

The MassHealth Cuts:

**What They Are.
Why They Don't Work.
What We Can Do.**

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I. Executive Summary

As the economy falters, Massachusetts is struggling to address both a sharp decrease in state revenues and an increased demand for social services. The response to the state budget crisis by the legislature and the administration has been to cut the services and eligibility of MassHealth, the state Medicaid program.

Administered by the Massachusetts Division of Medical Assistance, MassHealth provides health care coverage to nearly one million residents. It provides comprehensive benefits for eligible low and middle income people, including children under 19, parents, pregnant women, people with disabilities, people who are HIV positive, long-term unemployed, adults who work for qualified employers and people in nursing homes.

MassHealth is funded by both state and federal funds. For most MassHealth programs, Massachusetts receives fifty-cents for every dollar it spends on services. For others, e.g. the State Children’s Health Insurance Program (SCHIP), the Commonwealth receives sixty five-cents for every dollar spent. These federal funds – \$2.9 billion of the total \$5.38 billion MassHealth budget – go to the state’s General Fund and make MassHealth the largest revenue generator for the Commonwealth.

In October 2002, Governor Jane Swift announced the elimination of several benefits and programs for the nearly 600,000 adults enrolled in MassHealth. The eliminated benefits are:

- Dentures
- Prosthetics
- Orthotics
- Chiropractic Therapy
- Eyeglasses

The estimated savings from eliminating these services totals approximately \$22 million, or \$11 million in state costs.¹ Ultimately, these are not cost-saving measures because the needs that they serve will not go away. Instead, the result will be sicker people who require more expensive care in hospital emergency departments or nursing homes. Further, MassHealth recipients who rely on these critical services will be far less able to work without them.

These cuts to MassHealth come in the wake of a series of devastating cuts to health and human service programs. In January 2002, Governor Swift eliminated nearly all dental benefits for adults covered by MassHealth. The Governor also imposed increased cost-sharing in several MassHealth programs, which will discourage members from seeking care and shift costs to providers.

In its Fiscal Year 2003 budget, the legislature voted to eliminate eligibility for 50,000 MassHealth Basic members as of April 1, 2003. MassHealth Basic serves very low-income, unemployed adults with high health needs who will have few options for care except emergency rooms. Costs will be shifted to other state programs, including the

¹ based on Fiscal Year 2002 expenditures

Department of Mental Health and the Department of Corrections, as well as “off-budget” to the Uncompensated Care Pool, hospitals and health centers. In her announcement last month, Governor Swift asked the legislature to move the closure of the MassHealth Basic program to February 1, 2003, to save an additional \$11.5 million.

As this report was being written, the administration closed the Children's Medical Security Plan (CMSP) to new enrollees. Administered by the Department of Public Health, this November 4th closure effectively ends the Commonwealth's claim that every child – regardless of family income, age, or disability – will have access to health care coverage.

Instead of instituting these cuts that will condemn vulnerable populations to antiquated or non-existent care, this paper recommends the following alternative cost-saving measures:

- Maximize currently available Medicaid federal matching funds (FFP) for state programs
- Support an enhanced Federal Medical Assistance Percentage (FMAP)
- Implement better care coordination and early treatment to avoid preventable hospitalizations to reduce costs in MassHealth.
- Control Pharmaceutical Costs in MassHealth and other state programs.
- Support targeted fraud and overpayment initiatives.

We believe that these recommendations would address much of the gap in funding for MassHealth. The next few months are critical and will determine the future direction of the MassHealth program. It is a time for action. During the election campaign, Governor-elect Romney expressed his desire to restore the MassHealth Basic program. He also called for new federal revenue for the Medicaid program. Clearly he is in a strong position to provide leadership and we look forward to hearing the Governor-elect's plans for how we can avoid this impending crisis. We call on him to move forward quickly.

II. Introduction

The Commonwealth continues to grapple with an ongoing budget crisis. During Fiscal Year 2002, Governor Swift used her authority to reduce funding for many programs. During the budget deliberations for Fiscal Year 2003, more cuts in programs and services were instituted, including the scheduled elimination of a key MassHealth program for 50,000 very low-income unemployed, often homeless, adults with high medical needs.

Now, the Governor has proposed making further cuts in the MassHealth program for adults, effective January 1, 2003. These benefit cuts will do little to address the Commonwealth's fiscal problems, yet they will be devastating to the individuals who are deprived of necessary services. In some cases, cuts could lead to increased institutionalization, erasing any savings that might be generated. In other instances, the services that are eliminated are essential for “worker readiness.” Without them, MassHealth recipients may be trapped indefinitely on public assistance.

For example, taking away eyeglasses from working poor, elderly, and disabled adults will save less than \$2.59 million total and only \$1.3 million in state funds (half or more of MassHealth is funded federally). Thousands of MassHealth members will be left without a basic necessity that enables them to work and take part in daily living activities. Eliminating prosthetics and orthotics will save the MassHealth budget \$5.54 million total or about \$2.77 million in state funds in this year. However, it will still cost the state money. People with severe health care needs will require longer stays in hospitals and may be forced into more expensive settings, such as nursing homes, if they cannot take care of themselves. These are not cost-saving measures because the needs of sick people will still be addressed. These are cost-shifting measures.

Governor Swift also asked the legislature to move the implementation of the MassHealth Basic cut from April 1, 2003 to February 1, 2003. The impact of this cut, which will eliminate coverage for 50,000 people and undermine the state's Uncompensated Care Pool, will cause major disruptions in care for low and middle-income people, and we hope that the legislature will not act to move up the implementation. In his campaign, Governor-elect Romney spoke in favor of restoring this program, and his administration must find the time necessary to develop solutions to this critical problem.

This briefing paper provides:

- A brief overview of the MassHealth program, including coverage categories and financing.
- A description of the proposed cuts in benefits to the MassHealth program and the nominal savings.
- An analysis of the impact of cutting eligibility and services on beneficiaries, on other areas of state spending and on other parts of the health care system.

MassHealth has been called a “budget buster”, but blaming the program for the Commonwealth's budget problems is far too simplistic. While the program spent \$5.38 billion in Fiscal Year 2002, over half of those expenditures are paid for with federal matching funds. MassHealth generated \$2.9 billion in federal matching dollars. These

critical dollars are needed to sustain both Massachusetts’ health care system and its economy. Additionally, the expansions in MassHealth have significantly reduced the number of uninsured in Massachusetts.

We hope that a look at MassHealth, and the impact of these proposed cuts, will generate a better-tailored response to the current budget crisis – one that protects our most vulnerable residents and ensures a healthy future for them and the Commonwealth.

III. Overview of the MassHealth Program

The following is a brief description of the MassHealth Program. For a full analysis, please refer to Health Care For All’s previous report, **The Facts on MassHealth**, released in March 2002 and available at www.hcfama.org.

In Massachusetts, the Medicaid Program is referred to as MassHealth. Medicaid is a state-federal partnership. Under federal law, if a state operates a Medicaid program consistent with federal standards, it is eligible to receive federal matching funds for the costs of its program. Some federal standards are *mandatory*, i.e. a state must provide certain services to certain categories of people. Other standards are *optional*, i.e. a state can choose to provide services to additional people; if it does provide these services it will receive matching funds for them.² Finally, states can ask the federal government for a *waiver* from some requirements; waivers allow states to reallocate dollars to which they are entitled in order to expand coverage, test creative strategies and tailor their health care programs to local conditions.

Massachusetts, like many other states, currently operates much of its Medicaid program through a "waiver" from the federal government (elders and institutionalized recipients continue to receive Medicaid coverage under non-waiver rules). The federal waiver is a "living document" in the sense that it has been modified numerous times since it was first approved in 1996. The federal waiver is the document that defines the coverage expansions, financing arrangements, and service delivery structure for the MassHealth program. Understanding the waiver is critical to understanding the costs and benefits of the Medicaid program in Massachusetts.

A. Medicaid Coverage in Massachusetts

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The MassHealth program is administered by the Division of Medical Assistance and currently covers a total of 995,679 low and middle-income Massachusetts residents who are citizens or qualified immigrants. It provides comprehensive health benefits for eligible low and middle-income people who are under age 65, including families with children under 19, children under age 19, pregnant women, long-term unemployed, people with disabilities, adults who work with qualified employers, and people who are HIV positive. Medicaid also covers low-income residents 65 and older, as well as low and middle-income individuals of any age, who need long term care services.

Table I summarizes eligibility and the approximate number of MassHealth members.

² Once a state chooses to provide an optional service, there are some limits on how it may seek to restrict the benefit. Medicaid programs must provide services in an "amount, duration and scope" sufficient to achieve their intended purposes.

Table I: MassHealth Enrollment as of August 31, 2002

Coverage Group	Eligibility	Number Covered as of 8/31/02
Parents and Children	All children under age 19 are covered up to 200% of the FPL (\$30,048 per year for a family of three). All parents are covered up to 133% of the FPL (\$19,980 for a family of three). Pregnant women and infants are covered up to 200% FPL. For families under 200% FPL with employer based insurance, MassHealth will purchase the employer’s family plan.	403,495 Children 216,864 Parents 620,359 Total
People with Disabilities	Disabled adults are covered up to 133% of the FPL (\$11,784 for an individual) under the MassHealth Standard program. The CommonHealth program covers all working disabled adults as well as other adults over 133% FPL and children over 200% FPL. (Sliding scale premiums are required for higher income members)	21,811 Children 176,530 Adults 198,341 Total
Seniors	Income limit of \$9,108 for an individual if they are residing in the community. The income eligibility is higher for those in a nursing home, but they must contribute some or most of their income to the costs of care.*	116,599
Long Term Unemployed	These adults are now covered up to 133% of the FPL under the MassHealth Basic program, but according to the Division of Medical Assistance, most enrollees have incomes of 40% of the FPL (\$3,544) or less.	60,380

Source: Massachusetts Division of Medical Assistance

*Medicaid is the only public program that provides long-term care for low and middle-income people. Medicare only covers limited stays in nursing homes following a hospitalization.

B. Financing of the MassHealth Program

The MassHealth program accounted for one-quarter of the General Fund spending in Fiscal Year 2001. However, if we look at state spending on MassHealth, the percentage drops to 9.7% of the state budget. By comparison, state aid for local education in Fiscal Year 2002 will be \$4,092 billion, nearly double the \$2.466 billion spent for the state share of Medicaid.³

The MassHealth program receives Federal Financial Participation (FFP) for qualified expenditures. In general, the MassHealth Program receives fifty-cents in reimbursement for every dollar expended. This "match rate" is applicable to most MassHealth expenses, including services provided to the majority of children, adults, and elderly people in the Commonwealth. However, there is an enhanced match rate of sixty-five cents on the dollar for those children covered by SCHIP, which is a part of MassHealth.⁴ Total federal revenues for Fiscal Year 2002 are projected to be \$2.9 billion.

³ MassHealth: Dispelling Myths and Preserving Progress, Massachusetts Health Policy Forum. 2002.

⁴ SCHIP allowed states to either expand their Medicaid programs to cover children at income levels above federal Medicaid requirements, or to enact separate state health insurance programs for children. With federal permission, Massachusetts has implemented a blended program, combining the two approaches.

State funds used for matching purposes can come from a variety of sources. The General Fund has historically been used to provide the state share of the Medicaid program. However, it is also possible to use dedicated funding streams (e.g. dedicated taxes or tobacco settlement funds) for Medicaid matching purposes.⁵

MassHealth cost increases are largely due to medical inflation, including nursing home, pharmaceutical, community-based long-term care and hospital expenditures. The cost increases are primarily for elders and adults and children with disabilities, which account for 54% of all expenditure growth during the past five years. This is not surprising, since these are the members who need the most care. Growth rates are inextricably linked with average per-member-per-month (PMPM) costs. For instance the costs for seniors is nearly 10 times the costs for children and parents.⁶

There has been much debate about the effect on MassHealth costs of expanding eligibility to nearly 300,000 new members since 1996-7. However, as we discussed in detail in HCFA's March 2002 report, these expansions were accomplished without any new contribution from the General Fund. The new programs were financed by the 25-cent tobacco tax passed in 1996, by federal matching funds, by transfers from the Uncompensated Care Pool, and by an existing, small amount of funding from Emergency Aid to the Elderly, Disabled and Children (EAEDC).

Table II: Massachusetts Maximization of Federal Reimbursement through MassHealth

Health Coverage Programs Now Included under MassHealth	Additional Revenues Collected Through Federal Reimbursement
<ul style="list-style-type: none"> • EAEDC health coverage for low-income residents • CommonHealth program for people with disabilities • Medical Security Plan for people collecting unemployment insurance • Prescription Advantage program for seniors and people with disabilities (in process) <p><i>NB: these programs were previously funded with "state only" dollars. They are now included in MassHealth line items in the state budget, but net cost is reduced due to federal matching funds.</i></p>	<ul style="list-style-type: none"> • Medical care provided to special education students in a school-based setting • Home and community based services waivers for mentally retarded (DMR), elders (EOEA), and traumatic brain injury (MRC) • Care provided in public hospitals (DPH, DMH, and DMR state schools) • Case management services • Residential rehabilitation services • Distressed hospital payments • Enhanced matching funds for federally-approved Information Technology projects (e.g. HIPAA)

Source: Massachusetts Division of Medical Assistance

The MassHealth program has also grown because the availability of federal matching funds has made the MassHealth program an attractive mechanism for increasing revenues for the Commonwealth (see Table II). Services previously paid for by "state

⁵ A specific example of this strategy is the federal matching funds available for expenditures made by the Medical Security Plan (MSP). The MSP provides health coverage to unemployed residents. It is funded by an employer tax, currently set at \$16.80 per employee per year. Thus, an employer tax is used to provide the state share for funding in this case.

⁶ The Facts on MassHealth, HCFA, March 28, 2002.

only" dollars have been incorporated into the Medicaid program in order to receive the federal matching funds. An example of this type of effort is the increasing use of the Medicaid program to cover mental health costs for Massachusetts residents. The state receives a cost-offset in federal reimbursement for these services that can be used for any purpose. This dynamic has had a profound impact on the MassHealth Program and contributes substantially to its increasing share of the state budget.

IV. The Cuts in the MassHealth Program

A. Overview

Over the last year, the legislature and governor have made debilitating cuts in public insurance programs that affect the hundreds of thousands of Massachusetts residents who rely on MassHealth and the Children's Medical Security Plan. These cuts will be felt throughout the Commonwealth by our friends and neighbors, health centers, doctors and local hospitals.

In January 2002, Governor Swift cut nearly all dental benefits for the 600,000 adults on MassHealth, eliminating their ability to have a cavity filled or dental cleanings. During the Fiscal Year 2003 budget debate, the legislature eliminated the MassHealth Basic program, which provides health coverage for 50,000 very low-income adults.

On October 10, 2002, Governor Jane Swift announced a series of broad cuts in health and human service programs using her constitutional powers under section 9C. Under this section, a governor can make unilateral decisions to reduce spending or eliminate programs if there is an apparent shortfall in needed funds. The Swift administration predicts that tax revenues for Fiscal Year 2003 will be \$2.5 billion below projections.⁷

With these predictions, Governor Swift announced the elimination of the following health care benefits for the nearly 600,000 adults enrolled in the MassHealth program:

- Dentures
- Prosthetics
- Orthotics
- Chiropractic Therapy
- Eyeglasses

Cutting benefits like eyeglasses, prosthetics and orthotics will impede the ability of MassHealth recipients to obtain or maintain employment, thus reducing the likelihood of recipient income rising above MassHealth income limits through employment. This lack of stable employment also reduces the likelihood of recipients maintaining employer-based insurance as a primary payer of health costs. The cuts could increase costs to cash assistance programs such as Transitional Aid to Families with Dependent Children (TAFDC) and place additional burdens on the Massachusetts Rehabilitation Commission. Neither of these programs is funded to take on additional recipients.

⁷ Kevin J. Sullivan, Secretary, Executive Office of Administration and Finance, August 29, 2002 letter to Cabinet/Agency Heads.

These benefit cuts also seem counterintuitive in light of known strategies to keep health care costs down. Providing people with the benefits needed to keep them healthy, at home or in a less restrictive setting, will avoid unnecessary hospitalizations or nursing home care. The cuts could therefore increase costs in Medicaid for these other services.

The previous cuts in adult dental services have already increased demand on the underfunded Uncompensated Care Pool, which pays health centers and hospitals to provide care to the uninsured or the underinsured.

In addition, the Governor proposes changes in the following programs:

- Increasing premiums for the SCHIP program (Family Assistance) – The Governor proposes removing limits on the amount families can be charged in both premiums and co-pays;
- Creating new premiums for the HIV waiver program;
- Increased co-payments for medications from fifty cents to two dollars per prescription;
- Establishing one dollar co-payments for other MassHealth services.

Most recently, on November 4, 2002, the Children’s Medical Security Plan closed enrollment, forcing children to wait two to three months before granting them access to health care. Children will have to rely on emergency departments for care.

B. The MassHealth Basic Program

Nearly 50,000 adults are scheduled to lose their health care coverage on April 1, 2003. Governor Swift requested that the legislature return for a special session to accelerate this elimination to February 1, 2003. During his campaign, Governor-elect Romney stated that he supported restoring this important program, and we believe that the legislature should not act to move implementation to February. We call on the new administration to develop a plan to avoid closing this critical program.

MassHealth Basic provides health care to uninsured, long-term unemployed adults, many of whom have serious illnesses. People who get Basic benefits often have recurring or chronic mental health, substance abuse and other medical incapacities, which make it difficult for them to maintain employment. When the MassHealth Basic program was implemented in 1997, it was predicted that many of the high cost “predominant pool users” would be eligible for this program. “Predominant pool users” were disproportionately male and had particularly high rates of circulatory disease, mental illness and substance abuse.⁸

The MassHealth Basic population has indeed proved to be a high need group whose ongoing care cannot be well maintained by the Uncompensated Care Pool, which only covers services delivered in hospitals and health centers. For instance, MassHealth Basic members are more dependent on mental health services than any other MassHealth group. DMA estimates that 35,000 are enrolled in the Massachusetts Behavior Health Partnership (MBHP) and 18,000 are actively using mental health and

⁸ Report of the Special Commission on Uncompensated Care, February 3, 1997.

substance abuse services through the MBHP.⁹ Without access to prescription drugs and other services, many of these people will deteriorate and be forced into hospitals. Some will receive care in Department of Mental Health psychiatric hospitals, in designated beds in acute care hospitals, or in other state-funded health programs within DPH and DMH, all without federal reimbursement. Some of the current \$86.2 million behavioral health costs for MassHealth Basic recipients will be forced back into the Department of Mental Health at 100% state expense and some will fall on the Pool through outpatient hospital services and acute care hospital psychiatric inpatient admissions. Additionally, without access to health and mental health services and prescriptions, some MassHealth Basic members will end up in the courts and prison system at a far greater state expense.

Only 11,000 of the approximately 60,000 people currently on MassHealth Basic will continue to be eligible for the program. Those receiving EAEDC from the Department of Transitional Assistance or those who are clients of the Department of Mental Health and who have an income below 100% federal poverty level (currently \$8,860) will continue to receive coverage. For those no longer eligible, the loss of pharmacy and preventative services available under the Basic program will most likely cause their conditions to worsen, increasing the likelihood of them being determined disabled and qualifying them for MassHealth Standard.

MassHealth Basic members use over \$90 million each year in inpatient and outpatient hospital services (see Table III). Much of this cost will be shifted onto the Uncompensated Care Pool (UCP), which is capped at \$415 million. The Division of Health Care Finance and Policy estimates that the elimination of MassHealth Basic will add \$76 million in Pool costs, resulting in a \$153 million Pool deficit in FY03. The former MassHealth Basic members are expected to cost the Pool \$160 million in FY04. These shortfalls will result in lower reimbursement rates for hospitals and community health centers that provide free care to the 420,000 Massachusetts residents who are already uninsured. The estimated annual savings to the state budget for cutting MassHealth Basic is only \$137 million, or half of the annual cost of the program since the state will lose federal matching funds. The Pool cannot get federal matching funds for the new costs it will incur from this cut.

Table III: FY2002 Estimated MassHealth Basic Expenditures

Provider Type	Estimated Expenditure (\$million)
Behavioral Health	\$86.2
Pharmacy	\$48.6
Outpatient Acute	\$41.2
Inpatient Acute*	\$28.5
Physician	\$21.4
Community Health Center	\$8.1
Dentist	\$7.4
All Other	\$12.1
Total	\$253.6

Source: Massachusetts Division of Medical Assistance

* For a complete list of MassHealth Basic expenditures by hospital, see Appendix II.

⁹ Massachusetts Division of Medical Assistance

In addition to higher pool costs, a higher proportion of all services to this population will be delivered through emergency rooms, raising costs and increasing emergency room crowding. Without access to primary care and prescription drugs, Basic enrollees will also be hospitalized at higher rates. Massachusetts already has a severe problem with access to emergency care. Elimination of MassHealth Basic will make this already serious problem worse. Studies have shown that the uninsured are more likely to rely on the emergency room for care that could be treated elsewhere. For example, a study of people in Oregon who lost eligibility for Medicaid found that they were more than four times as likely to use the emergency room as their primary source of care than were Medicaid enrollees.¹⁰ Studies have also found that the uninsured spend more time in the hospital for conditions that could be treated elsewhere than does the Medicaid population.¹¹

C. Dental Services and Dentures

This spring, Governor Swift eliminated most adult dental benefits under MassHealth. Extractions – the removal of teeth – became the only alternative for most tooth problems. Now, without access to dentures, these adults will have no way to cope with the loss of their teeth.

The importance of oral health as a public health issue is largely misunderstood and undervalued. Oral health affects the ability to eat, speak, and sleep.¹² Poor dental health can lead to increasingly serious physical ailments. Dental problems can lead to a poor nutritional diet because of chewing difficulties.¹³ Untreated gum and oral tissue disease can damage insulin production and result in diabetes.¹⁴ Dental disease also impacts cancer treatment – it may complicate the delivery of both chemotherapy and head and neck irradiation.¹⁵ Poor oral health can even cause a woman to deliver a pre-term, low birth weight baby.¹⁶

Oral health is linked to heart disease, lung disease, stroke, low birth weight babies and other major health conditions. Oral cancer is more prevalent than melanoma, ovarian cancer and cervical cancer and can be detected during a routine dental visit. In the United States, approximately 3.6 million workdays are lost due to oral health problems.¹⁷

As in other medical services, preventative measures and early treatment are far less costly than emergency measures. An adult patient needing a filling can receive an oral exam, a cleaning and a filling for a total cost of \$137. If a patient has to see a dentist in

¹⁰ Oregon Health Plan Disenrollment Survey

¹¹ Guo et al, How are Age and Payors Related to Avoidable Hospitalization Conditions?, *Managed Care Quarterly*, 2001, 9(4):33-42.

¹² *Healthy People 2010: Oral Health*. Washington, DC: US Dept. of Health and Human Services; 2000.

¹³ National Center for Education in Maternal and Child Health, *Oral Health and Learning*, Georgetown University, (2001).

¹⁴ *The Nation's Health*, July 2001.

¹⁵ David Satcher, *Preface to U.S. Department of Health and Human Services, Oral Health in America, A Report of the Surgeon General*, 4 (2000).

¹⁶ American Academy of Periodontology, Press release, May 7, 2000.

¹⁷ Report to the Special Legislative Commission on Oral Health, *The Oral Health Crisis in Massachusetts*, February, 2000.

an emergency, the exam, extraction, and partial dentures cost \$343, a cost increase of two and a half times.¹⁸

Dentures, which include full and partial dentures, as well as bridges, are essential for those who have lost their teeth. Losing teeth is not a consequence of aging, as commonly believed, and affects many besides seniors.¹⁹ This loss may also lead to a greater risk of cancer and heart disease.²⁰ Even people with dentures may eat fewer fruits and vegetables, foods known for protective benefits, and eat more processed foods with higher cholesterol. All of this will exacerbate existing conditions or create new health problems and ultimately increase MassHealth costs.

AB is an elder resident at a Boston-area nursing home and a MassHealth recipient. While she was recovering from an operation at a rehabilitation hospital, her dentures were removed and no longer fit after being out for several weeks. She entered a nursing home and after six months has finally qualified for Medicaid. She needs new dentures, but if she cannot see a dentist by January 1, 2003, Medicaid will not pay and AB will not be able to afford them.

Comprehensive dental care is a critical part of quality health care. The administration should reverse this decision and restore adult dental benefits under MassHealth.

Table IV: MassHealth FY01 Expenditures for Dentures

Age	Expenditure
65 and older	\$3,955,565
Age 21-64	\$9,196,538
TOTAL	\$13,152,104
TOTAL STATE SHARE	\$6,576,052

Source: Massachusetts Division of Medical Assistance

D. Prosthetics and Orthotics

Prostheses are needed for people who lose a limb due to accident or illness or for those born without a limb. The average cost for a prosthetic leg is \$6,000 for below the knee and \$11,000 for above the knee. A prosthetic arm costs an average of \$10,000. Prostheses also require serious maintenance. Prostheses must be replaced as the stump continues to change in size and shape, and they deteriorate from continual use. If prostheses are not properly cared for they can cause skin infections, which may result in decreased functionality and an increased need for medical care. Generally, prostheses are replaced every one to three years.

While the overall number of MassHealth beneficiaries receiving prostheses is small, their quality of life would be seriously compromised without them. Without proper prostheses a patient faces the prospect of increased disability, related hospitalizations, sores, infections, emergency department visits, increased use of medication, continuing pain and perhaps a loss of independence.

¹⁸ Robert Alconada, Massachusetts Dental Society, Division of Health Care Finance and Policy hearing, April 9, 2002.

¹⁹ Centers on Disease Control and Prevention.

²⁰ Journal of the American Dental Association, November, 2001 as cited on American Dental Association web site, April, 2002.

Orthotic braces range from foot insoles and ankle braces to neck and back braces. Some braces are custom fitted, for instance to treat scoliosis or a fractured spine. The need for orthotic braces may be short-term, during rehabilitation, or permanent for a chronic condition. Specialized braces are often made from special plastics and metals and can cost anywhere from \$1,000 to over \$3,000.

JB is a woman on CommonHealth who works part-time as an Avon representative. She depends on orthopedic braces with custom-made shoes to function. One foot is very crooked and the other foot is weak. Without the shoes she cannot stand. Each of the shoes costs \$500, and she will not be able to afford the shoes after MassHealth stops covering them on January 1st. She feels that without her shoes it will be harder to keep working.

Table V: MassHealth FY01 Expenditures for Prosthetics and Orthotics based on Provider or Dispensing Agency

Provider/Dispensing Agency	Age	Expenditure
Prosthetics Supplier	65 and older	\$245,705
	Ages 21 – 64	\$2,077,038
	Total	\$2,322,744
Physician	65 and older	\$53
	Ages 21 – 64	\$103
	Total	\$156
Pharmacist	65 and older	\$1,141,194
	Ages 21 – 64	\$1,423,081
	Total	\$2,564,275
Podiatrist	65 and older	\$10,760
	Ages 21 – 64	\$26,792
	Total	\$37,552
Durable Medical Equipment Provider	65 and older	\$30,733
	Ages 21 – 64	\$77,482
	Total	\$108,216
Orthotics Supplier	65 and older	\$115,082
	Ages 21 – 64	\$393,438
	Total	\$508,521
Group Practice	65 and older	\$622
	Ages 21 – 64	\$42
	Total	\$665
TOTAL		\$5,542,129
TOTAL STATE SHARE		\$2,771,064

Source: Massachusetts Division of Medical Assistance

E. Chiropractic Therapy

MassHealth spent \$763,000 on chiropractic services in Fiscal Year 2001. Chiropractic manipulation, also frequently called chiropractic adjustment, is the manipulation of the spine to treat a variety of musculoskeletal problems. It has been recommended by the Agency for Health Care Policy as the only safe, effective and drugless form of initial treatment for lower back problems in adults.²¹ Lower back problems affect half of all working Americans and are the leading cause of temporary disability in people under age 45. Additionally, work-related neuromusculoskeletal disorders make up more than one third of worker compensation costs and are responsible for a third of all workday losses.²²

It is estimated that the cost of the care given by medical professionals to sufferers of back problems is \$50 billion a year.²³ Because chiropractors can offer in-house x-rays, ultrasounds and treatment, they tend to provide less costly care than doctors and surgeons. Additionally, hospitalization and medication costs are lower for chiropractic care than medical care, patients are diagnosed and treated in less time by chiropractors than by medical doctors, and patients treated by chiropractors miss fewer days of work than those treated by medical doctors.²⁴

Table VI: MassHealth FY01 Expenditures for Chiropractic Services

Age	Expenditure
65 and older	\$25,004
Age 21-64	\$737,890
TOTAL	\$762,894
TOTAL STATE SHARE	\$381,447

Source: Massachusetts Division of Medical Assistance

F. Eyeglasses

Eyeglasses are the primary means to correct vision problems, including diabetes, glaucoma or other aging related vision issues. While MassHealth beneficiaries will continue to cover vision screening and medical eye care, eyeglasses, the main prescription for vision care, will no longer be available.

There are several illnesses which cause vision to deteriorate, including diabetes and glaucoma. Eyeglasses in both instances can help mitigate the impact of vision loss.

Decreased vision capacity can increase utilization of emergency rooms due to falls and confusion from lack of sight.²⁵ The injuries or lack of independence can also lead to increased nursing home or long term care placements.

²¹ American Chiropractic Association; www.amerchiro.org.
²² A Rudimentary Shift in Health Care Delivery and Demand, pg. 1.
²³ American Chiropractic Association; www.amerchiro.org.
²⁴ A Rudimentary Shift in Health Care and Demand, pg. 2.
²⁵ Mass Society of Optometrists

Table VII: MassHealth FY01 Expenditures for Eyeglasses

Age	Expenditure
65 and older	\$309,022
Age 21-64	\$1,133,287
TOTAL	\$1,442,309
TOTAL STATE SHARE	\$721,154

Source: Massachusetts Division of Medical Assistance

Table VIII: MassHealth FY01 Expenditures for Dispensing Fees for Eyeglasses

Provider/Dispensing Agency	Age	Expenditure
Optometrist	65 and older	\$317,528
	Ages 21 – 64	\$740,074
	Total	\$1,057,602
Optician	65 and older	\$8,808
	Ages 21 – 64	\$59,893
	Total	\$68,702
Optometry School	65 and older	\$3,819
	Ages 21 – 64	\$19,916
	Total	\$23,736
TOTAL		\$1,150,040
TOTAL STATE SHARE		\$575,020

Source: Massachusetts Division of Medical Assistance

G. Increased co-payments

Increasing co-payments is often suggested as a strategy for reducing MassHealth spending and as an alternative to reducing eligibility or eliminating benefits. However, increasing co-payments in low-income populations is likely to reduce the efficiency and efficacy of the health care system and place an additional burden on health care providers while saving nothing, or even increasing costs, for the state.

Increasing co-payments to MassHealth recipients seems like a simple mechanism for controlling costs, but it not likely to be successful. Many studies have found that co-payments result in low-income people not utilizing necessary services. Even modest increases in co-payments have been shown to result in adverse outcomes for low-income people, and have actually cost states more money, as people forgo necessary and effective care.²⁶

The specific effect of co-payments on MassHealth may be to increase spending. An analysis by the RAND Corporation found just this effect as a result of increased cost sharing for physician services in the CA Medicaid program. While co-payments did reduce the utilization of physician services, utilization of hospital care increased, leading to a net increase in spending overall. In New Hampshire, increasing co-payments and

²⁶ Newhouse, et al. “Copayments and the Demand for Medical Care: the California Medicaid Experience.” *Bell Journal of Economics* (Spring 1978). See also, Stuart and Zacker. “Who Bears the Burden of Medicaid Drug Copayment Policies.” *Health Affairs* (March-April, 1999).

creating other barriers to prescription drug access led to increased use of mental health and long term care services. A study of the effect of cost sharing in Quebec province on the elderly and the poor also found that adverse effects associated with reductions in use of essential drugs doubled and led to a significant increase in emergency room use. In addition, they disproportionately impact the sickest individuals who tend to use the most services and thus incur the most co-payments.

Insofar as co-payments are collected by providers, they can be viewed as an indirect rate reduction – when people don't pay them the provider absorbs the cost. They are a particularly inefficient means to accomplish this doubtful end, and lead to more administrative work for overburdened providers.

Increasing co-payments have the potential to harm a patients' health without doing any good for the state budget. In addition, co-payments impose additional costs on providers, both in the form of more administrative hassle and because services must be provided whether a co-payment is made or not.

V. Children's Medical Security Plan

In the FY03 budget, the legislature did not provide adequate funding to the Children's Medical Security Plan (CMSP), administered by the Department of Public Health. In addition enrollment has increased faster than anticipated due to the downturn in the economy. More families seek out coverage from CMSP when they either lose their jobs or their employers drop coverage or increase cost-sharing. As a result, the program closed enrollment on November 4, 2002 and will remain capped at 26,000 enrollees. At the end of October, the program was covering 27,600 children. Further, the program eliminated coverage of emergency services for all children enrolled.

The Children's Medical Security Plan was originally the Healthy Kids program. Created in the early 1990's as a basic preventive health program for children ages 0-6, it has expanded over the years to be somewhat more comprehensive – limited prescription, dental, and mental health coverage along with well-child and sick care visits – and include children through age 18. Children with family incomes below 200% of the federal poverty level (FPL) pay nothing for this coverage, children between 200-400% FPL pay for part of their coverage through monthly premiums and co-pays and children with family incomes over 400% FPL pay the full amount for coverage. CMSP members receive their hospitalization through the Uncompensated Care Pool.

Closing CMSP marks the end of Massachusetts' commitment to making health insurance available to all of the Commonwealth's children. CMSP is the program that grants all children, regardless of age, income or disability, access to health insurance. Any family calling to enroll in the program will be placed on a waiting list until the number served drops below 26,000. Once this occurs, children will be enrolled only as others withdraw. Without this insurance, children through the age of 18 will no longer be able to go to the doctor when they have an ear infection, see a dentist or access vision care.

VI. Recommendations to Save Costs and Stabilize Funding

We call on the new Administration to work toward solutions that could reverse the actions taken by Governor Swift to eliminate essential services for MassHealth members. The income eligibility limits for MassHealth—generally about \$11,784 for an individual or \$30,038 for a family of three—mean that these beneficiaries cannot pay out of pocket for dentures, prostheses and other expensive services that have been eliminated. We also ask that the new administration work with the legislature to find alternatives to closing the MassHealth Basic program to 50,000 members.

We offer the following recommendations, some of which are discussed in detail in Health Care For All's report, "The Facts on MassHealth: What it is. Why it works." (www.hcfama.org/masshealthreport.html).

Seek more federal dollars to support Medicaid.

In his campaign, Governor-elect Romney proposed to seek additional federal matching funds for MassHealth. There is currently a proposal in Congress to temporarily increase the Federal Medical Assistance Percentage (FMAP)—the federal match rate—to address the current downturn in states' budget revenues. The new administration could play an important role in supporting action by Congress and the Bush administration to pass this federal initiative, which could bring in an estimated \$164.5 million to Massachusetts over the next year. Massachusetts would benefit from additional and continuing efforts in this arena to stabilize MassHealth.

Maximize MassHealth Federal Financial Participation Revenue.

While many major revenue maximization strategies to increase Federal Financial Participation funds have already been implemented, further projects should be shifted out of the Division of Medical Assistance's jurisdiction and into an Executive Branch office (either the Health and Human Services or Administration and Finance). This would minimize inter-agency disputes and assure a comprehensive perspective on budget issues.

Avoid Preventable Hospitalization.

Targeted initiatives should be encouraged to decrease preventable hospitalizations. Diverting "stuck kids" (those in psychiatric beds but ready for discharge and receiving hospital-level care) into community-based services is one possibility. The Mini-grants program, which supports community based outreach and enrollment activities, has also proven effective in linking people to community providers. Care coordination models that better organize quality care for high-risk or high-cost patients should also be explored.

Control Pharmaceutical Costs.

With pharmacy costs growing at an unsustainable rate, a variety of measures, some in progress, should be taken to restrain cost increases in this area. Such measures include bringing the cost of the Pharmacy Advantage program under Mass Health for low-income seniors, and exploring whether or not fair prices are being paid for pharmaceuticals.

Support Targeted Fraud and Overpayment Initiatives.

Overpayment and fraud hurt all citizens. The legislative task force and the Attorney General should be supported in their pursuit of stopping these practices, but should assure that providers are not harassed.

VII. Conclusion

These cuts in benefits and increases in cost-sharing are unlikely to result in significant cost savings. They have the potential to destabilize the health care system and result in very low-income residents going without essential care or utilizing more expensive services. Because of the federal matching system, Massachusetts will forgo significant federal funding, and will drive people into the Uncompensated Care Pool, which receives only a capped federal contribution. This cost-shifting will weaken an already fragile health care delivery system and will reduce the ability of the system to care for everyone, both MassHealth members and the general population. Similarly, increased reliance by the newly uninsured on emergency rooms will exacerbate existing problems with overcrowding and diversions, to the detriment of all. As detailed, the economic impact is significant. In addition, when specific services are eliminated, they are often replaced by more expensive, less tailored alternatives. We should avoid dismantling as a whole or in pieces a program that works well and provides critical services to a million Massachusetts residents.

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