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Bulletin

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MTF

Health Care in Governor Baker's FY 2017 Budget Proposal

MassHealth, the state's Medicaid program, makes up 39 percent of spending in Governor Baker's FY 2017 budget proposal – by far the single largest area of spending. This brief examines MassHealth spending in the Governor's budget, strategies employed to control cost and other notable elements of his proposal.

Health Care Spending in House 2

The Governor's budget (House 2) includes $15.47 billion in funding for MassHealth. This level marks an increase of $739.3 million (5 percent) over the FY 2016 level and accounts for 49.7 percent of all new spending proposed in House 2; in order to balance the budget and support this MassHealth increase, spending growth in all other line items is limited to 1.2 percent.

MassHealth is a joint program between the state and the federal government, which means that the costs of operating the program are borne by both. Generally, 50 percent of MassHealth spending is reimbursed by the federal government. Since enactment of the ACA, certain MassHealth members are reimbursed at a much higher rate, further reducing the net state contribution. House 2 assumes that of the $739.3 million proposed increase in MassHealth, $463.6 million will be reimbursed with new federal Medicaid funds, leaving the balance of $275.7 million to be paid by the state representing 37 percent of the total projected spending increase.[1]

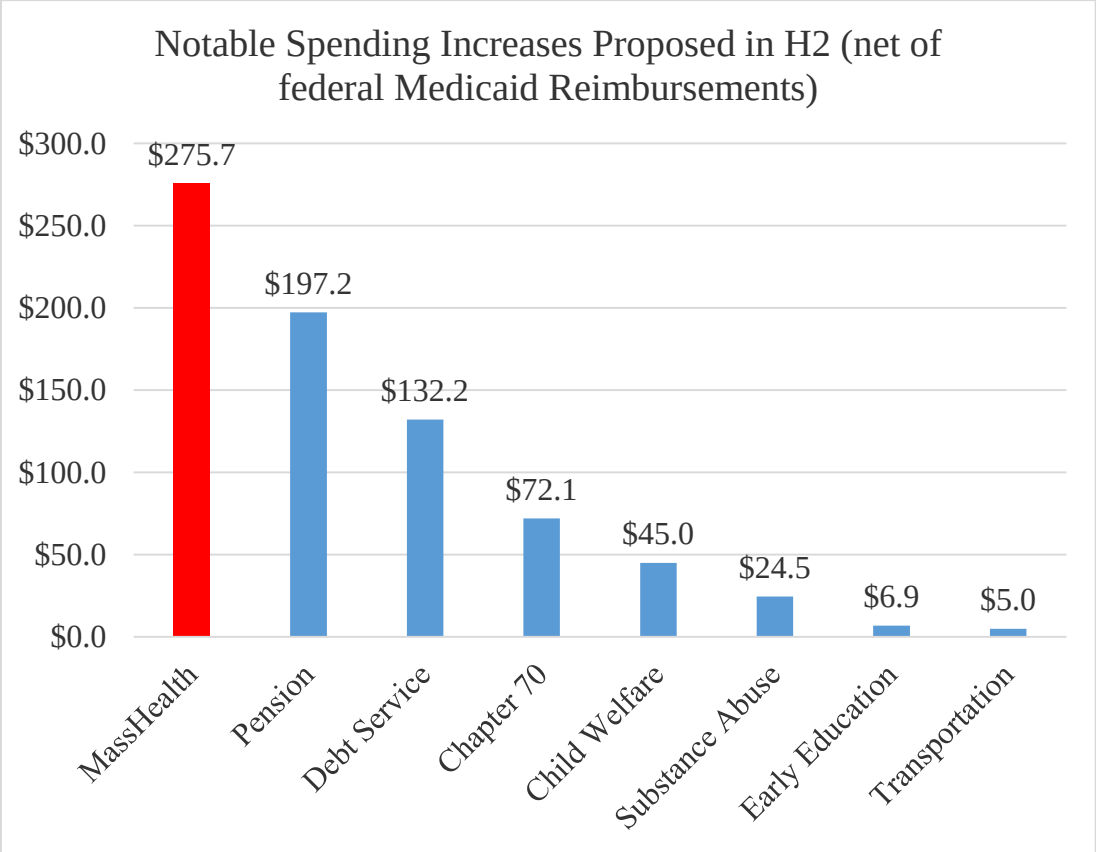
[1] This calculation of additional federal revenue includes $73.5 million in one-time revenue related to a proposal to expand the state's DSRIP program.

Figure 1. MassHealth Spending Increases in the Governor's FY 2017 Budget

Calculation of Net MassHealth Cost in H2	
H2 increase in MassHealth spending	$739.3
Associated increase in federal reimbursements	$463.6
Spending increase less new federal reimbursement is the net state cost	***$275.7***

Even when the federal reimbursement is taken into consideration, MassHealth spending far outweighs House 2 spending for other programs. The chart below illustrates the extent to which the net budgetary impact of MassHealth overshadows all other budget spending categories. This increase is almost $80 million more than the state's required pension contribution, the next largest spending category, and is close to four times greater than the Governor's proposed increase for education aid (Chapter 70).

Figure 2. Spending Increases in the Governor's Budget by Policy Area



This increase in MassHealth spending does not reflect an expansion of MassHealth services or eligibility for new populations. Rather, the MassHealth increases proposed in House 2 are required to maintain the current program in light of growing enrollment and higher health care costs. To put this in perspective, a $275.3 million increase in funding for subsidized childcare would double the number of children served by that program from 36,000 to 72,000 children per year.

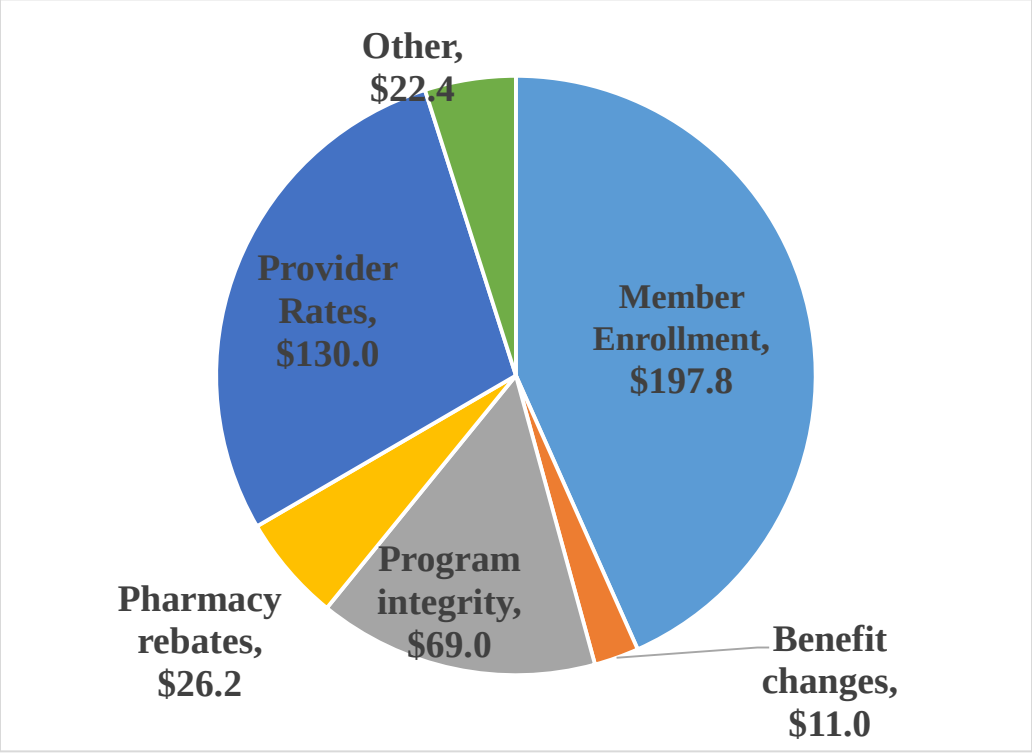
Analyzing MassHealth in House 2

Given the size and complexity of the MassHealth program, it is important to consider the Governor's FY17 spending plan in the context of several major factors that impact cost growth:

1. Member enrollment;
2. Provider rates;
3. Program integrity;
4. Benefit changes;
5. Pharmacy rebates; and
6. Other savings assumptions.

Among these categories, the administration identifies $456.4 million in assumed savings initiatives from the initial Executive Office of Health & Human Services FY 2017 cost projections for maintenance funding of MassHealth. In other words, had the Administration done nothing to manage cost, MassHealth costs would have grown by an additional half billion dollars in FY 2017.

Figure 3. MassHealth Savings Initiatives in the Governor's Budget



Member enrollment - $197.8 million savings assumption

MassHealth enrollment growth over the past decade has been the single largest cost driver in the program; therefore controlling that enrollment growth is the largest savings initiative included in House 2.

The Governor's budget assumes that member enrollment in FY 2017 will grow by 2.7 percent to 1.889 million, an increase of almost 50,000 members from the 1.84 million members FY 2016.[2] This member growth projection is well short of MassHealth enrollment increases in recent years and is far below the initial administration enrollment projection of 4.3 percent for FY 2017.

Figure 4. MassHealth Enrollment Growth, FY 2014 – FY 2017

	Enrollment Growth (including temporary)	Enrollment growth (not including termporary)
FY 2014	12.4%	5.9%
FY 2015	20.0%	15.3%
FY 2016	NA	6.3%
FY 2017 Initial	NA	4.3%
FY 2017 H2	NA	2.7%

The implementation of the ACA and the ensuing challenges faced by the Connector resulted in thousands of people being placed in MassHealth temporary coverage while eligibility for other types of care was determined. While those eligibility issues were being sorted out, the confirmation of existing MassHealth member eligibility was delayed. These two factors, among others, drove enrollment spikes between FY 2014 and FY 2016 that should abate in the years ahead.

While House 2's enrollment assumptions are more in line with enrollment trends prior to the implementation of the Affordable Care Act in FY14, annual enrollment growth has exceeded three percent in all but one year since FY 2010. Continuing enrollment redetermination efforts (expected to save $400 million in FY16), maximizing utilization of all third party insurance for eligible members, and ongoing improvements to the state's Health Information Exchange (HIX) make the enrollment projection of 2.7 percent an achievable, but ambitious, target.

[2] Current MassHealth enrollment, as of January 2016 is 1.86 million. The average monthly enrollment for FY 2016 through January is 1.836 million members.

Figure 5. MassHealth Enrollment Growth, FY 2010 – FY 2013

	Enrollment growth (Percent)	Enrollment growth (members)
FY 2010	4.4%	53,282
FY 2011	5.3%	67,173
FY 2012	3.7%	48,999
FY 2013	2.8%	38,613
Average	4.1%	52,017

Failure to achieve this enrollment target would have a significant budgetary impact. House 2 projects $197.8 million in savings ($98.9 million in net savings after accounting for federal revenue) from limiting enrollment growth to the 2.7 percent compared to the original 4.3 percent. However, as this savings figure implies, each percentage point increase in MassHealth enrollment is associated with increased costs of over $100 million. Given the fact that budgeted projections in recent years have consistently underestimated actual MassHealth enrollment growth, House 2's aggressive approach to enrollment growth represents a possible budget exposure for later in the year. However, if MassHealth costs are ever to be reined in, enrollment growth levels like those assumed in House 2 are essential.

MassHealth Rates - $130 million savings assumption

In addition to member enrollment, the rates paid by MassHealth to providers and plan administrators are another key factor for assessing cost growth assumptions. In his FY 2017 budget, Governor Baker proposes saving $130 million ($65 million net) by limiting MassHealth rate increases compared to standard growth assumptions. The biggest component of these savings ($116 million gross/$58 million net) comes from limiting increases to the capitation rates paid to MassHealth Managed Care Organizations (MCOs). MCOs manage the care of 48 percent of MassHealth members in exchange for a set per member per month payment for each covered life. This capitation model is designed to incent more appropriate and cost effective care because the amount of money they receive is capped. This is in contrast to fee for service payment arrangements that pay a provider for each discreet service a member receives.

The MassHealth process for developing MCO rates is complex. These rates must account appropriately for the broad range of possible medical services required for the diverse MassHealth population. In addition, MCOs, like other insurers, must meet state requirements regarding the maintenance of adequate reserves to meet unexpected costs and sufficient rates to cover health care costs for the specific demographics of the covered group. The Administration's approach to limiting MCO rates is aggressive and marks the second time in the last four years that the state budget has assumed a zero rate of growth for MCOs. It's important to note that MCO contracts with the state will not be finalized until the fall, therefore actual rate costs are not yet known.

A third source of savings in House 2 comes from the foregone rate increases to hospitals and other MassHealth partners. These $44 million ($22 million net) rate savings are partially offset by a $30 million increase in rates paid to nursing homes under the Governor's proposal.

Program Integrity - $69 million in savings assumptions

In FY 2017, the administration estimates $69 million in additional savings and revenues related to program integrity efforts. "Program integrity" refers to efforts to ensure that MassHealth aggressively pursues opportunities to maximize revenues owed to the program and to eliminate areas of unnecessary spending.

Among the program areas being more closely scrutinized is home health services. These services, typically provided to elderly MassHealth members, include personal care giving, homemaking and other benefits that enable members to stay in the community and avoid care in more costly nursing home settings. Recently, administration officials have identified a large spike in billing for these services. Between FY 2013 and FY 2015, spending on home health services increased by $268 million or 41%. Even more startling, the vast majority of this spending increase ($219 million) went to providers who are newly participating in MassHealth. In February, the administration announced that at least 12 of these providers have been referred to the state Attorney General for investigation for possible fraudulent billing practices.

In light of this substantial increase in home health spending, MassHealth is implementing several measures to better track home health services and eliminate unnecessary expenditures. Specifically, MassHealth is placing a moratorium on contracting with any new home health providers until a review of system controls can be completed. In addition, MassHealth will now require that members receive prior authorization of any new home health services. In total, MassHealth estimates $39 million in savings ($19.5 million net) through improved program integrity in this area.

House 2 also assumes $10M more ($5 million net) will be recouped from the estates of deceased members through enhanced estate recovery efforts. Unlike other savings assumptions included in House 2, this change requires legislative action.

Benefit Changes - $11 million in savings assumptions

The scope of benefits offered to MassHealth members is a major determinant of program costs. The Governor's budget proposal does not eliminate any benefits, perhaps because decisions to reduce or eliminate benefits have been rare and controversial. For example, the last major benefit reduction occurred during the Great Recession when the state eliminated restorative dental benefit coverage for most adult MassHealth members in order to save $56 million annually ($28 million net). In the debate over dental benefits, as in debates over most proposed benefit changes, the discussion revolved around the appropriate level of care as well as the efficacy of short-term savings if the lack of preventive care exacerbates long-term costs.

Instead of eliminating benefits, the Governor proposes to modify how some benefits are accessed. Vision, speech therapy and physical therapy benefits, among others, will no longer be offered through the MassHealth Primary Care Clinician program (PCC). Members impacted by the change will be required to enroll in an MCO to continue to receive coverage. This modification is estimated to save $11 million ($5.5 million net) in FY 2017 through reduced benefit costs. It also continues ongoing efforts to migrate more patients from the PCC program to MCOs in an effort to control cost. Currently, 21 percent of members are covered through the PCC program.

Pharmacy rebates and other savings initiatives - $48.6 million in savings assumptions

Another $48.6 million in House 2 savings ($24.3 million net) comes from a variety of initiatives, the biggest component of which is $26.2 million in savings and revenue ($13.1 million net) from increased pharmacy rebates and reduced pharmacy costs. As a large purchaser, the Medicaid program is able to negotiate substantial price rebates from pharmaceutical companies to reduce the cost of commonly prescribed medications. By targeting classes of medication for which a brand name may be less expensive than currently prescribed generic versions the state will also be able to further reduce pharmaceutical costs. By taking advantage of federal efforts to change the rebate process for certain specialty medications, the Governor's FY 2017 budget assumes rebate revenue of approximately $26 million more than the FY 2016 amount.

Additional MassHealth savings comes from downsizing the Infrastructure & Capacity Building Grant program to $20 million from the $30 million included in the FY 2016 GAA. This follows a similar $10 million reduction to the program earlier in the year by the Governor as part of his FY2016 mid-year budget cuts.

Other House 2 MassHealth savings and revenue initiatives

Health Safety Net

The Governor's budget eliminates the state contribution to the state's Health Safety Net Trust Fund (HSN) in recognition of assumed savings from upcoming regulatory changes. The purpose of the HSN is to reimburse hospitals and other providers who provide a disproportionate amount of emergency care to the uninsured and underinsured. The HSN is currently funded through a combination of assessments on both providers ($170 million) and insurers ($160 million), funding from the Medical Assistance Trust Fund ($70 million) and a contribution from the state ($30 million). Under the Governor's budget, this state contribution would be eliminated

The Governor is proposing a regulatory change that would limit reimbursement to patients with income up to 300% of FPL. This change would more closely align HSN income standards with eligibility for MassHealth. Currently, providers are eligible for partial reimbursement for the cost of caring for patients with incomes between 200% and 400% of the Federal Poverty Level (FPL). The proposal would also lower the income threshold at which those receiving HSN care would be responsible for a deductible from 200 percent to 150 percent of FPL. These changes, along with ongoing efforts to increase enrollment of HSN patients into subsidized care programs, are expected to reduce HSN payments by at least $30 million in FY 2017 and by $60 million when annualized.

More importantly, these changes may eventually lead to a reduction in HSN reimbursements. In the short term, changes to HSN eligibility may not impact the level of reimbursable emergency care provided to those seeking services. Over time, the change is intended to encourage hospitals to assist uninsured or underinsured people with enrollment in the appropriate subsidized health care programs (such as Medicaid) that will enable them to seek preventative care and avoid receiving care in more costly settlings (such as the emergency room).

DSRIP in House 2

The administration's budget includes a new Delivery System Reform Incentive Program (DSRIP) proposal that relies on a new hospital assessment and assumes approval of an upcoming federal waiver to generate hundreds of millions of dollars in revenue. This revenue will be used for supplemental provider payments and to incent health care providers to move toward new health care delivery systems for their MassHealth members. The federal government introduced DSRIP to provide transitional funding to those states moving toward more integrated and cost effective delivery models. Massachusetts currently has a relatively small DSRIP program which provides incentive payments to seven providers. The DSRIP proposal in House 2 reflects a substantial expansion and overhaul of the current program.

Under the House 2 DSRIP plan, at least $500 million in annual payments would be provided to health care providers. Of this amount, $250 million would take the form of supplemental rate payments based on a provider's share of Medicaid patients. The remainder of these payments would provide financial incentives to providers and their partners that move toward an Affordable Care Organization (ACO) structure. The structure of these incentive payments is still in the process of being determined as the state finalizes its waiver application with the federal government.

The DSRIP funds would be generated by a $250 million assessment on hospitals, based on their share of privately insured patients, and by $250 million in federal reimbursements generated by DSRIP expenditures. This DSRIP expansion is contingent upon approval of the state Medicaid waiver that will be finalized in negotiations with the federal government in the months ahead. It is possible that even without DSRIP approval, the state could move ahead with the $250 million hospital assessment to generate an additional $125 million in federal reimbursements.

Figure 6. Spending Revenue Summary of DSRIP Proposal

DSRIP Payments to Providers	
ACO Incentives	At least $250 million
Supplemental MassHealth hospital rates	$250 million
DSRIP Financing Sources	
Enhanced federal support	At least $250 million
Assessment on hospitals	$250 million

While the DSRIP program is designed to be revenue neutral in the aggregate (providers' assessment and the supplemental rate payments each total $250 million), the impact of this proposal on individual hospitals varies greatly. No official breakdown of the assessment or supplemental payment by provider is yet available, but the Foundation's projections indicate that more than half of the 65-70 effected providers would be net beneficiaries, i.e., the supplemental rate payments will exceed their assessment costs by approximately $70 million. However, approximately 30 providers will be net payers with an aggregate assessment that will exceed the supplemental payment by approximately $70 million. For a few individual providers, the annual

net assessment or payment could exceed $10 million – an amount that in some cases more than doubles the existing hospital assessment that funds the provider share of the HSN.

Conclusion

Spending on MassHealth dominates the Governor's FY 2017 budget proposal and dwarfs funding increases in all other areas of the budget. This is no surprise given the size and scope of the program even when federal contributions are considered.

House 2 assumes more than $400 million in savings assumptions and initiatives to limit spending growth to a five percent increase over FY 2016, which, if achieved, would be the smallest annual growth rate since the implementation of the ACA. While ambitious, restraint on the MassHealth program is necessary if the state is to have adequate funds for other budget items, which will grow by 1.2%.

As the budget process moves to the House and Senate, several elements of the Governor's plan will likely be subject of strong debate. Among them are:

Health Safety Net Funding **-** Recent action by the Senate indicates its likely opposition to the Governor's proposed regulatory changes. Citing concerns from providers and the impact on uninsured and underinsured families, the Senate included language in a supplemental budget which would prevent any regulatory changes to the HSN through the remainder of FY 2016. While the language was not included in the final version of the supplemental budget, it could signal the Senate's approach to the HSN in FY 2017.

DSRIP **-** This proposed program includes a $250 million hospital assessment which may prove to be controversial and meet with resistance from legislators representing providers with large net assessments. Should either the House or the Senate reject the Governor's plan, they would need to find $73.5 million in either savings or budget cuts to make up the difference.

Rates **-** The General Court may include more funding for MassHealth rates than the Governor's proposal as they did in the most recent supplemental budget which included $11 million for additional FY 2016 rates for acute care hospitals serving primarily MassHealth or Medicare clients. If they do so, they would need to offset this with additional savings or new revenues to pay for the higher rates.

Benefits **-** The budget debate affords legislators an opportunity to include language related to MassHealth benefit coverage. In addition to possibly weighing in on the Governor's proposal to change PCC benefits, dental benefit coverage enhancements have been added to the budget in the legislature in recent years.