ISSUE BRIEF
The Massachusetts Health Policy Forum

MASSHEALTH: DISPELLING MYTHS AND PRESERVING PROGRESS

Wednesday, June 5, 2002
8:30 to 9:00 - Registration and Breakfast
9:00 to 11:30 - Discussion

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Foreword

This Issue Brief is an effort to present an accessible overview of the MassHealth program. MassHealth is tremendously complicated and we have not attempted to explore or explain its many nuances. Instead, we have tried to highlight the major trends in the program and their underlying causes, in order to support a more informed public discussion of key policy issues and options.

We have drawn upon publicly available data from many different sources. Information on MassHealth enrollment and spending varies depending on when the data are collected, the methodology used, and the time frame for which the data are collected. For example, spending based on date of service varies from spending based on budgetary fiscal year. The most recent spending data are always based to some extent on projections, because there is a considerable lag between provision of services and provider billings and payment. There are also retroactive changes in membership. For these and other reasons, not all sources of data are entirely consistent. For the purposes of this report, we have attempted to use the most recent data available from DMA. However, in some cases, data have been obtained from other sources. In a few cases there are inconsistencies that have been difficult to resolve but which do not affect the analysis or conclusions.

We are grateful to the following individuals for supplying us with information, insights, and/or helpful comments on earlier drafts of this Issue Brief: The Division of Medical Assistance, particularly Tricia Spellman and Wendy Warring; Michael Miller of Health Care for All; Cindy Wacks, Elizabeth Kaiser, Amy Lischko and Katherine London of the Division of Health Care Finance and Policy; John McDonough of the Heller School, Brandeis University; Paul Dryfoos; Jay Himmelstein of the University of Massachusetts Medical School; Sarah Iselin of the Blue Cross Blue Shield of Massachusetts Foundation; Bruce Bullen and Charlie Baker of Harvard Pilgrim Health Care; Charlene DeLoach of Senator Richard Moore's office; David Mulligan of Stonehill College; and James Hunt, Jr. of the Massachusetts League of Community Health Centers.

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Executive Summary

As one of the largest components of the state's budget, MassHealth—the Massachusetts Medicaid program—has always been subject to close scrutiny. With the state's current fiscal situation, there is intense pressure to find ways to curb MassHealth expenditures, without jeopardizing the program's success in expanding coverage and access.

This Issue Brief is designed to contribute to current discussions and debates about the MassHealth program. It provides an overview of MassHealth, an analysis of the factors and forces that determine program spending, compares trends in the MassHealth program to those of Medicaid programs in other high-income states, and analyzes a number of options that have been, or could be, suggested to reduce the rate of increase in MassHealth spending and/or reduce the impact of MassHealth on the state budget.

Among the major conclusions of the report are:

The Commonwealth should be proud of the accomplishments of the MassHealth program: MassHealth is an essential source of health coverage for many of the most vulnerable residents of the Commonwealth. With significant, *deliberate* expansions over the past five years, MassHealth is now one of the largest health "insurers" in the state, covering one million people, or almost one of every 6 people, in the Commonwealth. The state's efforts to expand MassHealth have been a tremendous success and are one of the major reasons that Massachusetts has a relatively low rate of uninsurance—about 6%—compared to a national average of 16%. The program is also responsible for the fact that only 3% of children in Massachusetts are uninsured—one of the lowest levels in the country and much lower than the national average of 12%. The MassHealth program is also an essential source of payment for the state's safety net providers, including community health centers, nursing homes and hospitals that provide disproportionate amounts of care to low-income patients. A strong and vital MassHealth program is critical to the health of many individuals and communities in the Commonwealth, as well as to the financial health and stability of many essential providers of care.

MassHealth is not more "generous" than the Medicaid programs in states with comparable levels of state income: The eligibility standards for MassHealth are similar to and, in some cases, less generous than, those in other high-income states. Although Massachusetts covers more optional Medicaid benefits than most, but not all, peer states, most of these benefits are relatively inexpensive services intended to improve the quality of care provided to members and to promote lower-cost alternatives to other covered services.

Less than half of the cost of MassHealth is paid by the state: Federal matching payments and inter-governmental transfers finance the majority of the spending for MassHealth. In FY 01, total MassHealth spending was $4.8 billion of which $2.4 billion, or 46%, was state spending. The state's share of the total cost of MassHealth has been relatively constant over the past five years, at about 45-46%, despite significant expansions in enrollment, an indication of the success of the state's deliberate efforts to maximize federal sources of revenue for MassHealth. Although the program represented almost 22% of the state budget in FY01, the state's share of MassHealth spending was 9.7% of the budget. The fact that the federal government pays more than half of MassHealth spending also means that it takes more than $2 of reductions in total MassHealth spending to reduce state spending on MassHealth by $1.

Recent expansions in MassHealth eligibility account for a relatively minor share of total MassHealth spending: Massachusetts expanded MassHealth eligibility significantly in 1997. Although the populations covered by this expansion now represent about 30% of total MassHealth enrollment, they account for only 11% of total MassHealth expenditures. The expansions in eligibility accounted for about only one-third of the total increase in MassHealth spending from FY97 to FY02. Even with no expansions in eligibility, MassHealth spending would have grown at an annual rate of nearly 6% per year during the past five years.

Most MassHealth spending is for a relatively small proportion of members, most of whom are disabled or elderly: Although MassHealth is often thought of as a health program primarily for low-income children and women, most of the program's budget is spent on services for elderly and disabled individuals. While the elderly and disabled comprise only 32% of total MassHealth members, the majority of MassHealth expenditures (71%) is spent on services provided to these members. In fiscal year 2001 MassHealth spent an average of $2,022 for each family member, and $3,460 for each long-term unemployed adult (MassHealth Basic), compared to $8,723 for each non-elderly disabled adult and $17,515 for each elderly enrollee.

MassHealth expansions have not been a drain on the state's General Fund: Expansions in MassHealth eligibility have been almost entirely funded by new revenues and not the General Fund. Although the Children's and Seniors' Health Care Assistance Fund, the mechanism through which all revenues and expenditures for the expansion populations flow, has a shortfall, this is entirely due to the fact that smaller amounts having been transferred to the Fund from the Uncompensated Care Pool (UCP) than planned in the original budget projections. The MassHealth expansions would have been fully funded by designated revenue sources other than the General Fund had the UCP transfers been made as originally planned.

All health care payers, including other Medicaid programs and employers, are experiencing the same types of cost increases as MassHealth: MassHealth is not alone in its recent cost increases. In fact, the 2% average annual increase in per member spending for the MassHealth program is far below the 11-15% average annual premium increases recently seen by employers. The overall rate of growth in MassHealth spending is somewhat below Medicaid spending growth in other states, despite the fact that the MassHealth population grew faster than national Medicaid enrollment.

Prescription drugs, hospital services, and nursing home care account for most of MassHealth spending and most of rising costs: Nearly three-quarters of the increase in MassHealth's fee-for-service (non-managed care) spending in the past three years is accounted for by just three services: prescription drugs (34% of total spending increase), acute care hospitals (21%), and long-term care facilities (18%). The average rate of growth in these three services is very different. Total prescription drug costs are increasing at an average annual rate of nearly 20%, while total hospital spending is rising at an annual rate of 11.6%, and the annual rate of increase in long-term care is much lower, only 3.6%.

Cutbacks in MassHealth eligibility are penny wise and pound foolish: The Legislature is considering tightening eligibility standards for certain categories of MassHealth members as a way to reduce program spending. But eliminating poor and vulnerable people from MassHealth will not reduce their need for health care services or address their inability to pay for the cost of medical care. Instead, these cuts will shift the cost of many services to the state's Uncompensated Care Pool, thereby increasing pressure on an already strained financing system. Some of these benefits lost by these MassHealth recipients may be replaced by services from other state agencies or municipalities at 100% state or local cost, with no federal reimbursement. Other services will be furnished to individuals but go unreimbursed to providers. And the gravest effect of all is that many of individuals will forego needed services, resulting in delayed care, use of more expensive services and poorer health.

There are no easy solutions to rising MassHealth spending; many appropriate savings efforts are already underway, and others are needed: The Division of Medical Assistance has been working aggressively over the past several years to limit the growth of MassHealth spending and maximize federal revenues. These initiatives are well targeted at the three areas that are contributing most to spending increases-prescription drugs, institutional long-term care, and acute care hospitals. DMA's efforts need to be supported and expanded—in particular, implementation of the Senior Care Options program, development of preferred drug lists, and implementation of care management and disease management programs. In addition, the state must undertake further efforts to develop innovative high quality and lower cost systems of care in the community, particularly for seniors and individuals with disabilities.

Massachusetts must adopt a long-term approach to planning and financing MassHealth, including a major reform of the financing and delivery of long-term care services: While the size of the MassHealth budget may make it an attractive target for cutbacks in tight fiscal times, sudden cutbacks in eligibility, benefits or provider payments are not the most effective policy tools to apply. Instead, the state needs to continue to take a long-term strategic view of MassHealth, grounded in commitments to eligibility and to stable state and federal financing. At the same time, it is essential that the state find long-term approaches to ensuring that MassHealth spending is affordable, including reform of the financing and delivery systems for long-term care services, which accounts for more than one-third of the cost of the MassHealth program.

There is a need for ongoing monitoring of the MassHealth program: MassHealth has a tremendous impact on health care access and outcomes, the state budget, the health care industry and the Massachusetts economy. Yet there is no ongoing mechanism for independent analysis and public discussion of MassHealth programs, policies and spending. The establishment of a permanent entity to work collaboratively with state agencies, providers, consumer groups, academic and research organizations and other organizations would promote the ongoing development of innovative, effective policy solutions by providing independent, timely and actionable information to legislators, providers, consumers and other key stakeholders.

Introduction

MassHealth—the Massachusetts Medicaid program—is an essential source of health coverage for the most vulnerable (the poorest and sickest) residents of the Commonwealth. The Commonwealth should be proud of the accomplishments of the MassHealth program. With significant, *deliberate* expansions over the past five years, MassHealth is now one of the largest health "insurers" in the state, covering one million people, or almost one of every 6 people in the Commonwealth. The state's efforts to expand MassHealth have been a tremendous success and are one of the major reasons that Massachusetts has relatively low rate of uninsurance—about 6% by state estimates[*]—compared to a national average of 16%. The program is also responsible for the fact that only 3% of children in Massachusetts are uninsured—one of the lowest levels in the country and much lower than the national average of 12%.[2] The MassHealth program is also an essential source of payment for the state's safety net providers, including community health centers, nursing homes and hospitals that provide disproportionate amounts of care to low-income patients. A strong and vital MassHealth program is critical to the health of many individuals and communities in the Commonwealth, as well as to the financial health and stability of many essential providers of care.

As one of the largest components of the state's budget, MassHealth has always been subject to intense scrutiny. With the state's current fiscal situation, there is intense pressure to find ways to curb MassHealth expenditures, without jeopardizing the program's success in expanding coverage and access. This Issue Brief is designed to contribute to current discussions and debates about the MassHealth program, which range from continuing coverage for certain "expansion" populations, to controlling the use and costs of prescription drugs, to developing more cost-effective community-based models of care. It provides an overview of MassHealth program—the people it covers and the costs of the program; provides an analysis of the factors and forces that determine MassHealth spending; compares trends in the MassHealth program to those of Medicaid programs in other high-income states; and analyzes a number of options that have been, or could be, suggested to reduce the rate of increase in Mass-Health spending and/or reduce the impact of Mass-Health on the state budget.

Section 1: A MassHealth Primer

What is MassHealth?

MassHealth is a joint state and federal program administered by the state Division of Medical Assistance (DMA) and includes both the Medicaid and State Children's Health Insurance Program (SCHIP). The Medicaid program was established by the federal government to provide essential medical and medically related services to vulnerable populations. While they are often confused, Medicaid is a totally separate program from Medicare.

A diverse group of people receives health insurance through the MassHealth program, including children, low-income parents, adults with long-term unemployment, children and adults with disabilities, and seniors. While many people associate MassHealth primarily with low-income women and children, the majority of the program's funds provide health care for persons who are elderly or have disabilities. MassHealth is an essential source of health coverage for our poorest and sickest residents.

Medicaid: In Massachusetts, called MassHealth. Joint state and federal program to provide health care coverage to low-income families and individuals who lack health insurance. The Medicaid program was established in 1965.

SCHIP: Also part of MassHealth program in Massachusetts. Joint state and federal program to expand health insurance to children whose families earn too much to qualify for Medicaid, but not enough to afford private insurance. The SCHIP program was established in 1997.

Medicare: Federally funded and administered program to provide health care coverage to individuals who are over 65 and to individuals with permanent disabilities. Some low-income Medicare beneficiaries are also eligible for coverage under Medicaid. The Medicare program was established in 1965.

Massachusetts receives federal reimbursement, or federal financial participation (FFP), for qualified expenditures. Most MassHealth expenditures are reimbursed at 50%. SCHIP expenditures are reimbursed by the federal government at a rate of 65%. In addition, certain administrative expenses, such as computer system expenditures, are reimbursed at a rate as high as 90%. In general, federal Medicaid assistance percentages (FMAP) vary from state to state, ranging from 50% to 75%. States such as Massachusetts, with a higher per capita income relative to the national average, receive lower FFP. Massachusetts is one of twelve states across the country at the 50% FMAP level.

DMA claims federal reimbursement for all Medicaid eligible expenditures, including services provided for MassHealth recipients by other state agencies, which would otherwise be paid for with state-only dollars, as well as eligible spending by municipalities. Examples of services provided by non-DMA agencies for which federal reimbursement is received include mental retardation facilities, mental health hospitals, public health hospitals, social service and youth service programs, special education, services funded by the state uncompensated care pool and special education and health services provided by municipal governments.

Who is Eligible for MassHealth and What Does MassHealth Cover?

Eligibility for MassHealth, as for Medicaid services in other states, is based on income level and specific categorical criteria such as age and disability.

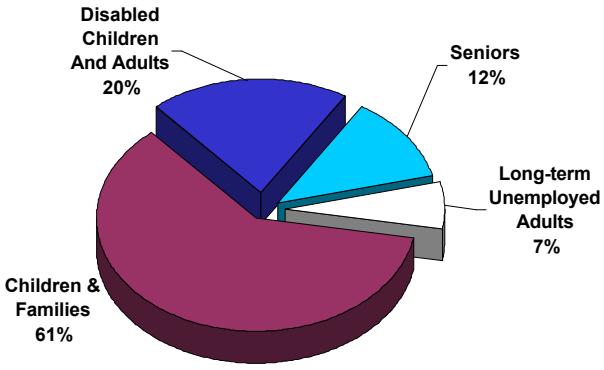
The federal Medicaid statute identifies specific populations at certain income levels that states are required to cover.

Mandatory Medicaid Eligibility Groups: Children under 6 years old with family incomes under 133% federal poverty level (FPL), pregnant women under 133% FPL, children 6-17 years old under 100% FPL, Temporary Assistance for Needy Families (TANF) recipients, aged, blind and disabled individuals who are eligible for Supplemental Security Income (SSI), and certain low-income Medicare beneficiaries.

In addition, states can provide optional coverage to other populations or individuals at higher income levels within the mandatory groups. The MassHealth program provides health care to low-income children and families, long-term unemployed adults, seniors and persons with disabilities (see Figure 1). The federal Medicaid statute also identifies mandatory services, which all states must provide in their benefit packages in order to participate in the program and receive federal reimbursement.

Mandatory Medicaid Services: Inpatient hospital, outpatient hospital, physician services, rural health clinic services, Federally Qualified Health Center services, lab and x-ray services, pediatric and family nurse practitioner services, Skilled Nursing Facility (SNF) services for those over 21, home health for those over 21 and eligible for SNF, EPSDT* for those under 21, nurse midwife services, medical/surgical dental services and some prenatal care.

Figure 1: Distribution of MassHealth Members, 2002



* Early and Periodic Screening, Diagnosis and Treatment

In addition, states may provide and receive FFP for additional services designated as optional by the federal government. There are currently 30 optional benefits that each state decides individually whether or not to offer. (See Appendix A.) Optional services include pharmacy, clinic services, case management, preventive services and rehabilitative services. Other than prescription drugs, these benefits are generally relatively inexpensive services intended to improve the quality of care provided to members and to reduce the overall cost of a state's Medicaid program by providing lower-cost alternatives. For example, comprehensive care management programs, including individual case management and preventive services, often can reduce the need for expensive hospitalizations. Even pharmacy benefits, which can be quite expensive, many times provide a higher quality of care and less expensive alternative to inpatient services.

The MassHealth program includes six major coverage types, each with different eligibility requirements and benefit packages. Eligibility criteria include family income, age, employment, disability and citizenship status. (See Table 1 for a general overview and Figure 2 for a detailed chart of eligibility categories.)

Table 1: MassHealth Coverage Types

MassHealth Coverage Type	Eligibility and Benefits	Number of Members as of 2/2002
Standard	o Low-income pregnant women and infants up to 200% FPL o Children up to 150% FPL o Parents and Adults with disabilities up to 133% FPL o Seniors with income at or below 100% FPL and assets of less than $2,000 for individual and $3,000 for couples (seniors may spend-down their assets and income in order to become eligible, also higher income and asset tests may apply for institutionalized seniors who have a spouse living in the community) o Comprehensive benefits	825,000
Basic	o Low-income, long-term unemployed adults with up to 133% FPL in unearned income and up to $3,000 in earned income o Standard benefit without long term care and non-emergency transportation	61,000
CommonHealth	o Higher income (over 133% FPL) disabled adults and children o Sliding scale premiums and cost sharing apply above 200% FPL o Comprehensive benefits (same as MassHealth Standard)	13,000
Family Assistance (includes Family Assistance Direct Coverage, Family Assistance Premium Assistance, and Insurance Partnership)	o Children with higher incomes (150%-200% FPL) o Persons with HIV up to 200% FPL o Either direct public coverage with Basic benefits and monthly co-pay or for those in qualified employer-sponsored coverage, assistance with premiums o Low-income workers up to 200% FPL o Assistance with premiums if at qualified small employer, mainly for childless adults o Small business (with low-income workers) o Assistance with premiums up to $1,000/year for family coverage ("Insurance Partnership")	34,000
Limited	o Immigrants who would otherwise qualify for MassHealth Standard, but for their particular immigration status o Benefits for medical emergencies (including labor and delivery)	28,000
Buy-In	o Medicare-eligible seniors or individuals with assets above MassHealth Standard benefits o Assistance with premiums, deductibles and co-pays	12,000
TOTAL		973,000

Source: Division of Medical Assistance

Figure 2: MassHealth Eligibility Overview

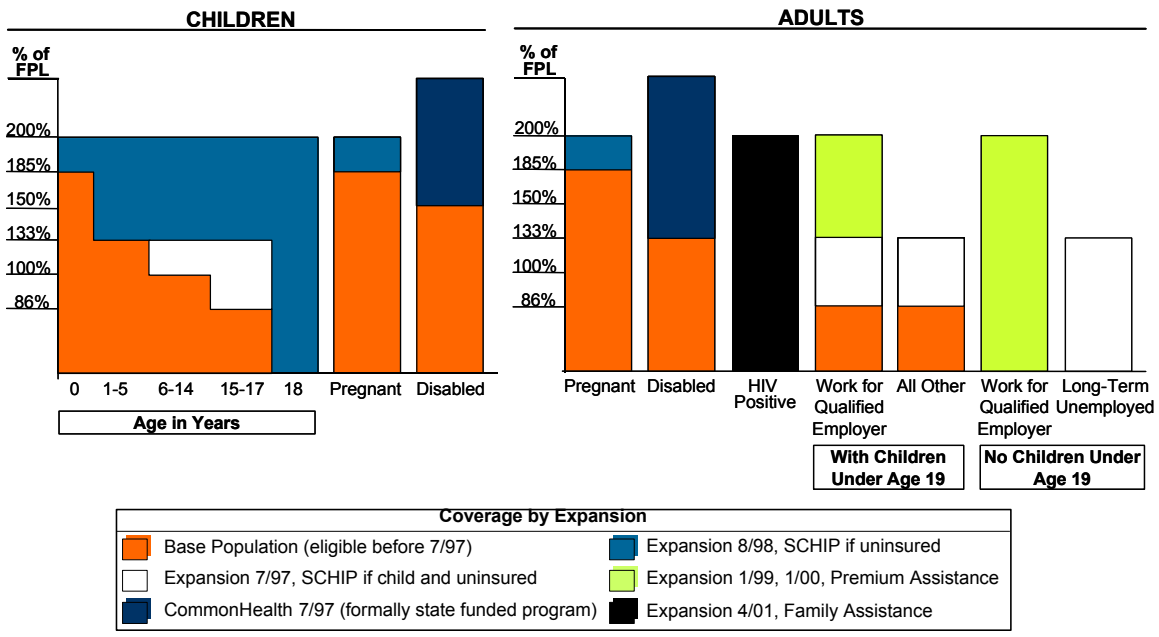
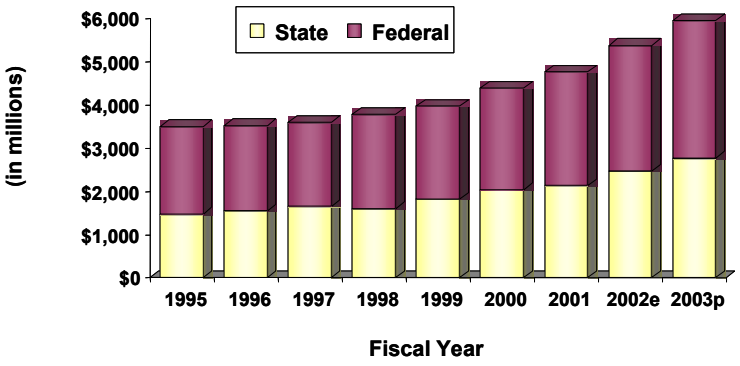


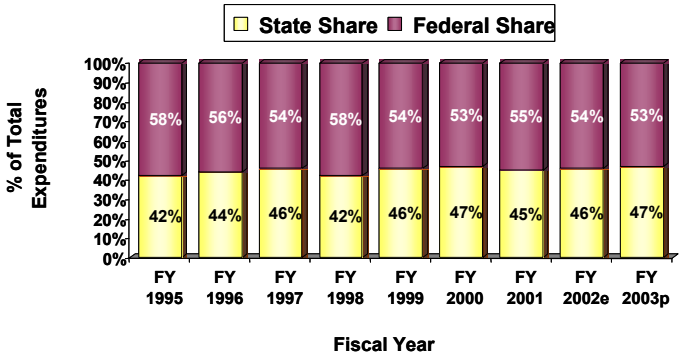
Figure 3:
MassHealth Spending: FY 1996-2003p*



**Excludes Disproportionate Share Hospital payments (DSH).*
Source: Mass. Taxpayers Foundation.

	1995	1996	1997	1998	1999	2000	2001	2002e	2003p
State	$1,476.7	$1,543.9	$1,657.5	$1,603.9	$1,819.9	$2,043.4	$2,140.4	$2,465.6	$2,769.9
Federal	$2,026.6	$1,980.6	$1,939.3	$2,172.8	$2,155.3	$2,347.0	$2,623.8	$2,910.2	$3,182.1
Total Medicaid	$3,503.3	$3,524.5	$3,596.8	$3,776.7	$3,975.2	$4,390.4	$4,764.2	$5,375.8	$5,952.0

Figure 4:
Percent of MassHealth Spending Paid by the State



Source: Division of Medical Assistance, enrollment as of 6/30/01 and FY 2001 estimated expenditures.

In July 1997, Massachusetts implemented a comprehensive health care reform initiative to expand access to coverage for uninsured and underinsured low-income families, children and individuals. The goals of health care reform were to increase health care coverage among the Commonwealth's most needy populations while dramatically reducing the number of uninsured residents, reducing the associated costs of providing care to the uninsured and maximizing federal reimbursement.

This health care reform initiative was authorized in 1995 through a federal Medicaid Research and Demonstration Waiver granted in accordance with Section 1115 of the Social Security Act. State legislation, Chapter 203 of the Acts of 1996, was then passed to authorize implementation. The federal State Children's Health Insurance Program (SCHIP) resulted in expanded coverage for children throughout the Commonwealth, beginning in 1998. In addition to expanding eligibility for direct MassHealth coverage, the Health Care Reform initiative included an insurance subsidy program to promote the purchase of private health insurance by low-income working adults and their employers (the Insurance Partnership and Family Assistance Program).

How is Care Delivered To MassHealth Members?

The MassHealth program pays hospitals, nursing homes, community health centers, physicians, other community and home-based providers and managed care organizations to provide services to MassHealth members.

Once an individual or family is determined to be eligible for MassHealth and is provided with one of the benefit coverage types, they must enroll in either the Primary Care Clinician Plan (PCCP) or a Managed Care Organization (MCO). Individuals who are over 65, have other insurance or are living in a health care institution can receive their care outside of either of these programs on a fee-for-service basis.

Primary Care Clinician Plan

The Primary Care Clinician Plan is administered directly by the Division of Medical Assistance. Members in the PCC plan chooses a primary care clinician who provides most of their medical care and refers them to other physicians as needed for specialty care. There are 1,200 medical practices throughout the Commonwealth participating in the PCC plan, serving approximately 449,000 members. Providers participating in the PCC plan are paid on a fee-for-service basis. MassHealth members in the PCC plan receive behavioral health (mental health and substance abuse) services through a private behavioral health managed care organization, the Massachusetts Behavioral Health Partnership (MBHP). The PCC plan also contracts for network management services to maintain a clinical management system to monitor the delivery of care by participating primary care clinicians.

Managed Care Organizations

Currently DMA contracts with four MCOs to provide care to approximately 223,000 MassHealth members (see Table 2). The portion of total MassHealth members enrolled in MCOs stayed fairly constant at approximately 17% between FY97 and FY01. After members choose (or in some cases are assigned to) an MCO, they select a primary care clinician from among the MCO's provider network. They receive care from MCO contracted providers. DMA pays the MCOs a monthly capitation payment to cover almost all of the services included in the members' benefit coverage plan. Any services in the plan not covered by the MCO are paid for on a fee-for-service basis by DMA. The DMA contract with each of the MCOs contains significant quality performance measures, which are monitored by DMA throughout the term of the contract.

Table 2: MassHealth MCO Enrollment by Health Plan

Health Plan	Current Enrollees
Neighborhood Health Plan	108,000
Boston Medical Center Health Net	69,000
Network Health	36,000
Fallon Community Health Plan	10,000
Total	223,000

What Does MassHealth Cost? Who Pays?

MassHealth spending was $4.8 billion in FY 2001, and is expected to be $5.4 billion for FY 2002 (see Figure 3). From FY1998 to FY2001, the average annual rate of increase in MassHealth spending has been approximately 9%.

Less than half of the cost of MassHealth is paid by the state; the remainder is financed by federal matching payments and inter-governmental transfers (see Figure

4). The state's share of the total cost of MassHealth has been relatively constant over the past five years, at about 45-46%, despite significant expansions in enrollment, an indication of the success of the state's efforts to maximize federal sources of revenue for MassHealth. The fact that the federal government pays more than half of MassHealth spending also means that it takes more than $2 of reductions in total MassHealth spending to reduce state spending on MassHealth by $1.

How Much of the State Budget Goes to MassHealth?

MassHealth accounts for a growing share of the state's budget, both in terms of the state's share of spending and total amount spent on MassHealth with both state and federal funds (see Figure 5). In fiscal year 2001, the program accounted for one-quarter of General Fund spending, with the state share of MassHealth representing 9.7% of the state budget. MassHealth is the largest program in the state budget, when total spending is considered, but much smaller than state aid for local education when only the state's share of MassHealth is considered (see Figure 6). In FY2002, state aid for local education will be $4.092 billion, compared to state spending for MassHealth of $2.466 billion. Over the last three years, spending for MassHealth, both in total and the state's share, has grown at an average annual rate of 10.6%—a faster rate of increase than the other largest categories of spending in the state budget.

How Much Is Spent on Which Groups of MassHealth Members?

Although MassHealth is often thought of as a health program primarily for low-income children and women, most of the program's budget is spent on services for elderly and disabled individuals (see Figure 7). While the elderly and disabled comprise only 32% of total MassHealth members, the majority of MassHealth expenditures (71%) is spent on these members. According to recent figures, in fiscal year 2001 MassHealth spent an average of $2,022 for each family member, and $3,460 for each long-term unemployed adult (MassHealth Basic), compared to $8,723 for each non-elderly disabled adult and $17,515 for each elderly enrollee (see Figure 8).

How Much of Current MassHealth Spending Is the Result of Expansions in Eligibility?

Although the expansion populations represent about 30% of total MassHealth enrollment, they are a much smaller proportion of program spending. Approximately 11% of total MassHealth expenditures in FY01 were for categories of individuals who were newly eligible as a result of the expansions (see Figure 9).

How Much of The Increase In MassHealth Expenditures Is Due to Recent Expansions in Eligibility?

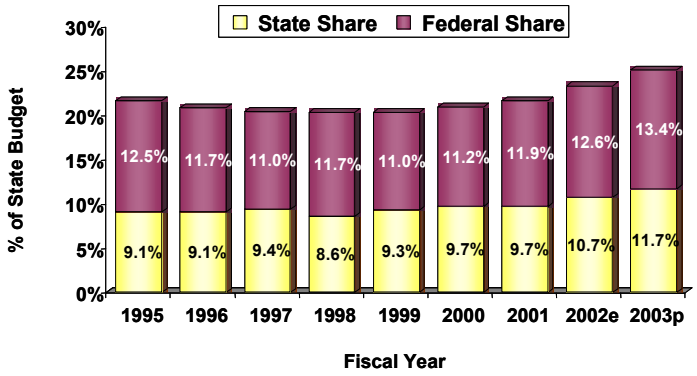
From FY97 to FY02, MassHealth expenditures grew by $1.8 billion. The expansions in eligibility associated with Health Care Reform account for approximately 35% of this total increase. The non-expansion populations account for approximately 65% of the increase (see Figure 8). Over this time period, the average annual rate of increase for the non-expansion populations was 5.9%, compared to an average annual increase of 8.5% for the overall program. In other words, even with no expansions in eligibility, MassHealth spending would have grown at an annual rate of nearly 6% per year.

How Was The MassHealth Expansion To Be Funded? How Has It Been Funded?

Expansions in MassHealth eligibility have been funded almost entirely by new revenues and not the General Fund. These new sources of revenue are: enhanced federal revenues, a dedicated portion of the state's cigarette tax revenues (funded by a 25 cent tobacco tax increase), and transfers from the state's Uncompensated Care Pool.

The expansion legislation created the Children's and Seniors' Health Care Assistance Fund, which is the mechanism through which all revenues and expenditures for the expansion populations flow. A small segment of existing welfare recipients (those receiving Emergency Aid to the Elderly, Disabled and Children's Health), were classified as an "expansion" population under the reforms, and their health care costs are paid through the Fund.

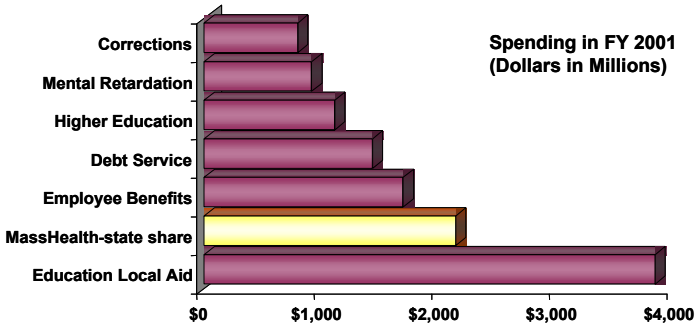
Figure 5:
MassHealth Is A Growing Share of the State's Budget



Source: MTF, 2002e based on governor's supplemental requests to date; 2003p Medicaid based on House 1, total budget based on MTF projection of 3% growth over 2001.

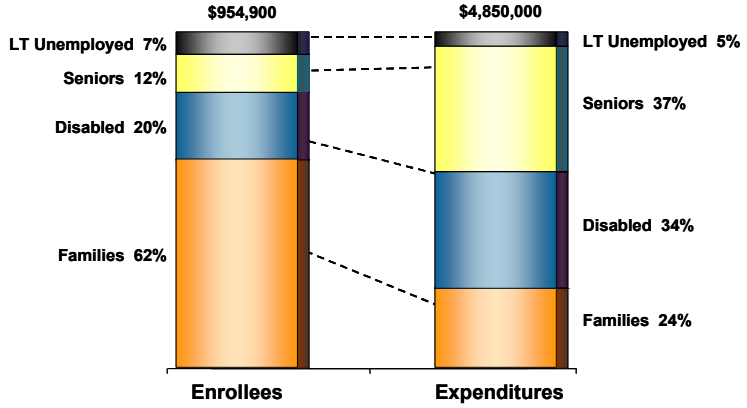
	1995	1996	1997	1998	1999	2000	2001	2002e	2003p
State Share	9.1%	9.1%	9.4%	8.6%	9.3%	9.7%	9.7%	10.7%	11.7%
Federal Share	12.5%	11.7%	11.0%	11.7%	11.0%	11.2%	11.9%	12.6%	13.4%
Total MassHealth	21.6%	20.9%	20.4%	20.3%	20.3%	20.9%	21.6%	23.3%	25.1%

Figure 6:
State's Share of MassHealth Spending Compared to Other Priorities



Source: Mass. Taxpayers Foundation.

Figure 7: Disproportionate Spending for Elderly or Disabled Members



Source: Division of Medical Assistance, enrollment as of 6/30/01 and FY 2001 estimated expenditures.

Table 3 shows the actual expenditures and revenues for the Children's and Seniors' Health Care Assistance Fund for FY98-02. As expected, in the early years of the expansions revenues exceeded expenditures, and the Fund had a significant positive balance. But beginning in FY01, expenditures exceeded revenues and the Fund has had a negative balance. The Fund shortfall, in aggregate, is entirely due to the fact that smaller amounts having been transferred to the Fund from the Uncompensated Care Pool (UCP) than planned in the original budget projections. Had the Legislature approved the originally budgeted transfers from the UCP, the Fund would not have a deficit (although it would not have much of a surplus either). This means that the MassHealth expansions would have been fully funded by designated revenue sources other than the General Fund had the UCP transfers been made as originally planned.

Table 3:
Children's and Seniors' Health Care Assistance Fund: FY98-02 *($millions)*

	FY98	FY99	FY00	FY01	FY02
Expenditures					
MassHealth Expansion Programs	$166	$322	$436	$537	$629
Pharmacy program	12	14	15	38	4
Total expenditures	$178	$336	$450	$576	$632
Sources of Funds					
Tobacco Tax Revenue	$101	$95	$93	$92	$90
General Fund transfers (EAEDC)	37	37	37	37	37
Federal Revenues – TitleXIX	82	170	190	265	310
Federal Revenues – TitleXXI			56	48	47
Premiums (CMSP, Family Asst)		1	2	3	3
Other revenues	4	4	1	2	0
UCP Transfer	0	0	47	44	45
Total Sources of Funds	$223	$308	$426	$489	$531
Annual operating surplus/deficit	45	-28	-25	-86	-101
Beginning balance	73				
Ending Fund Balance	$118	$90	$65	$(21)	$(122)
Shortfall of UCP transfers			30	44	54
Balance had UCP transfers occurred as projected in waiver			**$95**	**$53**	**$6**

Source: Mass. Taxpayers Foundation; Health Care for All.

What Effect Have The Expansions Had On the Uncompensated Care Pool?

The costs of the Uncompensated Care Pool had been rising steadily before the MassHealth expansions and were projected to continue to increase. Instead, the costs of uncompensated care fell in 1999 and 2000. Costs rose in 2001 and are projected to be higher in 2002, as a result of both rising medical costs and, most likely, an increasing number of people without insurance (see Figure 10).

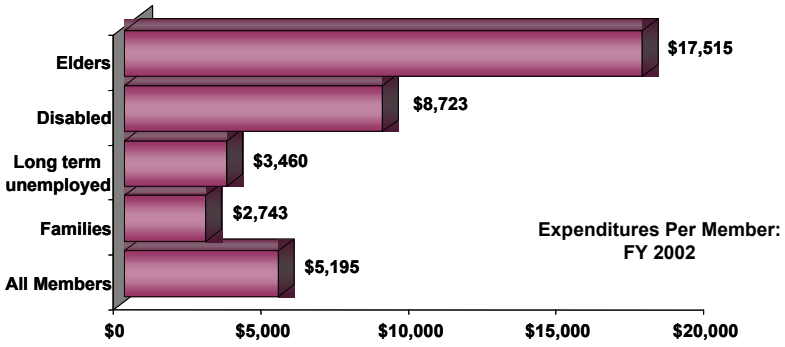
How Much of MassHealth Spending Goes to Program Administration?

MassHealth spends very little on administration compared to commercial health insurers. In fiscal year 2001, total administrative costs for the MassHealth program were $156.6 million, approximately 3.2% of total expenditures. As shown in Figure 11, this percent is far lower—only one-fifth to one-third—than the percent of revenues that is spent on administrative expenses by the three largest health plans in Massachusetts, which ranged from 9-12% in calendar year 2001. [MassHealth may not incur certain administrative expenses that occur in private health plans (e.g., underwriting costs)].

How does MassHealth Pay for Services?

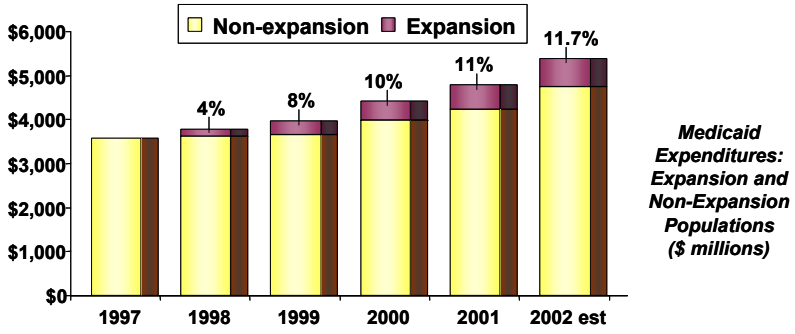
The vast majority of MassHealth expenditures are either direct payments to providers for health care services provided to the programs enrollees or capitation payments to managed care plans. In FY01, MassHealth spending was $4.85 billion. Of this amount, $4.09 billion, or 84%, was direct payments to fee-for-service providers; $760 million, or approximately 16%, was capitation payments to managed care organizations.

Figure 8:
Services to Elderly and Disabled Members Are More Expensive



Source: Division of Medical Assistance.

Figure 9:
Expansion Accounts for 11% of Total MassHealth Costs In FY01 and 33% of Increases from FY97-02

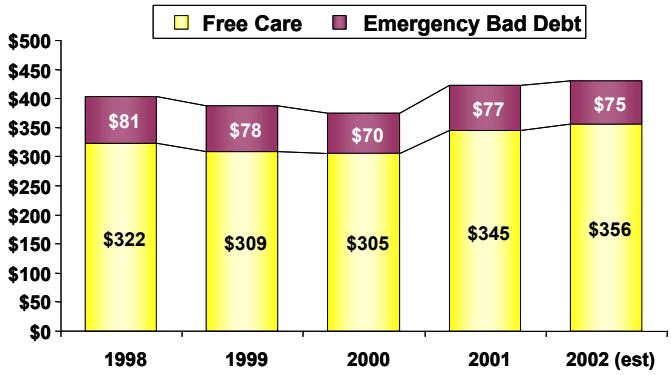


Medicaid Expenditures: Expansion and Non-Expansion Populations ($ millions)

	1997	1998	1999	2000	2001	2002est
Expansion		$166	$322	$436	$547	$629
Non-expansion	$3,570	$3,608	$3,652	$3,982	$4,236	$4,747

Source: Massachusetts Taxpayers Foundation. 2002.

Figure 10: Reduction of Uncompensated Care Costs During Initial Period of MassHealth Expansion ($ millions)



Source: Division of Health Care Finance and Policy.

What Services Are Used by MassHealth Members?

Note: This section of the analysis is based on fee-for-service/direct payments only and does not include services provided under DMA's capitated contracts with MCOs and for behavioral health service. Capitation payments are per member per month amounts that cover a broad range of services. It is not possible, from readily available public data, to determine the specific services provided to members under these arrangements. Therefore, the capitation payments have been excluded from this section of the analysis.

MassHealth expenditures are heavily concentrated in three categories: long-term care facilities (nursing homes, rest homes and chronic and rehabilitation hospitals), pharmacy, and acute care hospitals (acute and psychiatric hospital inpatient and outpatient). These three categories account for 72.3% of payments. By far the largest service category is institutional long-term care. Representing 37.5% of payments, it is twice as large as the next largest category. The distribution of direct payments by provider type is shown in Figure 12.

In all, approximately 50% of direct payments are for inpatient care and 50% are for services provided in the home or on an outpatient basis. Of the payment for inpatient care, 78.5% is for nursing home, rest home or chronic/rehabilitation hospital services, 21% is for acute inpatient care, and 0.5% is for psychiatric facilities. Of the 50% spent on outpatient services, 39% is for pharmacy, 25% is for community based care (including community health centers, community based mental health service and community based long-term care), 14% is for professional services (doctors, dentists, psychologists), 14% is outpatient services in acute or rehabilitation hospitals, and 7% is for ancillary/support services.

How Does Service Use Vary by MassHealth Member Group?

The mix of services used varies widely across MassHealth member groups. The distribution of services used varies widely by member category, as shown in Table 4.

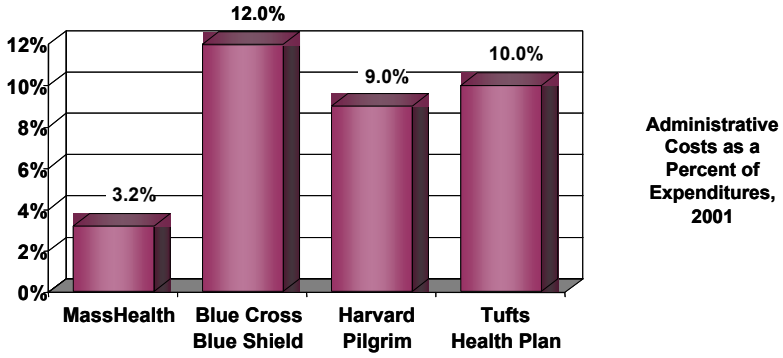
Excluding behavioral health, services used by non-disabled children and adults are heavily weighted toward acute hospital services (including maternity care), which are primarily used on an inpatient basis (61% versus 38% outpatient). For the disabled, pharmacy and community based services are the most heavily used services. For seniors, who generally also have Medicare coverage, MassHealth covers primarily institutional long term care and pharmacy services. Long term unemployed adults primarily use acute hospital services (41% on an inpatient basis and 59% outpatient) and pharmacy services.

Use of managed care plans also varies by category of enrollee. Managed care plan capitation (medical and behavioral) represents 35% of total payments for non disabled children and parents 14% for disabled children and adults, 0% for seniors, and 49% for long term unemployed adults. These managed care participation rates reflect in part the fact that seniors are not eligible for enrollment in MassHealth MCOs, while members of families and long-term unemployed adults can be assigned to an MCO.

Table 4:
Distribution of Direct Payments within Major Categories of Enrollees, 2001
(excluding capitation payments to MCO and MBHP)

	Non-Disabled Children and Adults	Disabled Children and Adults	Seniors	Long-Term Unemployed Adults	Total
Long Term Care Facilities	3%	14%	75%	0%	38%
Acute Care Hospitals	53%	17%	1%	44%	17%
Pharmacy	14%	31%	11%	26%	19%
Community Based Care	4%	20%	5%	7%	10%
Professional Services	24%	6%	1%	19%	8%
Medicare Crossover Payments	0%	7%	6%	0%	5%
Ancillary/Support Services	2%	5%	1%	4%	3%
Total	100%	100%	100%	100%	100%

Figure 11: Lower Administrative Costs for MassHealth Than For Commercial Health Plans*



Source: DMA and health plan 2001 financial reports. MassHealth includes administrative costs included in contracts with managed care plans and contract with UMass Medical School.

Figure 12:
Distribution of MassHealth Fee for Service Payments, FY 01

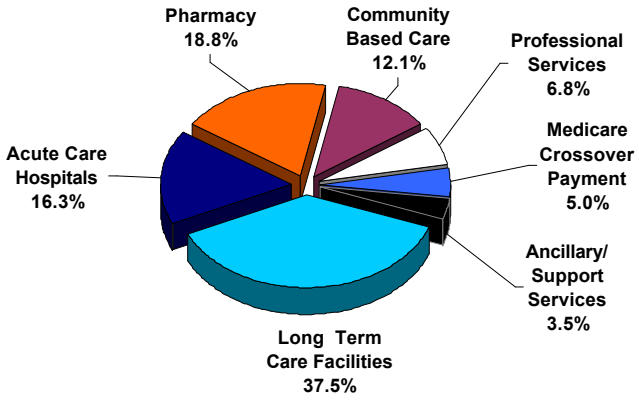
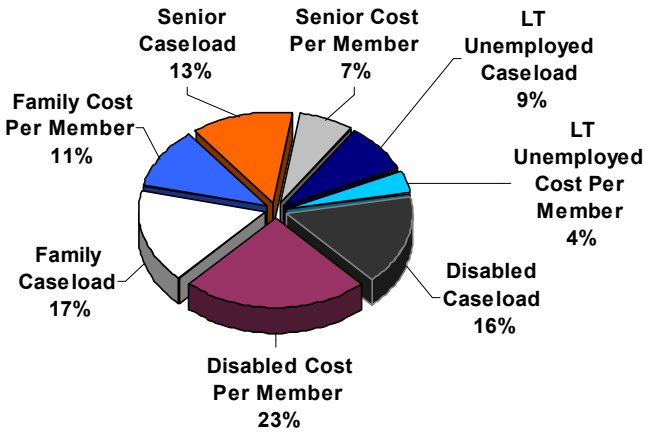


Figure 13: % Increase in Expenditures Due to Membership (55%) versus Cost per Member (45%), FY98-01



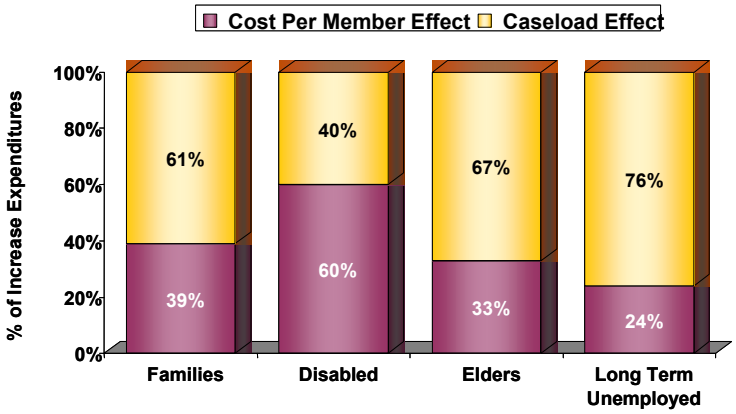
Section 2: Recent Trends in MassHealth

More Members or Rising Medical Costs: What's Fueling Expenditure Trends?

Both increasing membership and rising cost per member are causing MassHealth expenditures to increase. From FY98 to 01, growing membership accounted for slightly over half of the increase in total expenditures, while rising cost per member accounted for 45% of the change in spending (see Figure 13).

The relative importance of changes in membership and rising cost varies by type of member. For families, elders and the long-term unemployed, membership accounted for at least 60% of the change in total expenditures from FY98 to 01. In contrast, cost per member was a more significant factor for the disabled, accounting for 60% of the total increase in expenditures for MassHealth members with disabilities (see Figure 14).

Figure 14:
Effect of Caseload and Cost Per Member On Expenditures by Type of Member:FY 1998-2001



Why Has MassHealth Enrollment Been Increasing?

Enrollment levels in the MassHealth program have grown dramatically since July of 1997 when Massachusetts implemented a comprehensive health care reform initiative to expand access to coverage for uninsured and underinsured low-income families, children and individuals.

The health care reform initiative has been successful in reaching its original goals. MassHealth enrollment has expanded by over 300,000 people since 1997 (see Figure 15). The number of uninsured residents in Massachusetts has declined substantially—from over 700,000 in 1996 to 365,000 in 2000, according to estimates from the Division of Health Care Finance and Policy.

Virtually all of the enrollment growth in the Mass-Health program since FY97 has been due to health care reform. The overall level of enrollment growth associated with Health Care Reform has been slightly lower than projected. Within individual programs, however, growth has been much higher than project-ed among adults with disabilities and the long-term unemployed adult population (MassHealth Basic) and much lower than projected in the insurance subsidy program.

How Fast is MassHealth Spending Increasing?

Total MassHealth payments for health services increased at an average annual rate of approximately 9% from FY98 to FY01. The increase is primarily due to changes in caseload and to changes in the mix of enrollees across eligible groups, but also reflects changes in the underlying utilization and cost of services. The annual rate of increase on a per member per month basis was much lower, averaging approximately 2.0%.

Figure 15:
Growth of MassHealth Enrollment since FY97

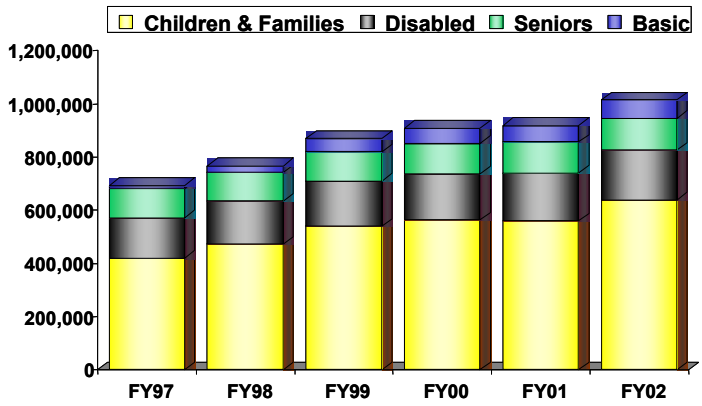
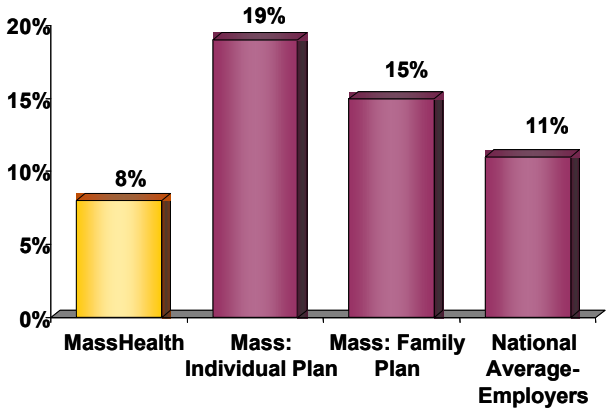
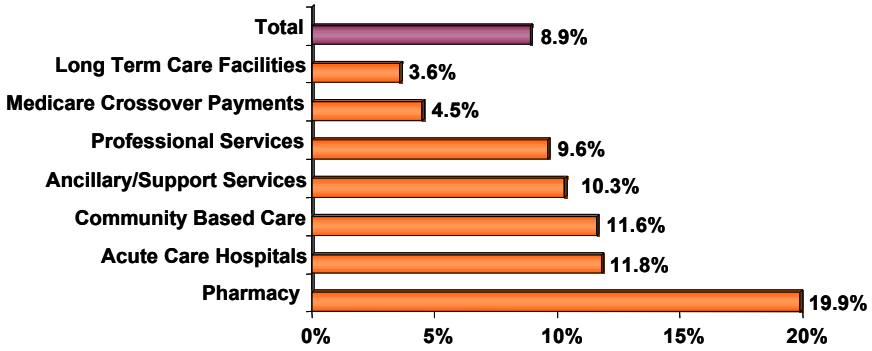


Figure 16:
Recent MassHealth Spending Growth is Lower than Trends for Private Health Insurance Premiums
MassHealth FY 2001 PMPM Growth Compared to Average Premium Growth



Source: DMA; Division of Health Care Finance and Policy, 2001 Employer Health Insurance Survey; Kaiser Family Foundation, Trends and Indicators in the Changing Health Insurance Marketplace, 2002.

Figure 17:
Pharmacy is Growing Twice as Fast as Any Other Service
Average Annual Percent Increases in Total Payments*, FY98 – FY01



**Total Payments reflect the effect of changes in membership, member mix, utilization and rates of payment.*

How Do Increases in MassHealth Spending Compare to Those of Private Payers?

MassHealth is not alone in its recent cost increases: all health care payers, including other Medicaid programs and employers, are experiencing significant rises in their health care spending. (See Figure 16 for a comparison of MassHealth spending trends with premium increases for other payers.) In fact, the most recent increases in per member spending for the MassHealth program are far below the double-digit premium increases for private health coverage in Massachusetts and nationally.

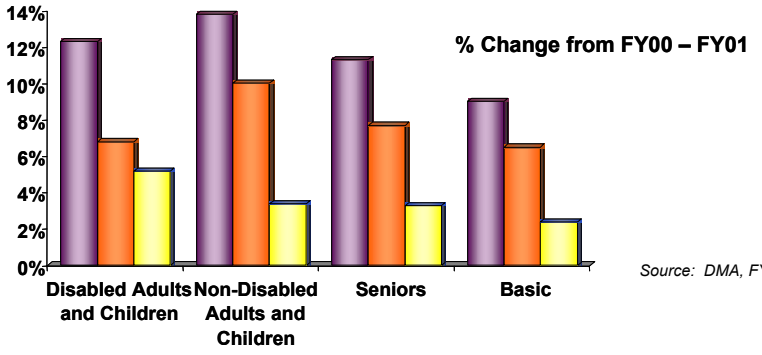
In What Areas Are Costs Increasing?

The average annual percent change in payments by provider type varies widely (see Figure 17). These data are influenced by many factors, including changes in caseload, mix of members across eligible groups, variation in benefits, changes in utilization, and changes in rates of payment. As noted earlier, over half the increase in payments is driven by increased membership. As a result, expenditures per member per month (PMPM) grew much less quickly than expenditures in total. For example, total expenditures for acute care hospitals grew at an annual average rate of 11.8% from FY98 to 01; on a PMPM basis, the rate of increase was much lower at 3.3%. In some areas, such as community-based services, growth is a deliberate DMA strategy, as a way to reduce costs by optimizing the use of less expensive services. But in other categories, such as pharmacy, underlying increases in utilization and costs have caused a substantial portion of the growth in spending. For pharmacy, the total average annual increase from FY98 to 01 was 19.9%; payment on a PMPM basis rose an average of 9.1% annually. The vast majority of the PMPM increase was due to increases in the cost per prescription, which is increasing two to three times as fast as increases in the number of prescriptions PMPM (see Figure 18).

From FY98 to FY01, MassHealth expenditures increased by a total of $1.1 billion. Of this, $839 million was in the form of incremental direct payments to providers; the balance was incremental capitation payments to managed care organizations. The majority of incremental direct payments went to two categories – pharmacy (34.3%) and acute hospitals (20.7%). Figure 18 shows the distribution of incremental direct payments over the major provider classes.

At the individual member level it is possible to identify the effects of per member per month increases in certain services on the overall change in PMPM payments. Figure 20 shows the percentage of PMPM increase for each enrollee category in FY01 that is accounted for by increases in acute hospital, pharmacy and community long term care services, the services with the highest average annual rate of growth in FY01. The three services taken together account for almost half of the increase in the PMPM for seniors and the disabled and for a lesser percentage for the family and long-term unemployed groups.

Figure 18:
Cost per Prescription is Driving Pharmacy Costs PMPM



Source: DMA, FY00 – FY01 Change, Data through 3/30/02.

	Disabled Adults and Children	Non-Disabled Adults and Children	Seniors	Basic
% Change in Total Pharmacy Cost PMPM	12.3%	13.8%	11.3%	9.0%
% Change in Cost/Script	6.8%	10.0%	7.7%	6.5%
% Change in Scripts/Member	5.2%	3.4%	3.3%	2.4%

Figure 19: Most Incremental Payments from FY98-01 Went to Pharmacy and Acute Hospitals

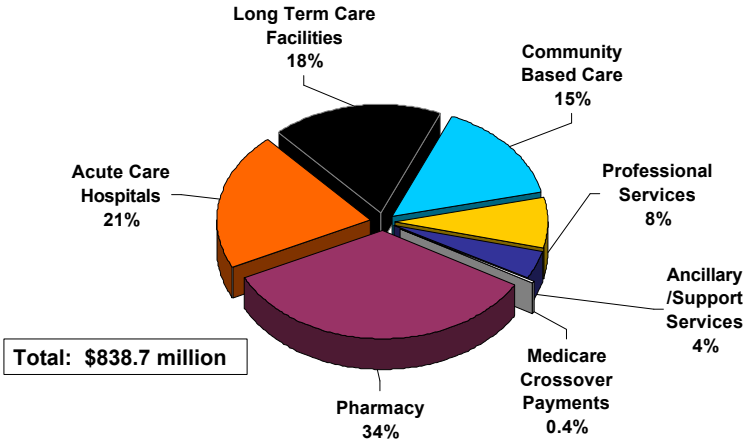
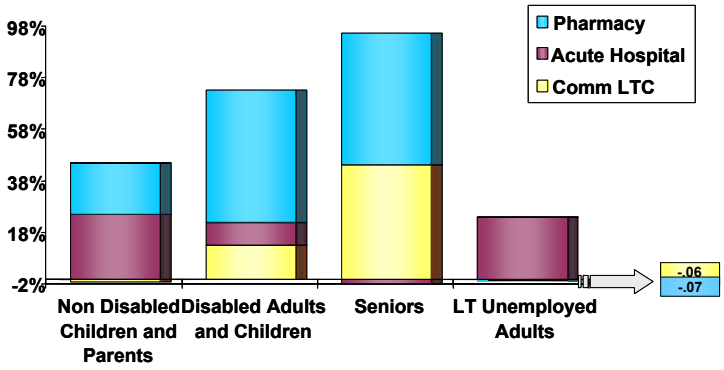


Figure 20:
Causes of PMPM Cost Increases Vary by Group
Percent Contribution of Three Services to PMPM Expense Increases by Enrollment Group, FY98 - FY01



	Non-Disabled Adults and Children	Disabled Adults and Children	Seniors	LT Unemployed
Pharmacy	20%	51%	51%	-0.7%
Acute Hospital	25%	9%	-2%	24%
Comm LTC	-1%	13%	44%	-0.6%

Section 3: How Does MassHealth Compare to Medicaid Programs in Other States?

MassHealth covers 14.5% of the state's population, a higher proportion than the 10.3% of the US population enrolled in Medicaid.[3] A significantly higher proportion of MassHealth members are seniors and persons with disabilities than in the Medicaid program overall (34% in Massachusetts compared to 27% in the U.S.).

Comparisons of MassHealth and Medicaid data from other states are not particularly illuminating because Medicaid is not one monolithic program nationwide, but fifty separate state programs. There are tremendous differences in Medicaid programs from state to state, in terms of eligibility, covered benefits, and other program requirements that have a major effect on caseload and expenditures. These differences make it very difficult to compare Medicaid programs in different states. Nevertheless, it is important to try to understand the MassHealth program in a broader context. So, we have attempted to compare MassHealth to a "peer group" of Medicaid programs in other high-income states. The states we have chosen, in consultation with staff at MassHealth, are the ones that qualify for the same 50% federal medical assistance percentage (FMAP) that Massachusetts receives. Since the FMAP varies inversely with state income, these peer states are comparable to Massachusetts in terms of income, and thus similar in terms of the state resources that might be available to support the Medicaid program. States, of course, make very different political and policy decisions about tax policy and state spending, and may be organized quite differently in terms of taxing authority and where financial responsibility for Medicaid lies.

The states that qualified for a 50% FMAP rate in FY 2002 are: California, Colorado, Connecticut, Delaware, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, and Washington.

Is the MassHealth Program More "Generous" In Terms of Its Eligibility Standards Than Other States?

As shown in Table 5, Massachusetts generally has income eligibility standards that are similar to and, in some cases, less generous than those in the peer states. For example, the income eligibility standards for pregnant women are more stringent in Massachusetts than in California, Colorado and New Hampshire. For families, Massachusetts has more stringent eligibility standards than Connecticut, Minnesota, New York and Washington. For example, a working family with two children can earn up to about $19,450 in Massachusetts and qualify for MassHealth, compared to an income limit of $22,000 in New York, $29,000 in New Jersey and Washington, and $40,200 in Minnesota (see Figure 21). Only in the case of children does Massachusetts have the most generous eligibility criteria among high-income states, providing some form of public coverage to children in families with incomes up to 400% of the federal poverty level (although the highest income children are eligible for the limited Children's Medical Security Plan rather than comprehensive MassHealth coverage).

Table 5: MassHealth Income Standards Are Generally Consistent With, And In Many Cases More Stringent, Than Those in Peer States

	MA	CA	CO	CT	DE	IL	MD	MN	NH	NJ	NY	WA
Eligibility as Percent of FPL Medicaid-Children												
Age 0 to 1	**200**	200	133	185	185	200	200	280	300	185	185	200
Age 1-5	**150**	133	133	185	133	133	200	275	185	133	133	200
Age 6-16	**150**	100	100	185	100	133	200	275	185	133	100	200
Age 17-19	**150**	100	43	185	100	133	200	275	185	133	100	200
CHIP	**150-400**	250	185	350	200	185	n.a.	n.a.	300	350	250	250
Pregnant Women	**200**	300	300	133	185	200	200	200	275	185	185	200
SSI	**74**	74	74	74	69	74	41	74	70	76	74	74
Families	**133%**	107%	42%	157%	107%	100%	100%	275%	100%	200%	150%	200%

Does MassHealth Provide More Benefits than Other States?

As discussed earlier, the Medicaid program has 30 optional benefits, which each state decides individually whether or not to offer, and which qualify for federal matching funds. Massachusetts covers 25 of these 30 benefits. As shown in Table 6, the number of optional benefits offered by the peer states ranges from 11 in Delaware to 28 in California. Five other states offer at least as many optional benefits as MassHealth (see also Appendix A).

Table 6: Number of Optional Medicaid Benefits In Each State (Maximum is 30)

STATE	MA	CA	CO	CT	DE	IL	MD	MN	NH	NJ	NY	WA
# of Optional Benefits	25	28	18	21	11	25	18	26	21	25	25	22

How Does MassHealth Spending Compare to Medicaid Expenditures in Other States?

It is difficult to compare Medicaid spending from state to state because of differences in eligibility, benefits, mix of members, and state policy regarding federal revenue maximization. There are also significant delays in the release of Medicaid spending data by many states. Despite these caveats, it remains important to look at comparative expenditures because there is frequently discussion about whether Medicaid spending in Massachusetts in higher than in other states.

The percent of total state expenditures devoted to the MassHealth is about average compared to other high-income states (see Figure 22). Medicaid spending as a percent of total state expenditures ranges from 10% in Delaware to 33% in New York. At about 21% of state expenditures, Massachusetts spending is lower than six of the eleven states, and higher than five. The state's share of MassHealth spending as a percent of total state expenditures, about 10%, is also average compared to other states—it is higher than five of the states and lower than the other six. (This figure varies widely, from 5% in Delaware to over 18% in Connecticut.)

How Does MassHealth Spending Per Member Compare to Per Member Expenditures in Other States?

As shown in Figure 23, MassHealth expenditures per member are higher than in all peer states except for Connecticut, New Hampshire and New York. Since eligibility levels and covered services vary across states, it is difficult to know how much of the spending differences are attributable to these factors. In addition, since Massachusetts has higher medical care costs than most other states (due in part to higher labor costs and a higher concentration of teaching hospitals), it perhaps is not surprising that the state's average Medicaid expenditure per member is higher.

Are There Factors Other Than The State's Generally Higher Medical Care Costs That Help Explain the Higher Spending Per Member In Massachusetts?

Several characteristics of the MassHealth population help to explain its relatively high average expenditures compared to peer states. Table 7 ranks

Table 7: A Larger Proportion of MassHealth Members are Elderly, Disabled and/or in Nursing Homes Than in Other States

Indicator		MA Rank
		of 13 states
Medicaid Spending Per Member		#4
Medicaid Spending Per State Population		#2
Percent of State Population on Medicaid		#3
Elderly and Disabled as % Medicaid Members		#1
Percent of state population 65+ On Medicaid		#3
LTC spending as % total Medicaid spending		#4
Percent of Medicaid Members 65+ in Nursing Homes		#6
State Health Spending/Capita		#1

Table 8: Comparison of States on Factors Associated with Higher Medicaid Expenditures

Indicator	MA	CA	CO	CT	DE	IL	MD	MN	NH	NJ	NY	WA
Medicaid Spending per Member	$5,352	$2,573	$4,183	$6,273	$3,939	$3,575	$4,194	$5,171	$6,505	$5,165	$7,180	$3,291
Medicaid Spending Per State Population	$742	$416	$344	$729	$542	$505	$490	$610	$486	$515	$1,318	$356
Percent of State Population on Medicaid	15%	21%	8%	12%	13%	11%	11%	11%	8%	10%	17%	24%
Elderly and Disabled as % Medicaid Members	34%	23%	30%	28%	21%	23%	28%	25%	24%	32%	29%	20%
Percent of State Population 65+ on Medicaid	15%	17%	11%	10%	7%	8%	6%	12%	9%	9%	17%	11%
Long term care spending as % Total Medicaid $	44%	28%	40%	52%	39%	35%	35%	58%	43%	39%	46%	36%
Percent of Medicaid Members in Nursing Homes	5.4%	1.7%	5.5%	7.4%	3.2%	5.4%	5.0%	7.0%	8.2%	6.0%	4.4%	1.7%
State Health Spending Per Capita	$4,920	$3,310	$3,470	$4,640	$3,980	$3,600	$3,900	$4,210	$3,810	$4,040	$4,660	$3,370

Massachusetts among the other high-income states on a number of factors that would be associated with relatively high Medicaid costs. On almost every measure, Massachusetts is one of the top ranked states. A higher proportion of MassHealth members are elderly or disabled (the two member groups with the highest average costs); a larger proportion of MassHealth are aged 65 or older; and a greater percentage of MassHealth members are in nursing homes. A more detailed comparison of high-income states on these measures is provided in Table 8.

Is MassHealth Spending Increasing More Rapidly Than Medicaid Spending In Other States?

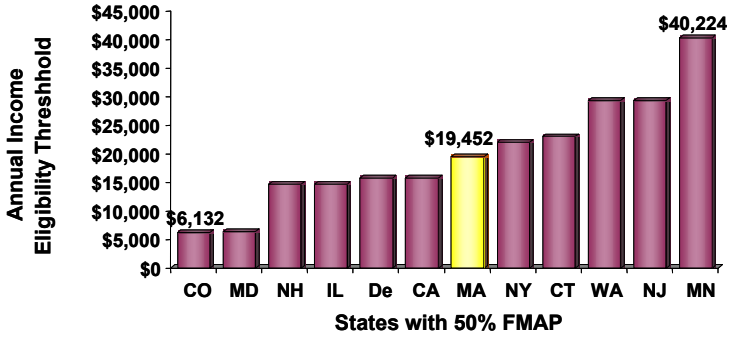
As shown in Table 9, although the Medicaid population grew faster in Massachusetts from FY98 to FY01 than the average in the U.S. as a whole, the rate of overall spending growth in Massachusetts was somewhat below average.

Table 9: Comparison with Selected Other States

State	Medicaid Expenditure Growth				Medicaid Population Growth		
	97-98	98-99	99-00	00-01	98-99	99-00	00-01
CT	-5.2%	-2.1%	6.8%	4.1%	2.0%	2.4%	3.0%
MA	2.7%	5.1%	7.7%	6.5%	12.8%	2.3%	4.2%
NJ	0.0%	5.6%	4.8%	6.7%	-2.7%	-2.0%	-0.1%
NY	5.7%	10.8%	7.4%	9.3%	-1.1%	-1.2%	-1.1%
PA	4.4%	12.2%	1.4%	8.5%	-2.6%	-0.7%	0.7%
IL	1.7%	-2.8%	15.7%	3.2%	-3.4%	5.5%	2.9%
MI	3.5%	9.6%	1.7%	4.3%	-3.2%	-2.2%	-2.4%
WI	2.3%	0.0%	8.7%	5.1%	-0.5%	21.0%	4.2%
MN	4.6%	2.3%	11.0%	9.4%	-4.7%	-0.5%	0.6%
TN	3.5%	10.7%	11.2%	8.7%	4.9%	3.0%	0.0%
CA	0.6%	11.1%	10.8%	16.0%	-0.1%	2.6%	1.9%
WA	3.2%	5.9%	8.2%	10.0%	-2.0%	4.5%	0.5%
MD	1.1%	6.4%	10.6%	5.0%	-1.0%	-1.0%	-1.2%
US Average	***2.2%***	***5.8%***	***8.2%***	***7.4%***	***-0.1%***	***2.6%***	***1.0%***

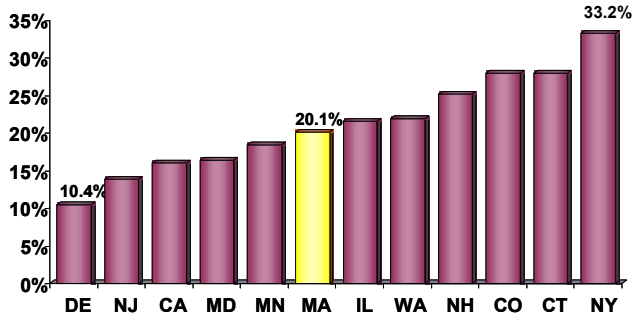
Source: National Association of State Budget Officers (NASBO)

Figure 21:
How Much Can A Working Parent with Two Children Earn and Still Be Eligible for Support?



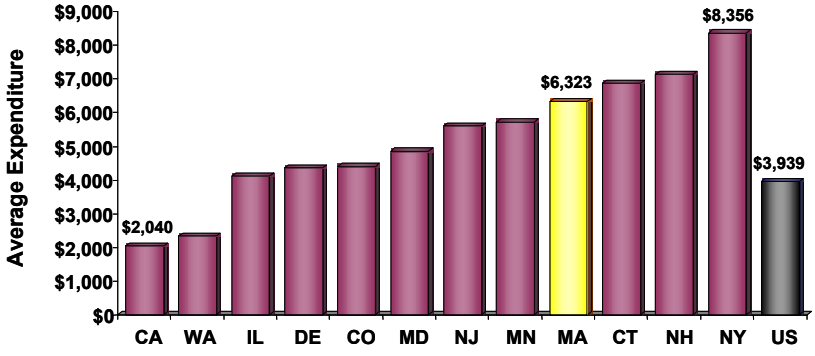
Source: Center on Budget and Policy Priorities, July 2001.

Figure 22:
Total Medicaid Expenditures as a Percent of Total State Expenditures, FY01



Source: National Association of State Budget Officers.

Figure 23:
Average Medicaid Expenditure Per Member, FY98



** CMS A Profile of Medicaid: 2000. Amounts exclude disproportionate share hospital payments (DSH).*

Section 4: Confronting the Policy Challenge: Rising Costs, Greater Needs and Declining State Revenues

It is important to state at the outset that there are no easy solutions to rising MassHealth spending and that there are many appropriate efforts already underway. Massachusetts is not alone in its current fiscal crisis or in the pressures experienced within its Medicaid program. With the exception of Delaware, all of the 50% federal Medicaid assistance percentage states (states of comparable wealth) projected FY2002 budget deficits of at least several hundred million dollars in January 2002. Delaware is now projecting a deficit, although at lower levels.[4]

Given the proportion of the state budget that Medicaid typically comprises, the program is often an early target for consideration of program reductions in difficult fiscal times. Unfortunately, there are no easy solutions to reducing spending levels. The new federal Health Insurance Flexibility and Accountability (HIFA) waiver process gives states much more latitude to make changes in their Medicaid programs, both in terms of expanding to new populations and constricting existing programs. As will be described below, most comparable states have proposed to implement controls on Medicaid costs through utilization and cost management initiatives rather than through the elimination or reduction of benefits or populations served.

The Policy Tools Available

As Massachusetts and other states across the country struggle with rising health care costs, greater needs and declining state revenues, a variety of Medicaid policy or programmatic changes are being considered. These options fall into the following general categories:

Reducing or eliminating benefits or eligibility groups

States that are planning to eliminate optional benefits include Virginia (interpreter services) and Washington (details not yet announced). Other states are proposing to restrict financial eligibility standards. Minnesota is considering the repeal of its Prescription Drug Program for seniors between 120% and 135% of the federal poverty level (FPL) and repealing a new eligibility category for uninsured women up to 250% of the FPL diagnosed with breast or cervical cancer.

Cutting optional services or services in general for optional eligibility groups is not an effective strategy for the MassHealth program. The optional benefits tend to be lower cost services and often provide a more cost-effective alternative to other covered benefits (for example, rehabilitative services, case management, preventive services and physical therapy). The optional eligibility groups served through MassHealth, primarily through the waiver expansion (e.g., adults and children at higher levels above the FPL and long term unemployed adults) are among the least expensive MassHealth populations. In addition, many of the costs associated with these populations would shift to the UCP. Finally, every dollar cut would only result in a fifty-cent state cost savings, due to the loss of federal financial participation (FFP).

Reducing rates of payment to providers

Many states are considering cutting provider payments as a tool for dealing with Medicaid spending shortfalls. These initiatives include reducing dispensing fees and other reimbursements to pharmacies (Colorado and Connecticut), rescinding planned rate increases for physicians, hospitals or nursing homes (Connecticut, New Hampshire, Minnesota and Washington), and reducing current rates of payment to physicians and facilities (California, Minnesota, New Hampshire, New York, Virginia and Washington).

A recent state-commissioned study concluded that MassHealth hospital payment rates are already low and contributing to significant financial problems within the Massachusetts health care industry.[5] A number of other provider groups have expressed concern about Medicaid payment rates. Many providers and others believe that further payment reductions could have an extremely negative impact, jeopardizing not only the financial stability of providers, but also their willingness to participate in the MassHealth program, which in turn could have harmful effects on health care access.

Implementing consumer cost sharing initiatives

The introduction of cost sharing mechanisms, primarily in the form of copayments, is under consideration in a number of states. These include California (copayment for physician visits), Connecticut (copayments for adults at certain income levels with children in the SCHIP program), Illinois (copayments for physician visits and drugs) and Washington (details not announced).

Research has shown that even modest increases in copayments have resulted in adverse outcomes and eventual higher state costs.[6] Furthermore, to the extent providers are expected to collect copayments, these initiatives tend to translate into provider payment decreases as providers absorb the cost of copayments for patients who are unable to pay. Finally, these initiatives also can have a negative impact on health care access by serving as a deterrent to individuals from seeking needed care.

Implementing more aggressive cost and utilization management initiatives

Given the risks associated with many of the other options, most states comparable to Massachusetts are considering more aggressive management initiatives to control costs and utilization. These include Colorado (seeking discounts on drug prices and considering implementation of a new utilization management program for home health care), Connecticut (discounts on drug prices), Illinois (cost reductions in managed care contracts and drug prices) and Minnesota (discounts on drug prices and developed of a preferred drug list). New Hampshire and Vermont are collaborating in joint drug purchasing pool; New Hampshire is also working with physicians on prescribing patterns. Virginia is seeking drug discounts and also working with physicians on prescribing patterns.

Cost management and utilization management techniques can be very effective means to reducing Medicaid spending. Discounts on pharmaceutical rates will address directly the skyrocketing pharmacy costs being experienced by MassHealth and other health care purchasers in Massachusetts and across the country. Utilization management programs also can have a direct impact on costs but must be carefully monitored to ensure that they are not resulting in barriers to appropriate care.

Implementing disease or care management programs

Disease management or care management programs are now being developed by a number of states. These programs are designed to improve health care outcomes and control Medicaid spending through prevention and regular monitoring of patients with chronic conditions. There are programs in place or under development for Medicaid members in Florida, Mississippi and Virginia (for asthma, diabetes and a variety of other chronic illnesses), Texas (diabetes), Utah (hemophilia), and West Virginia (diabetes).

These programs have the potential to be very effective tools for controlling Medicaid spending in that they are focused on high cost, long-term conditions and can significantly improve health care quality and health outcomes. However, cost savings will not often be immediate so expectations need to be set over reasonable time frames.

Implementing revenue maximization initiatives

All states pursue revenue maximization initiatives as a major tool to reduce net state Medicaid costs. These efforts include more aggressive identification of services provided by other state agencies and municipalities for Medicaid eligible individuals so as to obtain federal reimbursement for those expenditures. Illinois received federal approval to include the costs of low-income participants in prescription drug programs for seniors. Many states are also advocating to the federal government for increased federal reimbursement levels as countercyclical support for declining state revenues during recessionary periods.

The Division of Medical Assistance has been working aggressively over the past several years to limit the growth of MassHealth spending and maximize federal revenues. A summary of DMA's most recent efforts is included in Appendix B.

Section 5: What More Can Be Done?

Why Broad Program Cuts Are Not The Answer

There are compelling reasons not to implement broad cuts in MassHealth programs. These factors instead argue for the development of more targeted, carefully designed spending controls and revenue maximize-tion initiatives as the most effective way to manage MassHealth spending.

The MassHealth program provides health care coverage to the poorest and most vulnerable residents of the Commonwealth. Eliminating or reducing the health care services provided to them through MassHealth will in no way eliminate or reduce their health care needs or address their in-ability to pay the high cost of medical care. Instead, necessary care may well be avoided until absolutely necessary, resulting in poorer health outcomes, and end up being provided in emergency rooms and other higher cost settings as a direct result of the lack of access to preventive and primary care services in more appropriate, lower cost settings.

Every state dollar spent on the MassHealth program generates fifty (and in some cases up to ninety) cents in federal revenue for the state budget. Therefore, in order to achieve a certain state spending reduction level, program cuts of at least twice that amount must be implemented. In other words, the state will save only one tenth to one half of the program dollars actually cut.

Furthermore, the costs for many of these services will be shifted to the state Uncompensated Care Pool, increasing pressure on an already strained financing system. To the extent these expenses exceed the fixed amount of state and federal funds available for the Pool, the costs to providers of delivering these services will remain unreimbursed. Alternatively, some of these benefits lost to MassHealth recipients may be replaced by services from other state agencies or municipalities at 100% state or local cost, with no federal reimbursement.

Finally, during periods of economic downturn, it becomes even more important to maintain Medicaid programs. Medicaid is often a critical source of health care coverage for unemployed individuals and their families.[7] In addition, cutting provider payment rates will only further destabilize the health care industry, which historically has been one of the most vibrant sectors of the Massachusetts economy and one that has generated significant job creation.

The restriction of dental benefits for MassHealth adults reflects the strategy of broad program cuts. More recently, the House budget for FY2003 significantly restricts eligibility for the MassHealth Basic program. For all the reasons described above, these strategies are very high risk from both a financial and health outcomes perspective. The continued decline in oral health resulting from the withdrawal of dental coverage is likely to result in the need for much more significant and high cost medical intervention. Many of the former MassHealth Basic individuals who no longer would be covered under the House proposal will turn to hospital emergency rooms as their only source for acute care. This substitution of hospital based emergency care for community based primary care will not only increase overall health care costs, but also place an increasing demand on the already strained Uncompensated Care Pool (UCP). To the extent that they continue to seek any preventive or primary care, the costs for those services will either also be charged to the UCP, or have to be absorbed by providers who are not eligible to bill for free care.

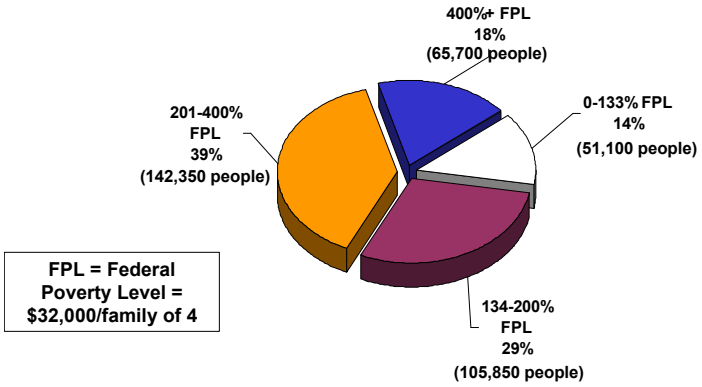
Amid discussions of potential spending cuts, it is also important to note that, although much progress has been made, there are still many uninsured people in Massachusetts. Approximately 43% of the uninsured in Massachusetts are in families with incomes below 200% of the federal poverty level (FPL) (see Figure 24). The Massachusetts residents most likely to be uninsured are those with family incomes just over the level that would qualify them for MassHealth (151-200% FPL).[8] There are also many individuals throughout the Commonwealth who are eligible for current MassHealth programs but not yet enrolled, despite expanded outreach and enrollment efforts.

Major Spending Areas and Cost Control Opportunities

While all efforts to control costs and maximize revenue should be encouraged, there are three specific areas that contribute most to MassHealth spending levels and growth. Interventions in these three areas, therefore, will have the most significant impact on MassHealth spending levels. In addition, there appear to be significant additional opportunities to maximize federal reimbursement, thereby decreasing the net state cost of the MassHealth program, all of which merit serious consideration.

Figure 24:

Almost Half of Uninsured Adults In Massachusetts Are Low Income



Source: Division of Health Care Finance and Policy.

Institutional Long Term Care

As previously described, expenditures for long-term care (nursing homes, rest homes and chronic and rehabilitation hospitals), comprise 38% of the Medicaid fee-for-service budget. Medicaid payments represent 70% of nursing home revenues, leaving these facilities very little opportunity to offset losses with higher paying private patients. Given the financial challenges currently facing nursing homes and other long term care facilities, and the growing need for these services as the "baby boom" generation ages, payment rate reductions are not an effective long term strategy for controlling costs. Instead, efforts should continue to develop innovative high quality and lower cost systems of care in the community for seniors and individuals with disabilities. The Program for All-Inclusive Care for the Elderly (PACE program), which has been in place since 1990 and is designed to meet the needs of frail elders living in the community, is an example of such a system of care. In addition, the Division of Medical Assistance should continue to review and revise its eligibility rules to ensure that it is focusing its resources on the low-income population of the Commonwealth.

Implementation of the Senior Care Options Initiative (SCO) – Enactment of SB527, An Act Relative to the Senior Care Options Demonstration Project, would enable DMA to create a comprehensive network of health and social service providers in the community for seniors. These networks would use blended Medicaid and Medicare dollars to provide an accessible system of care in the community, providing the resources and care management to allow many seniors to avoid the need for higher cost institutional care. Similar care systems could be developed for persons with disabilities, combining cohesive networks of providers with individual care management services to provide high quality, comprehensive community based care. Integrated systems of care have proven to have a significant impact in reducing costs and improving quality for persons with certain chronic illnesses, such as HIV/AIDS and physical disabilities.

Reform of the financing and delivery of long term-care – Given the significant portion of total MassHealth spending supporting long-term care services, it is critical that a comprehensive strategic approach be undertaken to reform their financing and delivery. While the goal of establishing a high quality community-based continuum of care as well as quality facility-based care for those who need it is held by many, the process for developing and financing such a system is less clear. Efforts to undertake a thorough, long-range view of this component of the Massachusetts health care system should be encouraged.

Pharmacy

Pharmacy costs account for almost 19% of MassHealth fee-for-service payments and grew from $300 million in FY95 to $769 million in FY01. During the next two years, pharmacy expenditures are expected to grow about 15% per year.[9] This trend is not unique to the MassHealth program, and is being experienced by public and private health

purchases throughout the nation. Research indicates that costs are rising at this rate due to an increase in the price of existing drugs, an increase in the number of drugs prescribed per person and an increased use of new, more expensive drugs as they come onto the market.[10]

The Division of Medical Assistance must be supported in its efforts to manage pharmacy cost and utilization effectively while maintaining access and quality. Appropriate pharmacy utilization can result in improved health outcomes and reduced hospitalization costs and should not be restricted. At the same time, appropriate cost containment initiatives that are underway, such as prior approval processes for brand name drugs when equivalent generics are available, pricing methodology changes, prescription refill controls, and return and re-use of medications in nursing homes should be encouraged and carefully monitored to understand their impact. Further steps to reduce price and to manage utilization are necessary to address skyrocketing pharmacy costs.

- **Development of Preferred Drug Lists** – DMA is in the process of developing a MassHealth Drug List, which will identify certain drugs within a therapeutic class (e.g., ulcer medication) that will be preferred on the basis of clinical efficacy, safety and cost effectiveness. Other drugs within that same class will then require prior authorization. Other components of the DMA pharmacy program changes will be the implementation of "step therapy", whereby use of established medications will be required before authorization is granted for newer drugs in the same therapeutic class. In addition, DMA will expand efforts to eliminate therapeutic duplication (patients receiving multiple drugs from the same therapeutic class for the same condition).
  All of these efforts must be carefully guided and monitored by clinicians from within and external to DMA to ensure that there is no negative impact on health outcomes or access to care.
- **Pharmaceutical Price Reductions** – DMA and the Executive Office of Health and Human Services (EOHHS) should investigate the feasibility and potential savings associated with bulk purchasing by the many state agencies currently purchasing pharmaceuticals. DMA should also continue its efforts to ensure that it is not paying inappropriately high rates to pharmaceutical companies by reviewing existing pricing methodologies. Finally, expansion of the federal 340B pharmacy program, which enables certain community health centers and disproportionate share hospitals to qualify for discount drug purchasing should be supported.
- **Federal Reimbursement for Prescription Advantage** – A waiver would allow DMA to obtain federal reimbursement for the costs of the Prescription Advantage program available to seniors and persons with disabilities under 200% FPL, thereby directly reducing these net state pharmacy costs by 50%.

Acute Care Hospitals

Spending on acute care hospital services (acute and psychiatric hospital inpatient, outpatient and emergency services) accounted for 16% of Mass-Health fee-for-service spending in FY01 (inpatient was 10% and outpatient was 6%). Increasing hospital costs were a major source of expenditure growth for certain groups of MassHealth members (i.e., non-disabled families and children and the long-term unemployed). Residents of Massachusetts use hospital outpatient departments and teaching hospitals at a much higher rate than in other parts of the country. At the same time, Massachusetts' many hospitals have incurred significant financial losses over the past several years and much focus has been put on the issue of the adequacy of public payment rates. Acute hospital inpatient and outpatient care must continue to be accessible to MassHealth members and other Massachusetts residents when appropriate. However, care that can be as, or even more, effectively delivered in lower cost community based settings should be encouraged in those settings.

- **Encouragement of Community Based Care** - DMA is initiating an "Appropriate Site of Care" initiative to understand better the use of acute hospital and community services for routine ambulatory care. This initiative, with the input of providers and MassHealth members, could provide valuable information about services that could equally effectively be provided in the community at lower cost. Incentives and other supports should then be put in place to expand capacity (e.g. services provided, hours, space) in community health centers and other community based practices.
- **Implementation of Care Management and Disease Management Programs** – Most of the spending within the MassHealth program is for seniors and persons with disabilities. There are examples from within Massachusetts and from several other states of effective care and disease

management programs that emphasize prevention and regular monitoring of individuals with chronic conditions.[11] These programs usually involve the development of an integrated system of care intended to improve health care outcomes and reduce costs. Components of these programs typically include identifying and proactively monitoring high-risk populations; helping patients and providers adhere to treatment plans; promoting provider coordination; increasing patient education; and preventing avoidable medical complications and hospitalizations. While these programs some-times are challenging to implement, their development should be strongly encouraged within the MassHealth Program.

In looking ahead to the challenges confronting the MassHealth program, two additional issues should be highlighted.

Reform of the Uncompensated Care System

The impact of policy decisions about the MassHealth program and the Uncompensated Care Pool (the uninsured) are inextricably linked. The expansion of MassHealth through Health Care Reform signi-ficantly reduced the projected spending growth within the Pool. On the other hand, the decision not to transfer funds from the Uncompensated Care Pool as scheduled to the Children's and Seniors' Health Care Assistance Fund had the direct impact of creating a deficit in the fund. The Uncompensated Care Pool is itself under considerable financial strain. A special legislative commission has been created to review such issues as the Pool's funding mech-anisms, payment methodologies, reimbursement policies and operations. Reforms in the state's system for financing health care for the uninsured should be strongly supported.

Need for Ongoing Monitoring of the MassHealth Program

MassHealth is a major state and federal program serving the most vulnerable Massachusetts residents. The program has tremendous impact on health care access and outcomes, the state budget, the health care industry and the Massachusetts economy. It is important that there be on-going mechanisms for independent analysis and public discussion of MassHealth programs, policies and spending. The establishment of a permanent entity to work collaboratively with state agencies, providers, consumer groups, academic and research organizations and other organizations would promote the ongoing development of innovative, effective policy solutions by providing independent, timely and actionable information to key legislators, providers, consumers and other key stakeholders. In California, the Medi-Cal Policy Institute was established in 1997 by the California HealthCare Foundation to serve this purpose. The Institute conducts research, distributes information about California's Medicaid programs and the people they serve, highlights the programs' successes and identify the challenges.[12] There are also models of more general public health policy institutes in other states, including Kansas, Louisiana, Michigan, Minnesota, New Hampshire, New Jersey, Oregon, Texas and Washington. Many of these models, while not specific to the review of Medicaid programs, incorporate various aspects of these functions. A review of these different models would be beneficial as a next step toward establishing such an entity in Massachusetts.

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Appendix A

Optional Medicaid Services Covered by 50% FMAP States as of July 2001

(Does Not Include SCHIP Services)

	MA	CA	CO	CT	DE	IL	MD	MN	NV	NH	NJ	NY	VA
Optional Medicaid Services[1]													
Case Management Services	x	x	x	x		x	x	x	x	x	x	x	x
Chiropractic Services	x	x		x		x		x	x[2]	x	x	x[5]	
Christian Science Nurses		x				x					x[4]		
Christian Science Sanitorium		x		x		x					x		x
Clinic Services	x	x	x	x		x		x	x	x	x	x	x
Dental Services (Including Dentures)	x	x		x		x	x	x	x[3]	x	x	x	x
Diagnostic Services	x	x		x	x	x		x	x[2]	x	x	x	x
Hospice Care	x	x	x		x	x	x	x	x		x	x	x
ICF/MR	x	x	x	x	x	x	x	x		x	x	x	x
IMD for 65 + (Inpatient Hosp. and SNF)	x	x	x	x	x	x		x	x	x	x	x	
Inpatient Psychiatric for < 21	x	x	x	x		x	x	x	x	x	x	x	
Medical Social Worker								x					
Nurse Anesthetists		x	x			x	x	x					
Occupational Therapy	x	x				x	x	x	x	x	x	x	x
Optometrist Services (Including Eyeglasses)	x	x	x	x	x	x	x	x	x	x	x	x	x
PACE	x	x	x	x			x					x	
Personal Care Services	x	x			x		x	x	x	x	x	x	
Physical Therapy	x	x		x		x	x	x	x	x	x	x	x
Podiatrist Services	x	x	x	x	x	x		x	x[2]	x	x	x	x
Prescription Drugs	x	x	x	x	x	x	x	x	x	x	x	x	x
Preventive Services	x	x	x	x		x	x	x	x	x	x	x	
Private Duty Nurse	x		x				x	x	x		x[4]	x	
Prosthetic Devices	x	x	x	x	x	x	x	x	x	x	x	x	x
Psychologist Services	x	x		x				x		x	x		x
Rehabilitative Services	x	x	x	x	x	x	x	x	x	x	x	x	x
Respiratory Care	x	x	x			x			x			x[5]	
Screening Services	x	x		x		x		x	x	x	x	x	
SNF for < 21	x	x	x	x	x	x	x	x	x	x	x	x	
Speech, Hearing and Language Disorders	x	x	x	x		x	x	x		x	x	x	x
Tuberculosis-Related Services		x				x		x				x	

Source: Centers for Medicare and Medicaid Services (CMS) State Profiles, 2001.

Appendix A (cont.)

Other Services Considered Optional by States (and Listed Separately)

Naturopathic Services – CT
Extended Prenatal Care Services - DE, MA, MD, NH, NJ, NY, WA
Pediatric Care Services – MD
Medical Supplies and Equipment – MD
Adult Day Health Care - MA, NV
Organ Transplant Services – NY
Assertive Community Treatment – NY
Medicare Part B for Medically Needy – VA
DME – WA

Abbreviations:

ICF/MR = Intermediate Care Facilities for the Mentally Retarded
IMD = Institutions for Mental Diseases
PACE = Programs of All-Inclusive Care for the Elderly
SNF = Skilled Nursing Facility

Notes:

[1] Mandatory Medicaid services include inpatient hospital services, outpatient hospital services, physician services, rural health clinic services, FQHC services, lab and x-ray services,
[2] In Nevada, chiropractic, diagnostic, and podiatrist services are covered under EPSDT only.
[3] In Nevada, only emergency dental services and dentures are covered, except under EPSDT .
[4] In New Jersey, private duty nurse and Christian Science nursing are covered under EPSDT only.
[5] In New York, chiropractic and respiratory services are covered under EPSDT only.

Appendix B

Division of Medical Assistance

In addition to the continual program integrity, revenue maximization and cost avoidance activities, each year the Division identifies new areas of savings. *In fiscal year 2003, the Division plans to implement over 50 savings projects worth approximately $255 million.* DMA has already implemented some of these projects while others are in the planning stages. These projects cover the spectrum of activity at DMA but most of the projects fall into one of the following categories: projects continued from FY 2002, projects requiring legislation, program integrity and audit projects, Third Party Liability and Benefit Coordination projects, pharmacy projects, clinical decision support, and other projects.

Projects Continued from FY 2002

DMA implemented Part B re-pricing in February, 2002. A provision included in the FY 2002 GAA permits the Division to pay Medicare Part B crossover claims up to the Division's maximum allowable amount less any Medicare payment, or the coinsurance and deductible amount, whichever is less. *DMA expects to save over $25 million annually from this project, but will only realize a full year of savings in FY 03. Similarly, DMA will institute the dental restructuring project in mid-March, but will not experience the bulk of the $34 million in annual savings until FY 03*.

Projects Requiring Legislation

DMA requires legislative approval before it can proceed with the Income Deeming First project. The project calls for DMA to change the methodology it uses to determine the ability of a family to pay for nursing home costs. Instead of using interest from assets as the basis for determining the financial wherewithal of a community spouse, DMA will use the income of the institutionalized spouse as the primary factor in determining a family's ability to pay their nursing home costs. This methodology, which was recently upheld by the U.S. Supreme Court, is used by many other states. *The change will save DMA at least $10 million annually in nursing home expenditures.*

Program Integrity/Audit/Recoveries

DMA continually seeks to ensure the integrity of its caseload to ensure that only eligible members receive services through the MassHealth program. Eligibility savings projects include: matching DMA caseload data against Department of Revenue hiring information to ensure that individuals who report having no income continue to remain unemployed; and matching DMA caseload data against Department of Correction data to ensure that the Division does not continue to pay for members who are incarcerated.

Benefit Coordination and Third Party Liability

DMA is working with other insurers to ensure that MassHealth is the payer of last resort. DMA has recently enhanced its data sharing with Medicare, allowing DMA to more quickly identify MassHealth members with Medicare coverage. DMA is also working with hospitals to ensure that members with other insurance who have significant medical needs receive coordinated care. *Coordinating members' care will result in cost savings for DMA and improved services for our members*.

Pharmacy

DMA, like other insurers, has seen pharmacy costs skyrocket in recent years. DMA is in the process of implementing numerous projects designed to ensure proper use of pharmaceuticals and to control drug costs. The most significant project in the pipeline is the MassHealth drug list. Under this project, DMA will identify clinically appropriate drugs to be included on its list. When a physician seeks to prescribe a drug not on the list, he or she must

receive approval from the Division and explain why the member requires the drug. *This project will generate savings by reducing the over-prescription of high-cost drugs.*

Clinical Decision Support System

The capability now exists to combine information from claims, laboratories and pharmacies into one electronic file for each MassHealth member. That file can then be evaluated using evidence-based-medicine logic to determine if the treatment that is being provided is appropriate or inappropriate. Firms providing this service report that hundreds of cases per month can be discovered in time to save patients from harm or even death. In addition, substantial direct savings, easily outpacing the cost of this service, can be achieved. *Contracting with such a firm to serve, for instance, the Primary Care Clinician Plan (PCCP) population could dramatically improve both the quality and cost-effectiveness of the care provided to the more than 410,000 members in the PCCP*.

Miscellaneous

DMA has begun a variety of other savings projects, including identifying costs that can be shifted to the federal government and recovering overpayments to out-of-state hospitals.

Source: DMA, MassHealth Program Response to Legislative Inquiries, March 29, 2002