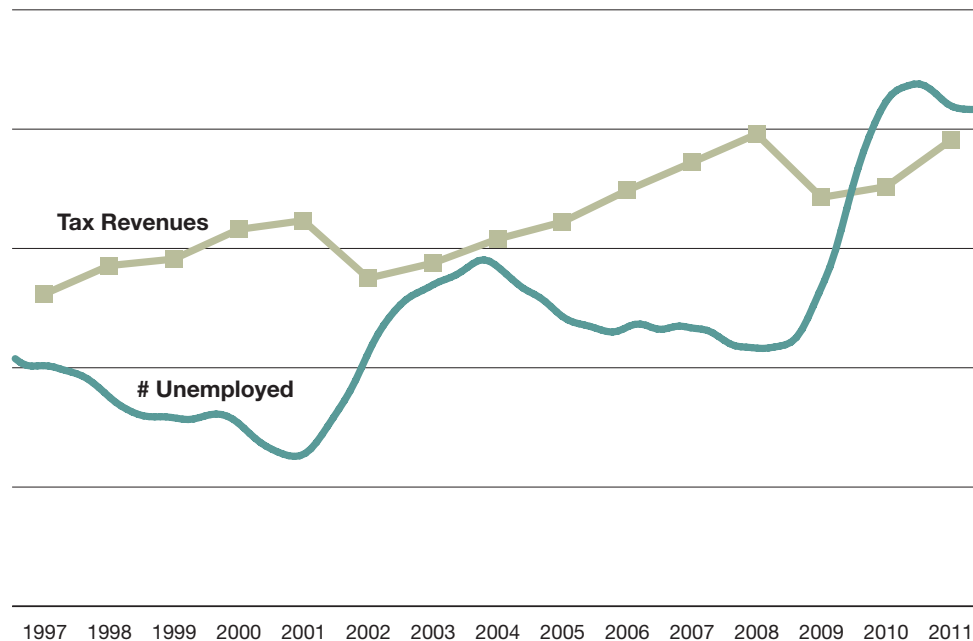
Source: Comptroller of the Commonwealth (1997-2010); Department of Revenue, "June 2011 Tax Collection Summary (Preliminary as of July 19, 2011)" (2011).

⁹ Federal reimbursement typically covers about half of state MassHealth expenditures. In the last two economic downturns, the federal government has provided additional revenues to states to avoid drastic reductions to Medicaid through enhanced federal match for a limited time period. The latest provision of enhanced match ended on June 30, 2011.

¹⁰ State tax policy also contributed to these trends. Several income tax rate cuts between 1997 and 2002 reduced revenue, as did an increase in the personal exemption and other changes from 2006 to 2008. In 2009, an increase in the sales tax and corporate tax changes mitigated the economy-related drop in revenue. (Source: Massachusetts Budget and Policy Center)

Figure 4 summarizes the unemployment and revenue trends.¹¹ In general, as unemployment rises, tax revenues fall, and vice-versa.

Figure 4. Massachusetts Revenue and Unemployment Trends



Source: Comptroller of the Commonwealth (revenue trend); U.S. Bureau of Labor Statistics (unemployment trend).

Research clearly confirms the positive relationship between unemployment and Medicaid enrollment.¹² In Massachusetts, MassHealth enrollment accelerated during the recent recession, at the same time that revenue to support the program was declining. Enrollment dynamics during the 2001 recession were less typical, possibly due in large part to policy changes that had the effect of slowing enrollment or, in one case, eliminating coverage for a time for an entire category of MassHealth members.¹³ As Figures 5a and 5b show, MassHealth enrollment grew 15 percent faster during the most recent period of *rising* unemployment than during the period of *falling* unemployment that immediately preceded it. Most of the enrollment volatility is among children and families, or adults without dependent children — groups whose MassHealth eligibility is more likely affected by the labor market and economic conditions generally. In contrast, the enrollment levels of persons with disabilities and those aged 65 and older remain relatively

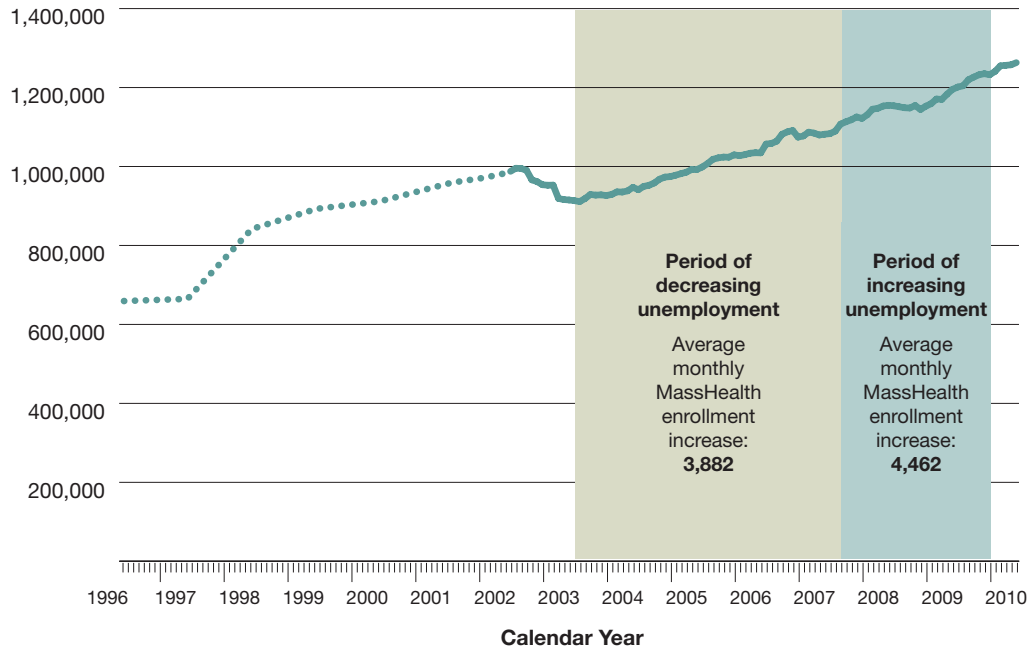
¹¹ Figure 4 overlays the unemployment and revenue trends, without a scale, simply to show their interaction. The unemployment trend from Figure 1 has been plotted here on a state FY axis to match the tax revenue trend.

¹² For example, Ku, L. and Garrett, B. *How Welfare Reform and Economic Factors Affected Medicaid Participation: 1984-96*. Washington, DC: Urban Institute; 2000.

¹³ Enhanced federal financial participation in the Medicaid program has occurred only during the two most recent financial crises. To receive the enhanced federal match, states needed to maintain eligibility rules during the recession. Because that was not the case in previous recessions, states did make changes to eligibility rules that masked growth in eligibility due to economic downturns.

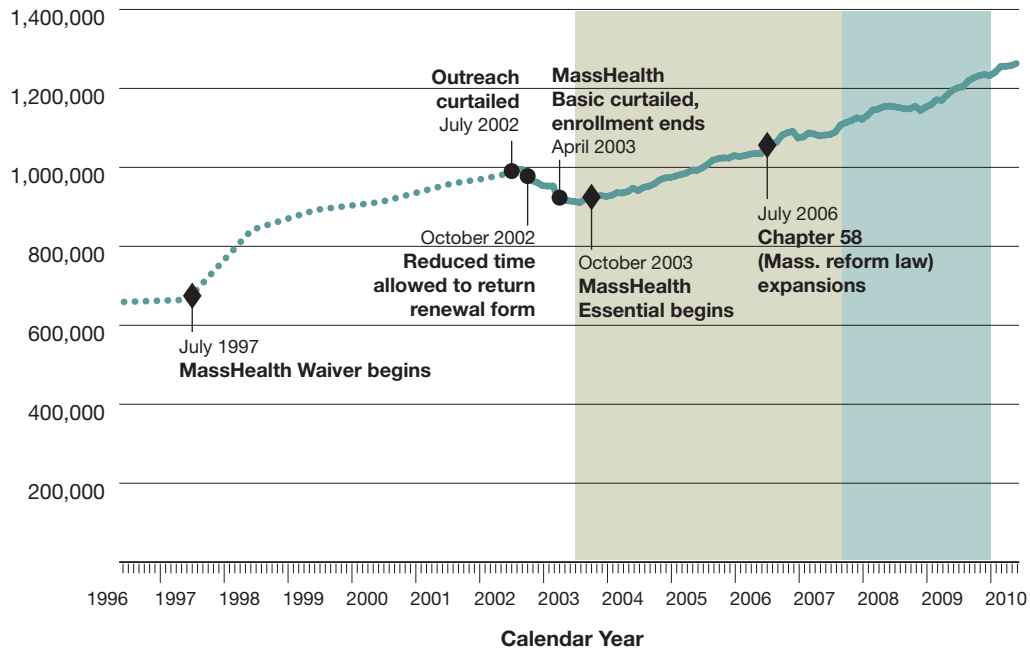
steady over time, keeping pace with demographic trends such as the aging of the baby boomer population, but not fluctuating significantly with the economy (see Figure 6).

Figure 5a. MassHealth Enrollment



Source: MassHealth. Monthly enrollment from 1997-2002 imputed based on actual enrollment in June of each year.

Figure 5b. MassHealth Policy Changes Affecting Enrollment

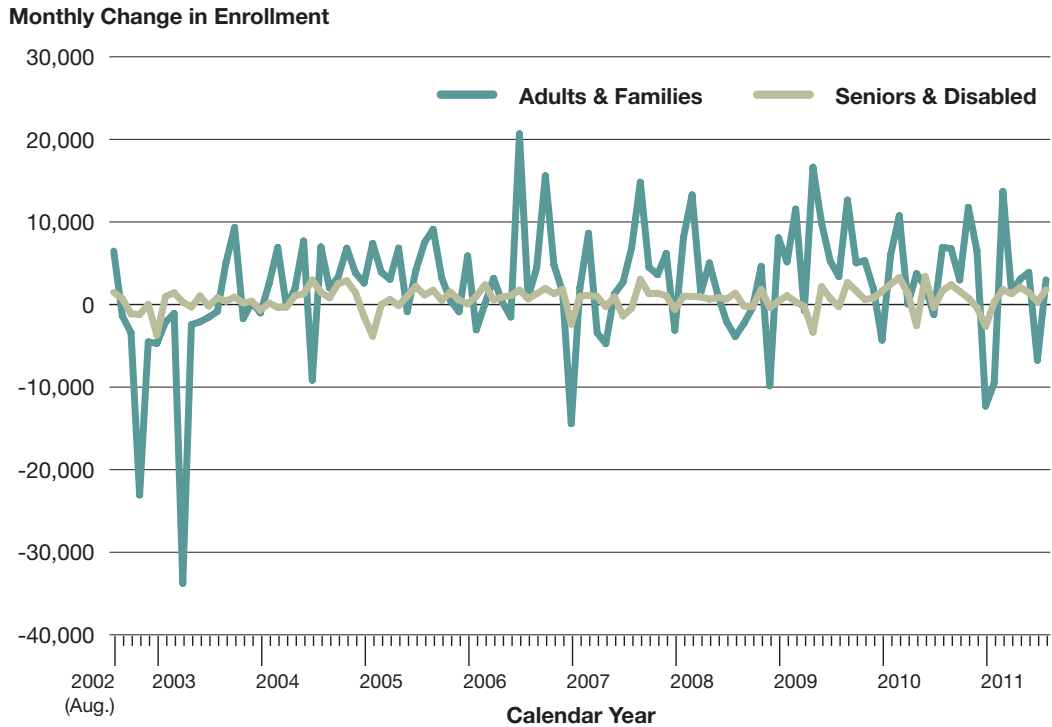


Source: MassHealth. Monthly enrollment from 1997-2002 imputed based on actual enrollment in June of each year.

Notes for Figure 5b:

- In July 2002, the state budget eliminated “mini-grants” for community organizations to conduct **outreach and enrollment** activities for people potentially eligible for MassHealth. In addition, MassHealth removed outreach staff working in most sites.
- MassHealth redetermines the eligibility of most members at least once a year. If a member does not respond to a **redetermination notice**, the member is disenrolled from the program until eligibility can be re-established. In October 2002, MassHealth reduced the time allowed for responding to the notice from 60 days to 30. In addition, MassHealth stopped including a return envelope with the notice and discontinued sending a reminder notice.
- **MassHealth Basic** is an optional MassHealth program for long-term unemployed individuals with family income below the federal poverty level. In April 2003, enrollment in MassHealth Basic was closed and eligibility eliminated for about 40,000 of its members.
- **MassHealth Essential** began in October 2003, covering many of those who lost eligibility for MassHealth Basic but offering a slightly narrower benefit package.

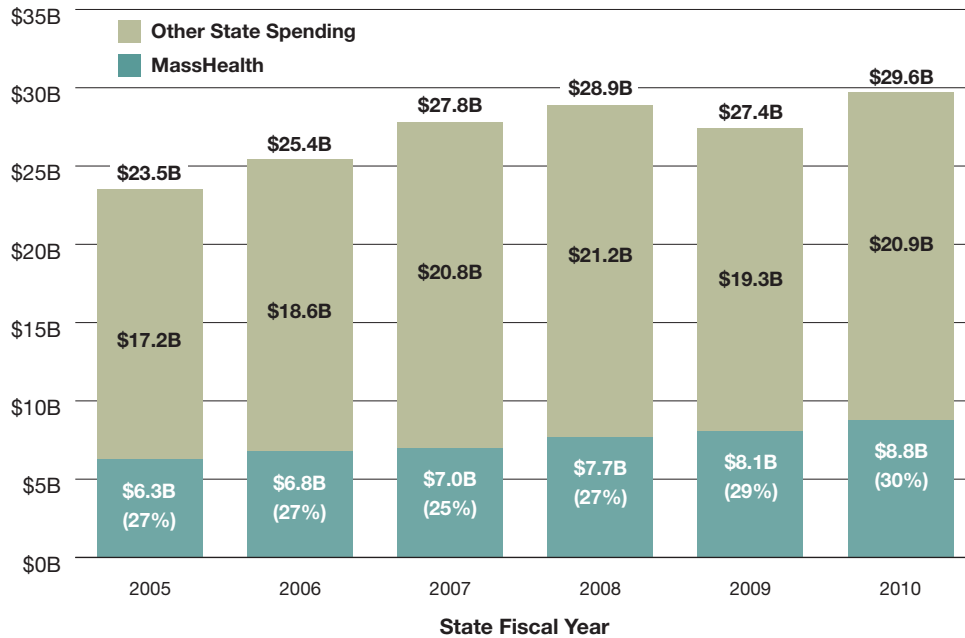
Figure 6. Fluctuations in MassHealth enrollment, adults and families vs. seniors and people with disabilities



Source: MassHealth enrollment snapshot data.

Increasing demand for MassHealth services and anemic tax revenues, both largely the result of economic conditions in the state, have led to increased budget pressures as MassHealth spending has grown. Federal Medicaid rules, combined with the state’s focus on insuring all of its citizens, limit policy choices that can be made in both stable and unstable economic climates, leading to MassHealth’s continued growth in real dollars and the charge that it is a “budget buster.” Figure 7 shows MassHealth as a portion of the total annual state budget from state fiscal years 2005 through 2010. (The chart shows gross MassHealth spending, which includes the federal revenue the Commonwealth receives to support the program — about half the total MassHealth budget.) The impact is magnified during recessions, often leading to the need to make significant cuts elsewhere in the state budget, particularly other health and human services agencies.

Figure 7. MassHealth as a portion of all state spending (in billions)



Sources: EOHHS (MassHealth data); Office of the Comptroller, Statutory Basis Financial Reports (other state spending).

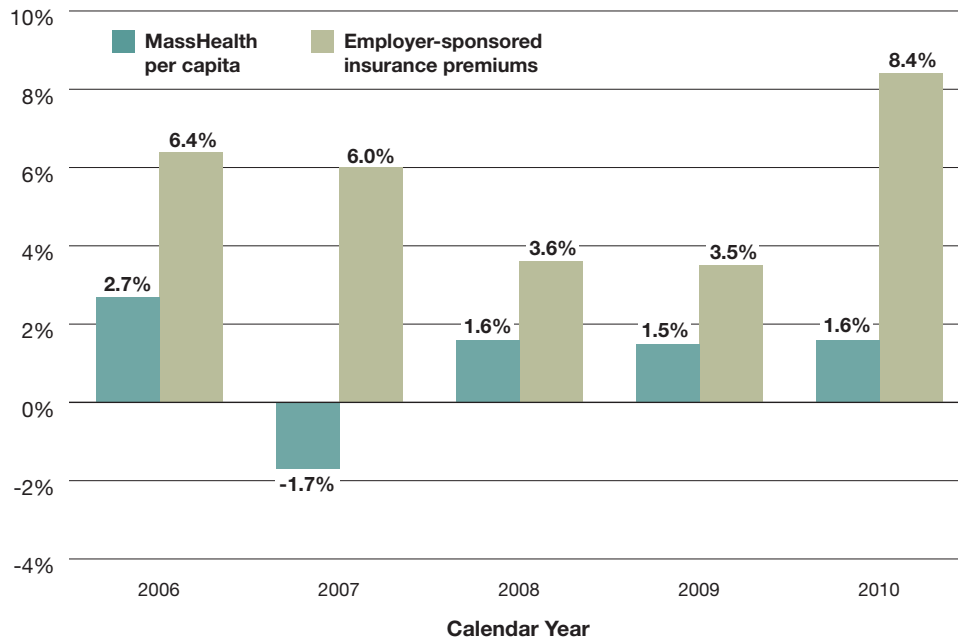
Note: The federal government reimburses Massachusetts for more than half of its spending on MassHealth, so the state's net spending on MassHealth is less than half of the totals shown.

While there is some flexibility to reduce Medicaid spending, Medicaid's entitlement status limits how much cost savings can come from Medicaid within a budget cycle because, by federal law, mandatory populations and services may not be reduced. In addition, recent federal policy to provide enhanced match to states during the recession was coupled with requirements that states maintain eligibility, further constraining policy leaders' options in tight budgetary times. Likewise, some spending cuts, though producing short-term savings, may lead later to cost increases (e.g., reducing home and community-based services — an optional benefit — may lead to increased use of more costly nursing facilities — a mandated benefit). Alternatively, Medicaid cuts may lead to increases in other parts of the state budget (e.g., MassHealth budget cuts to certain substance abuse services may require the Bureau of Substance Abuse Services at the Department of Public Health to add capacity for certain levels of residential treatment).

While MassHealth spending undoubtedly places pressure on the state budget, it is important to recognize that its spending growth has been predominantly tied to increased enrollment, *not* increased per capita spending. As Figure 8 makes clear, MassHealth per capita spending growth has been well below that of employer-sponsored premiums throughout the recent period. MassHealth administrative costs are also well below the proportion of private premiums that goes

to non-medical expenses.¹⁴ For the last several years, MassHealth has restrained spending growth primarily by limiting growth in provider reimbursement rates. An argument can be made that this has contributed to increased private premiums due to provider pressure for higher private rates to make up for the MassHealth rate reductions.

Figure 8. Change in monthly MassHealth per capita spending vs. change in monthly employer-sponsored individual insurance premiums



Sources: Authors' calculations based on data from MassHealth Budget Office; Division of Health Care Finance and Policy, *Massachusetts Employer Survey 2010*. The employer survey was conducted in 2005, 2007, 2009, and 2010. Annual percentage increases are derived by imputing premiums for 2006 and 2008 using the midpoint of the two-year interval. ESI premium trends are for small and large employers.

¹⁴ MassHealth's administrative budget is about 2 percent of its total program costs; its actual administrative spending is slightly higher, given that some administrative spending occurs through other state agencies. See http://www.massmedicaid.org/-/media/MMPI/Files/FY2012GAABudgetBrief_Aug2011.pdf. Private insurers spend roughly 9 percent of premium on non-medical expenses, such as administration. See http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/premium_report.pdf.

3. The Impact of Economic Cycles on MassHealth Program Policy

The fairly regular cycle of budget highs and lows, requiring short-term cost savings in tight budget years and allowing for reversals of reductions as the budget expands, has significantly impacted the ongoing administration of the MassHealth program and its ability to provide high quality health care for its members. This section looks at the impact of the cycle across MassHealth administrative costs, consumers and providers, and across other state agencies, both generally and as illustrated by the example of dental coverage for adults.

Administrative Costs: Developing an annual budget is a resource-intensive process in both good and bad economic times. Typically, the budget process begins in August with direction from the Executive Office of Administration and Finance (ANF) on the amount of growth/reduction an agency may submit for the upcoming state fiscal year. Over the fall, the state's Office of Medicaid submits a proposal to reach the suggested budget target to the Executive Office of Health and Human Services (EOHHS). EOHHS holds public hearings on the budget, followed by back and forth negotiating throughout the fall, until the Governor releases the Administration's budget in January. The House and Senate then develop separate budgets in the spring, with a final budget usually completed in June for the fiscal year beginning in July. In difficult fiscal times, the budget development process requires significant focus across the entire MassHealth program to define a series of cost-saving initiatives that will quickly result in cost containment and that will meet the projected budget.

This year, once again, the state is struggling to balance its books with respect to MassHealth; it needs to reduce total program spending by 7 percent in state fiscal year (FY) 2012 alone. This requires MassHealth to reduce spending by \$770 million — an unprecedented amount for the program to achieve within a single year. During the current economic downturn, the federal government raised its matching rates for all states on the condition that no eligibility cuts would be made. Enhancing matching rates with these contingencies is indeed an effective federal approach to stabilizing the continuity of Medicaid enrollments when state revenues plummet. The loss of this stabilizing funding in FY 2012 was, in fact, a major factor in explaining why the need for spending reductions is so large this year. If MassHealth is unable to reach its target, cuts may be needed in other areas of the state budget, as MassHealth spending crowds out other public investments such as education, transportation, and infrastructure.

Since state policymakers are loath to spend money on administration that could instead be spent on programs and services, MassHealth always operates within stringent administrative funding limits. This is particularly true in a difficult budget cycle. Constraining administrative funding, though ostensibly releasing more dollars for programmatic spending, limits the ability of state officials to monitor, manage, and improve the program. It also restricts program management

flexibility, including MassHealth’s ability to invest in crucial strategic planning, improvements in operational effectiveness, and innovation. In many instances, state Medicaid officials must focus on “putting out fires” rather than engaging in strategic forward planning.

The budget choices facing MassHealth administrators are made even more difficult because the state must balance its budget every year. This requires MassHealth to implement programmatic savings that can be realized within the very same period during which the program’s resources are constrained. As already emphasized, such a policy runs the very real danger of resulting in short-term savings decisions that bring higher costs in the long term. Repeated cuts in coverage over time can also erode provider confidence in the program, reducing provider participation in MassHealth and diminishing access to care for enrollees, even when a benefit is reinstated in a stronger economy. One example is the elimination of adult dental benefits, which may lead to increased health risks for individuals and increased emergency room use. (See Dental Coverage example on page 21.) Another example is cuts to adult day health services¹⁵ that may reduce provider capacity and impact the Commonwealth’s longer-term goal of serving individuals through community-based services, rather than in nursing facilities and other institutions.

In offering “savings,” MassHealth officials try to select cuts that can gain the most savings while being implemented most efficiently from an administrative resource perspective. Once state revenues begin to improve, the same officials typically go about restoring cuts made in previous years. But cutting the MassHealth budget is, in any case, an economically inefficient way to save state dollars. Since MassHealth spending as represented in the state budget includes the federal share of program funds, two dollars of service cuts are required to achieve one dollar of cost savings for Massachusetts.¹⁶

The continuous pressure and focus on the budget, either cutting or reinstating, can reduce consumer and provider confidence in MassHealth and can lead to destabilization of the MassHealth program and attrition in provider participation. In addition, attention that is focused on meeting budget demands diverts focus from program maintenance, improvement, and strategic planning.

MassHealth has a longer-term focus on improving the program’s efficiency and the quality of services its members receive. Initiatives aimed at these goals typically require a number of years to develop and implement, however. The long-term projects include care management and integration programs (e.g., care coordination for PCC Plan members, the Patient Centered

15 The FY2012 budget cuts \$35 million from adult day health services, which provide care to frail elders and adults with disabilities in community settings as a means to prevent hospitalization and, in some cases, to avoid or delay nursing home placement. See MMPI Budget Brief, *The Fiscal Year 2012 Budget: General Appropriations Act (GAA) After the Governor’s Vetoes*, August 2011.

16 The federal government realizes the other half of the savings, which the state loses from its revenues. The state has focused some of its cost reduction efforts on coverage for legal immigrants who have been in the United States for less than five years for precisely this reason. Since this group is not covered under federal Medicaid rules, the savings resulting from any reduction in services for them is fully realized by the state’s general fund.

Medical Home Initiative, integration of care and financing for dual eligible members), payment reforms (e.g., reduced payment for preventable hospital readmissions, bundled payment methods), and other incentives to reduce service costs (e.g., policies and contracts that reduce use of higher-cost sites and services in favor of lower-cost ones, funding primary care and community-based supports to reduce the need for more costly medical care). These projects require staff resources and financial investments in the short term, with better care and control of the program's costs as an expected payoff into the future. MassHealth's commitment to these initiatives acknowledges the necessity of payment and delivery system reform to the future stability of the program, but the staff's ability to focus on these types of projects is hampered by the need to solve immediate budget issues and other crises.

Consumers: The MassHealth program exists to provide access to health care for low-income Massachusetts residents. When budgets are tight, the state needs to consider whether it can continue to serve all of its current members, and whether those members can continue to receive the same level of benefits they have been offered in the past. As mentioned above, certain groups of individuals are required by federal law to be covered under the Medicaid program.¹⁷ This limits those members who are considered “optional” under the federal rules and whose eligibility may be directly affected.¹⁸ Budget cuts affecting consumers generally take four different forms:

- *Eligibility reductions:* For example, elimination of an entire category of covered individuals, such as state-funded Aliens with Special Status and MassHealth Basic and Essential, or decreases in financial eligibility income or asset standards.
- *Benefit reductions:* For example, the elimination of dental benefits for adults, first in 2002 and then again, after reinstatement in 2006, in 2010.
- *Administrative changes:* For example, reducing the amount of time an individual has to provide redetermination information prior to losing benefits, or introducing new prior authorization requirements for certain services. In 2002, MassHealth reduced the time a member could submit required information in response to annual eligibility determination from 60 days to 30 days. After subsequently restoring the allowed response time to 60 days, MassHealth again shortened the period to 45 days in 2007. At that time, MassHealth estimated the change would result in savings of \$70 million per year,¹⁹ largely through reduced monthly capitation payments to

¹⁷ Generally, mandatory members include children and their parents, pregnant women, persons with disabilities, and seniors with incomes below eligibility standards. Beginning in 2014, mandatory populations will also include adults without dependent children with incomes to 133 percent of the federal poverty level.

¹⁸ Optional members include individuals who categorically fall within the populations described in the previous footnote, but are at higher levels than the federal minimum requirements, and expansion populations, including those covered through an 1115 Demonstration Waiver. MassHealth CommonHealth, which covers persons with disabilities to any income level, is an example of an optional coverage population.

¹⁹ *MassHealth Considers Quicker Cut-offs*. A Healthy Blog, November 14, 2007. <http://blog.hcfama.org/2007/11/14/masshealth-considers-cutting-permitted-response-times/>. Accessed August 17, 2011.

Medicaid managed care organizations (MCOs) on behalf of MassHealth members who would lose eligibility for a temporary period.

- *Reduced provider rates*, which can indirectly affect consumers because some providers might decide to no longer accept MassHealth patients, thus reducing access to services.

Providers: In recent years, MassHealth has made a policy decision not to make significant eligibility or benefit reductions, particularly in light of the goal of universal coverage in Massachusetts and a federal requirement to maintain eligibility and certain benefit levels²⁰ as a condition for receiving enhanced federal match during the economic downturn. As a result, many of the short-term cost containment activities undertaken by EOHHS have focused on reduced payment rates to MassHealth providers.²¹ Likewise, MassHealth has attempted to hold down capitation payment rates — within federally required actuarially sound ranges — to its Medicaid MCOs. As with direct MassHealth rate cuts, MCO rate reductions may lead to reduced rates for providers serving MassHealth patients through MCOs. This may lead, in turn, to further reductions in the pool of providers accepting MassHealth patients. In addition, as mentioned above, constraining MassHealth rates may lead some providers to pressure commercial payers to pay higher rates to make up for their Medicaid shortfalls.

Other State Agencies: Because MassHealth serves many Massachusetts residents who are also served by other agencies within EOHHS, budget cuts impacting MassHealth may put additional pressure on those other agencies and their budgets. For example, previous MassHealth budget cuts reduced MassHealth coverage of certain substance abuse services. Based on those cuts, the Bureau of Substance Abuse Services at the Department of Public Health has been forced to add capacity for certain levels of residential treatment, and the Department of Corrections has faced a steep increase in the number of new inmates requiring substance abuse treatment under its medical services contracts. Conversely, budget cuts at other EOHHS agencies may impact MassHealth adversely by increasing the health care needs of the population. When the Department of Mental Health (DMH) reduces its case management services, the use of emergency rooms by individuals who previously received support from DMH is likely to increase.

²⁰ For instance, states were not able to make changes to their nursing facility levels of care or reduce availability of home- and community-based service waivers.

²¹ According to the Massachusetts Budget and Policy Center, the state saved \$200 million from provider rate cuts in the FY2010 budget and \$175 million in the FY2011 budget. In addition, \$235 million in mid-year cuts in FY 2009 focused on provider rates. (*FISCAL FALLOUT: The Great Recession, Policy Choices, and State Budget Cuts*. http://www.massbudget.org/documentsearch/findDocument?doc_id=614&dse_id=1293. Accessed July 22, 2011.)

Dental Coverage: An Example of Benefit Coverage Cycling²²

Dental coverage is an optional service under the Medicaid program for adults.²³ As such, in tight fiscal climates, dental is among the optional services often considered for cuts to help state Medicaid programs live within their available budgets for a given fiscal year; in better economic times, it is often reinstated as a covered benefit.

Until March 2002, MassHealth covered dental services for adults as an optional service. Then, facing an untenable fiscal situation, MassHealth reduced a number of optional services, including dental coverage. In January 2003, MassHealth made further cuts to adult dental by eliminating most adult coverage for preventive dental services, periodontal treatment, and restorative treatments (such as replacement teeth or dentures).²⁴ MassHealth continued to cover emergency dental services, including teeth extractions, and to provide coverage for a limited number of developmentally disabled adults for whom lack of dental services would create a medical hardship.²⁵ In order to implement the cut, MassHealth had to undertake a number of administrative steps to reduce the benefit, including notification to providers and members, modifications to its provider and member regulations, and obtaining approval for a state plan amendment from the Centers for Medicare and Medicaid Services (CMS). In addition, because the state chose to maintain coverage for certain individuals with a developmental disability, MassHealth was charged with developing criteria for such special circumstances, gaining CMS approval to continue providing dental services in limited circumstances to adults, and then implementing a limited program that assured access to dental services for these individuals.²⁶

In state FY 2004, MassHealth spent about \$35 million less for dental services than it had in 2001, providing net savings to the state budget of \$16.5 million.²⁷ Almost 100,000 fewer MassHealth beneficiaries received dental services in FY 2004 than in FY 2001.²⁸ While almost 20,000 members received a special circumstances designation, only 8,000 of those members, in

22 This example should not be taken as implying any position on whether or not to restore a dental benefit to MassHealth at this time.

23 Despite the fact that research on the impact of oral health on overall health has shown the importance of dental coverage and its positive impact on general health, dental remains optional coverage under the federal Medicaid program. The Institute of Medicine recently released a report stating that dental coverage for all Medicaid beneficiaries is a critical and necessary goal. See *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*. Institute of Medicine, July 2011. The mouth may be an entry point for diseases and there is increasing research that links oral diseases to other physical health issues, including diabetes, heart disease, stroke, and poor pregnancy outcomes. See U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

24 See Pryor, Carol and Monopoli, Michael. *Eliminating Adult Dental Coverage in Medicaid: An Analysis of the Massachusetts Experience*. Kaiser Commission on Medicaid and the Uninsured; September 2005.

25 Ibid.

26 Ibid. To receive a special circumstances designation, primary care physicians serving members with developmental disabilities needed to send a letter to an individual's dentist verifying that the disability criterion was met; the dentist, in turn, was required to submit the letter to MassHealth. Approximately 20,000 individuals received such a designation.

27 Ibid.

28 Ibid.

fact, received dental services.²⁹ Where many MassHealth members already had trouble accessing dental services prior to the cuts, the cuts exacerbated the access issue, as some dentists stopped accepting MassHealth patients.

Through Chapter 58 of the Acts of 2006, the state's health reform law, MassHealth restored comprehensive dental services for adults. However, in state FY 2010, although the state preserved preventive services, coverage for restorative and periodontal services was cut. The FY 2012 budget does not restore these cuts, but it requires MassHealth to report annually "on the percentage of MassHealth recipients receiving dental care in emergency rooms, community health centers, or dentist offices, and the number and types of procedures performed."³⁰

When MassHealth cut adult dental benefits in 2002 and again in 2010, it exacerbated an already difficult provider relationship. Historically, dentists have been less willing than physicians to provide care to MassHealth beneficiaries. In cutting dental benefits for adult MassHealth members, the state reinforced the dentists' long-held belief that the state was not a good business partner. Prior to its 2002 adult dental benefit cuts, only 795 of the 5,000 practicing dentists in Massachusetts participated in MassHealth; following the 2002 reductions, that number fell to 678 (a drop of 15 percent).³¹

Community health centers (CHCs), which can receive some reimbursement for dental services from the state's Health Safety Net (formerly the Uncompensated Care Pool) in the form of a flat fee per dental visit, increased their capacity to cover dental services to maintain some dental access for adult MassHealth members.³² This has resulted in unequal access to dental coverage for adults, however, based on member proximity to CHCs and knowledge about which CHCs provided dental services. As of December 2010, out of 52 CHCs, 33 (roughly two-thirds) offered dental services.³³

The state's decision to continue dental coverage for members that met special circumstances requirements protected dental coverage for the most vulnerable. But it also required additional effort on the part of primary care physicians and dentists serving those with developmental disabilities without an accompanying additional payment. It also affected the Department of Developmental Disability Services (DDS), which helped MassHealth to design and administer

²⁹ Ibid.

³⁰ FY 2012 Massachusetts State Budget, 4000-0300.

³¹ Pryor, Carol and Monopoli, Michael. *Eliminating Adult Dental Coverage in Medicaid: An Analysis of the Massachusetts Experience*. Kaiser Commission on Medicaid and the Uninsured; September 2005.

³² Prior to the FY 2012 budget, the state also provided some infrastructure money to CHCs to increase dental capacity. The FY 2012 budget does not include any funding for this initiative. See *The Fiscal Year 2012 Budget: General Appropriations Act (GAA) After the Governor's Vetoes*. Budget Brief, Massachusetts Medicaid Policy Institute, August 2011.

³³ Massachusetts League of Community Health Centers. *Impact of Cuts to Medicaid and Commonwealth Care Adult Dental Coverage on Massachusetts Community Health Centers, 2010-2011 Report*.

the program for clients with developmental disabilities who were potentially eligible for the special circumstances designation.

In addition, the policy affected the Health Safety Net (HSN), administered by the Division of Health Care Finance and Policy (DHCFP). With the reduction in MassHealth benefits, the HSN reimbursed CHCs for providing dental services to Medicaid, uninsured, and underinsured individuals who met financial eligibility requirements. This increased the demand for Health Safety Net resources in CHCs, reducing the amount available to hospitals, which were already absorbing a HSN shortfall in FY 2011.

4. Stabilizing Medicaid Funding Going Forward

Massachusetts policymakers now have the opportunity to begin a conversation on how to mitigate these cycles.³⁴ The economy appears to be stabilizing, if not returning to its peak levels. Additionally, the state will soon see a significant influx of federal dollars to support its health coverage programs. In 2014, the federal government will begin to pay an enhanced Medicaid match to Massachusetts for the expanded populations under the federal ACA that the state already covers. Specifically, Massachusetts will receive an increasing federal match toward coverage of childless adults up to 133 percent of the federal poverty level, reaching 90 percent match in 2020, compared to 50 percent today.

As the Massachusetts economy begins to improve and these new federal funds become available, Massachusetts policymakers and stakeholders could well use this opportunity to think strategically about how to fund health care coverage going forward.

To stabilize MassHealth, the state could, for example, consider investing a significant portion of these expected additional federal funds to avoid repeating the past cycles of expanding and cutting Medicaid coverage based on the state's economic health.³⁵ Stabilizing MassHealth funding is not a substitute for managing the MassHealth program effectively and economically. But stabilizing funding will, in fact, provide the Administration the time and staff resources it needs to plan strategically and to implement initiatives with longer-term savings and quality improvement potential, such as global payments or other payment and delivery system reforms.

Any mechanism to stabilize MassHealth funding should uphold, at a minimum, the following cross-cutting principles to provide the greatest potential for success in meeting its ultimate goal. The mechanism should:

- improve MassHealth's ability to conduct long-term planning, including improved forecasting;
- include a well thought-out governance structure that provides oversight and assigns clear accountability for the implementation and use of the mechanism;

³⁴ This would not be the first attempt to create a mechanism to stabilize MassHealth funding. A number of attempts since the late 1980s have not succeeded for a number of reasons, most prominently the Executive Branch and Legislature's understandable desire to maintain control within each budget year and have all unspent funds at its disposal. Other examples of dedicated funding for health related expenditures include the Massachusetts Tobacco Settlement Fund, which for two years was utilized as anticipated — funding anti-smoking campaigns — but was eventually diverted to other funding priorities. The Medical Security Fund maintained large surpluses during periods of strong economic times but was “raided” in difficult budget times, leaving the Medical Security Program (MSP), which provides health coverage to individuals receiving unemployment insurance, without sufficient funds. The shortfall led to benefit cuts and cost-sharing increases for MSP enrollees.

³⁵ The Commonwealth might also use part of these funds to keep some or all current Commonwealth Care members at the same level of cost-sharing as they have today, or implement approaches that lessen the impact of the higher copayment levels under the federal reform law for those with lower incomes under the former Commonwealth Care program.

- be transparent, providing clear and understandable information on the mechanism and its allowable use; and
- apply lessons learned from past experience with similar mechanisms meant to stabilize spending or dedicate funds.

Following are three potential mechanisms to begin the conversation.³⁶ These options are not mutually exclusive and could be considered in any combination. There may be other feasible mechanisms that should be considered to accomplish these goals.

Option 1: A Medicaid Stabilization Fund

One option is to authorize and establish a Medicaid Stabilization Fund that can serve as a MassHealth-specific “rainy day fund.” The state could deposit a portion of the enhanced funding the state will receive under the ACA, as well as retain any appropriated dollars not used by MassHealth in a given fiscal year for use by the program in future years. The Fund could also receive deposits, as available, during richer budget years to help the state prepare for the inevitable down cycle in future years. Other sources of deposits could include recoveries from one-time, large-scale provider fraud and abuse lawsuits successfully settled or adjudicated by the state Office of the Attorney General, audits conducted by the state auditor’s office, or a new provider tax dedicated to this fund.³⁷

The Medicaid Stabilization Fund would be governed by a Board made up of Administrative and Legislative representatives. It would only be accessible to the Office of Medicaid for program spending under specific economic circumstances and the funds would not be available to provide for expansion of benefits or rate increases not otherwise affordable within a state fiscal year.³⁸ Specifically, we recommend that once the Fund is established, aggregate MassHealth spending growth in the general fund be limited to a defined amount.³⁹ This would bring predictability to both the Administration and the Legislature in developing annual budgets. If MassHealth should require less funding than the targeted growth in a particular year to maintain its current

³⁶ Some policymakers have argued for states to be given more latitude in managing their Medicaid program budgets through “block grants.” This option is not explored in this paper as it cannot be adopted by the state without federal intervention. For an in-depth analysis of the implications of block grant proposals on Massachusetts and other state Medicaid programs see <http://www.kff.org/medicaid/upload/8173.pdf> and <http://www.kff.org/medicaid/upload/8185.pdf>.

³⁷ Routine recoveries garnered by MassHealth program integrity and third party claiming efforts already get deposited to a MassHealth appropriated line item each year, which in turn funds existing MassHealth expenditures, so diversion of these to the rainy day fund would be counterproductive.

³⁸ Detailed trigger requirements would need to be developed to ensure that the MassHealth Stabilization Fund is used only for its intended purpose. For example, a rule might be that the Fund is only accessible where the overall state revenue projections are at or below current year revenues. Another rule might be that to access funds, the Office of Medicaid would need to request a specific amount of funding and provide justification for such coverage, providing a detailed accounting to the Fund’s governing body of why use of the Fund is necessary, how the dollars would be spent and how that funding fits within the overall Medicaid budget.

³⁹ For example, the target may be 8 percent growth per year; this is only provided as an example and not to suggest that this is the appropriate increment. If this option were adopted, it would be necessary to establish a targeted growth rate based on a detailed financial analysis of Medicaid spending over a rolling time period and to review and update the targeted growth rate on a regular schedule.

program structure, eligibility, and benefits, the difference between the actual budget growth and the allowable trend would be placed in the Fund to help build program reserves. In stronger economic times, a minimum deposit in the stabilization fund should occur prior to any eligibility or benefit expansions. The targeted growth rate should be reviewed on a regular cycle (e.g., every five years). As envisioned, the Fund should be used for specific purposes during down economic cycles to allow the state to maintain major aspects of MassHealth in its current form. These include eligibility rules to maintain coverage for MassHealth members; benefits that improve health outcomes for MassHealth members and without which members are likely to suffer more acute, urgent, or emergent (and costly) care needs; and provider rates, at either current levels or minimal increases to account for inflation. Policymakers may also want the capability to use the Fund to pay for new federally mandated requirements during an economic downturn in the state and to, in limited cases and dollar amounts, fund up-front investment requirements of initiatives that can reduce the overall costs of MassHealth or have been proven elsewhere to slow the rate of growth in Medicaid.

Even without the ACA's additional funds, it is important to the long-term stability of MassHealth to develop a better process for dealing with fluctuating revenue cycles. Some state budget experts believe that, even as the economy recovers in Massachusetts, state revenue may never reach its previous peak. To prepare for such an eventuality, the state should strategically consider what pieces of MassHealth are essential to protect from budget cycles, and invest a sufficient amount in a Medicaid Stabilization Fund to maintain core populations and services without impacting other parts of the state's budget. In addition to an investment in the Medicaid Stabilization Fund, the state could allow for any remaining monies within the Medicaid line item accounts at the end of the fiscal year to be placed in the Medicaid Stabilization Fund instead of being returned to the general fund. This would provide MassHealth with an additional incentive to be efficient in its administration, even when the state economy is strong.

As illustrated above in the dental benefit example, even a significant programmatic reduction in MassHealth can result in only marginal savings to the state budget. In the state FY 2012 budget, as noted, the Administration and the Legislature are counting on \$770 million through increased efficiencies. This is an unprecedented amount to save within the MassHealth program in a single year. It will be particularly difficult to achieve absent a reduction in eligibility — a difficulty compounded by the fact that the substantial administrative resources required to implement the projected savings target will be simultaneously needed to enable the state to take advantage of all the opportunities offered through the ACA.⁴⁰

If MassHealth is unable to make sufficient progress towards this savings target and state revenues come in as expected, one or both of two things may become necessary. The Governor may

⁴⁰ See Waldman, B. and Nordahl, K. *The ACA's Impact on Medicaid: Changes and Opportunities for MassHealth*. Massachusetts Medicaid Policy Institute; July 2011.

need to use his emergency powers to reduce spending during the middle of the year and/or the Legislature may need to identify new revenue sources by cutting elsewhere in the state budget. With a Medicaid Stabilization Fund, the state may be able to avoid future potential threats of this kind by providing a stable funding source to allow the MassHealth program to weather financial storms and maintain program stability.

At least one other state has considered and now adopted this type of policy to address its Medicaid budget challenges. The State of Utah enacted a Medicaid reform law in 2011 that includes the creation of a “Medicaid Growth Reduction and Budget Stabilization Account,” a restricted account within its general fund. Subject to certain budget conditions, if Medicaid expenditures in a fiscal year are less than 8 percent greater than the previous year’s expenditures, the legislature would add to the stabilization account an amount equal to the difference between actual spending and the 8 percent target growth. The legislature may appropriate money from the stabilization account only for the Medicaid program, and only when expenditures in a fiscal year are estimated to exceed the previous year’s expenditures by 8 percent or more.⁴¹ To link the creation of the stabilization account to long-term Medicaid improvements and cost containment strategies, the account will not be created until the federal government approves Utah’s pending Medicaid waiver, submitted in July 2011, which proposes to replace the fee-for-service delivery model with an “accountable care” model.⁴²

Option 2: Multi-year Budgets for MassHealth

A second option for maintaining MassHealth’s stability in economic down cycles is to allow for some or all of the MassHealth budget to be appropriated over a multi-year period. Currently 20 states use two-year budgeting cycles for their entire state budget. Some do this by necessity, as their legislatures are in session biennially. But others (including Connecticut and Ohio) use a multi-year budget process within the structure of legislatures that meet annually, as is the case in Massachusetts. Critical issues for a state to decide up front in either case are: 1) what process, if any, to put in place for modifications to the budget in the off-year of the cycle and 2) what level of flexibility to provide to the Executive Branch to transfer funds between state budget accounts as needed.⁴³ In Kansas, a number of smaller agencies are budgeted on a two-year basis while the rest of state government, including Medicaid, is budgeted on an annual basis.⁴⁴ Several cities, including San Luis Obispo in California, also use multi-year budgeting.⁴⁵ We recommend that a

⁴¹ Utah Code 63J-1-315.

⁴² Utah Department of Health, Division of Medicaid and Health Financing. *Utah Medicaid Payment and Service Delivery Reform 1115 Waiver Request*. July 1, 2011.

⁴³ *Biennial Budgeting, Three States’ Experience*. United States General Accounting Office, GAO-01-132, October 2000.

⁴⁴ See Kansas Budget Instructions to State Agencies, Division of the Budget, June 2011, accessible at http://budget.ks.gov/publications/FY2013/FY2013_Budget_Instructions.pdf.

⁴⁵ For details on the San Luis Obispo experience see <http://www.slocity.org/finance/download/multi-year-budgeting.pdf>.

multi-year budgeting process be longer than two years, allowing for true long-term planning and contracting within the program.

A multi-year budget can allow programs time to invest in improvements and infrastructures that ultimately contain costs in a later year of the budget. Such a process would give MassHealth additional time for thoughtful planning of program improvements that allow for an up-front investment with the potential to improve quality and contain costs during the budget period. In addition, a multi-year budget would allow the state to contract with multi-year rates, instead of having to renegotiate MCO contracts and many other provider, contractor, and vendor rates each year. Finally, a multi-year schedule would reduce the administrative burden and costs of these activities when required on an annual basis and reduce significantly the associated fiscal uncertainties that annual renegotiations create for all concerned.

Under a multi-year budget cycle, the state could implement a requirement that if the Administration or the Legislature wanted to expand the populations covered or services provided by the Medicaid program, it would need concurrently to provide a sustainability plan for funding the expansion for a period of at least five years.⁴⁶

However, a multi-year budget runs the risk of a shortfall not easily addressed later in a cycle, which might trigger the need to implement emergency cuts. Likewise, the practice may delay the introduction of new initiatives during the multi-year cycle. An alternative to multi-year budgeting would be a requirement that the Office of Medicaid conduct long-range forecasts and provide the Administration and Legislature with multi-year spending plans that take into account spending trends over a rolling period of past and projected years (e.g., two prior years, current year, and two projected years). This may provide some of the same stability that a two or more year budgeting process would be trying to achieve, while still providing the flexibility to implement long-term program improvements.

Option 3: Establish the Medicaid Agency as a Public Authority

A third option is to convert administration of the Medicaid program from an agency of the Executive Branch to a different governance structure that could allow more flexibility for a longer planning horizon, while maintaining public accountability. One possibility is a public authority, governed and overseen by a Board of Directors appointed by the Governor and the Legislature. A number of other health coverage programs have this structure, including the Commonwealth Health Insurance Connector Authority in Massachusetts and the Dirigo Health Agency in Maine. Most directly comparable is the Oklahoma Health Care Authority, which is that state's single state agency for the administration of the Medicaid program.

⁴⁶ This requirement could be implemented today, without a multi-year budget process or another larger stabilizing mechanism for the program.

As an independent authority, the MassHealth program could, for example, hold public board meetings, which would increase scrutiny of major decisions but also allow the agency to strengthen public support by communicating its long-term goals and short-term challenges. Given the entitlement nature of the Medicaid program, the authority would still require state appropriations for current spending but, depending on how it is established, it also could retain a dedicated sum of money that the authority controls, providing more flexibility in the management of its budget on an annual and long-term basis. Such flexibility would, for example, provide MassHealth with the ability to conduct longer-term rate negotiations with its managed care organizations and large providers such as hospitals, bringing greater financial stability to the program. This stability, in turn, might persuade MCOs and providers to partner with MassHealth on more ambitious payment and delivery system reforms that, over time, could improve the management of the program and slow its cost trajectory.

A change in governance of this sort would require serious thought and consideration of its impact on the agency itself, the Executive Branch and the Legislature, other state agencies whose efforts to serve populations are intertwined with the Medicaid program, stakeholders (including vendors, providers, and advocates), and, most importantly, on the individuals MassHealth serves.

5. Conclusion

It is abundantly clear that economic cycles adversely impact the Medicaid program and its ability to provide high-quality services to its members, and stability to its provider network. As policymakers look forward to enhanced federal funding coming into the state with implementation of the ACA, Massachusetts policymakers have a unique opportunity to develop a clear strategy to allow for a more stable Medicaid program across all economic conditions.