Massachusetts House of Representatives

House Task Force on Medicaid

April 10, 2003

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The Commonwealth of Massachusetts

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Dear Colleagues:

Thank you for your interest in the Medicaid Task Force and the current fiscal situation facing the Commonwealth of Massachusetts. We are confident that by working together, we will continue to confront the very difficult choices that lie ahead in order to protect core services while ensuring budget stability.

As you are aware, the Commonwealth's current fiscal crisis first became apparent in March 2001. In the fiscal year ending June 30th, 2002, the Commonwealth's tax collections dropped from the previous year by approximately $2.5 billion, a 15% reduction in collections. This revenue drop is unprecedented in Massachusetts history. By comparison, during the last recession of the early 1990's, Massachusetts tax collections dropped by approximately $300 million or roughly 3.5%.

In dealing with this current situation, we have engaged in a three-pronged plan to bring the Commonwealth through these unprecedented times. The plan included spending reductions, use of reserves, and tax increases. Since September 2001, the Commonwealth has enacted spending reductions of approximately $2 billion, used nearly $2.5 billion of reserves, and enacted tax increases of approximately $1.5 billion. Even with all of our efforts, the Commonwealth's FY'04 fiscal deficit could approach as $3 billion.

These conditions present a test of our collective skills, wisdom and resolve. Only by working together, with the entire membership engaged in the process, can we successfully tackle the challenge presented by the Fiscal Year 2004 budget. To this end, Speaker Finneran has requested that we establish task forces to increase the transparency of the budget process, to assist the House Committee on Ways and Means in conducting an honest appraisal of the Governor's proposals, and to help the Committee develop its budget proposal. Our fiscal situation has magnified the challenge of budgeting, forcing us to evaluate basic assumptions on what role government should play and how much we are willing to pay for these services. The Medicaid task force has allowed us an additional forum to address these issues.

The Medicaid Task Force consisted of the Chair and Vice-Chair of the Medicaid Committee, four members of the Committee on Ways and Means, and all interested members of the House. The Medicaid Task Force held its first public hearing in conjunction with the Committee on Ways and Means in Pittsfield on March 19th. Additionally, we held hearings on Tuesday,

March 25th and on Thursday, March 27th. These hearings offered us vital information which was used to prepare proposals for consideration.

The attached proposals are not intended to be an exclusive list reached by consensus of the task force, but rather a list of potential measures that should be considered in light of our current fiscal situation. Not all members agree with every proposal, but do agree that the process by which we solicited input and ideas was extremely beneficial.

We recognize that we must work together if we are to solve not only this FY'04 fiscal problem, but also our long-term fiscal situation. We are confident that, together, we will continue to confront our fiscal difficulties while attempting to preserve the most essential gains of the past decade.

Very Truly Yours,

The Medicaid Task Force

Estimated savings: $15 million

7. **Implement asset test for adults 19 to 65**
   Currently, MassHealth only considers assets for people ages 65 and older or people in, or applying for, nursing home care. MassHealth does not now count the assets of non-institutionalized people who are under 65 years old. With this change, assets would be considered for all adults who are applying for or receiving MassHealth. People with assets above that limit would not be eligible. Legislation is required and is found in Section 13 of H 3732.
   Estimated savings: $10 million

8. **Require applicants to verify lack of employer-sponsored insurance**
   Upon applying for MassHealth, every applicant who is working and reporting income, in addition to furnishing proof of income with two recent pay stubs, would also have to provide a certification directly from the employer that health insurance coverage is not available to that employee before they could be determined eligible. Legislation is required and is found in Sections 5 and 11 of H 3732.
   Estimated savings: $20 million

9. **Tighten disability eligibility criteria including adjustments to re-determination processes, changing eligibility for non-SSI disabled adults**
   The proposal seeks to tighten current MassHealth eligibility criteria and the review process in two ways: 1) individuals who only have specific vocational limitations which prevented them from certain employment, but who otherwise did not meet the SSI disability criteria, would no longer qualify as "disabled" and receive MassHealth; and 2) the criteria applied to the member's on-going review (done as the Continuing Disability Review or CDR) would be tightened to be the same criteria and process as used in determining eligibility during the original disability review. Legislation is required and is found in Section 4 of H 3732.
   Estimated savings: $20 million

10. **New assessment on insurers**
    The new proposed assessment will be $89.5 million to be paid in installments, by each health insurer, including health insurance companies, hospital service corporations, medical service corporations, health maintenance organizations, and possibly self-insured plans, which conduct business in Massachusetts. (The $89.5 million assessment will be a user fee on insurers to help fund existing MassHealth services.) Legislation is required and is found in Section 19 of H 3732.
    Estimated savings: $89.5 million

11. **Impose an enrollment cap on Family Assistance and CommonHealth adults**
    DMA proposes to cap enrollment in the CommonHealth and Family Assistance programs at a predetermined level and create a waiting list for new adults to enroll in these programs. The enrollment caps have yet to be determined and will not affect children in either program. Legislation is required and is found in Section 8 of H 3732.
    Estimated savings: $3 million

12. **Eliminate state funded coverage for Special Status Immigrant adults**
Certain immigrants are not eligible to receive the full scope of federally funded Medicaid benefits. MassHealth has provided those benefits at full state cost. These changes mean that adults (19 and older) with a certain immigration status will no longer qualify for full MassHealth benefits. Many of these individuals, however, will continue to qualify for emergency services only through MassHealth Limited. Legislation is required and is found in Section 7 of H 3732.
Estimated savings: $13 million

13. **Implement income first-deeming**
Resource-first deeming is currently used when determining the eligibility of an institutionalized spouse when the other spouse lives in the community. DMA proposes to replace that methodology with income-first deeming. Legislation is required and is found in Section 9 of H 3732.
Estimated savings: $13 million

14. **Expand estate recovery**
DMA proposes three expansions in estate recovery: 1) Federal law requires that Medicaid programs provide procedures and standards for waiving estate recovery claims when they would cause an undue hardship. Currently, DMA will waive an estate recovery claim if certain conditions are met by the requestor. DMA proposes to: a) look at combined family income; b) lower the defined FPL from 200% to 133%; and c) make the initial waiver granting determination a conditional waiver; 2) DMA proposed to use fair market value as the single standard for setting the value in intra-family transfers/sales of property; and 3) DMA currently limits estate recovery to the probate estate of the deceased member. The probate estate limits items to those generally held by the deceased member in his/her name alone. Accordingly, joint ownership of real estate, bank accounts, equities, etc. are excluded from probate and therefore excluded from estate recovery. DMA proposed to recover assets that pass outside of probate. Legislation is required and is found in Section 15, 16, 21 and 28 of H 3732.
Estimated savings: $10 million

TOTAL estimated savings for new FY'04 DMA/Governor Romney Proposals (Legislation Required – H 3732):
$230 million – FY'04 Gross
$167 million – FY'04 Net

II. <u>New FY'04 DMA/Governor Romney Proposals (No Legislation Required)</u>

1. **Expansion of the MassHealth drug list**
DMA implemented the MassHealth Drug List (MHDL) to contain pharmacy expenses by moving to greater use of generic drugs and the most cost effective agent from within a therapeutic class.
Estimated savings: $156 million

2. **Implement a prior authorization trigger for members with 7 or more prescriptions per month**
   DMA is implementing prior authorization to ensure that MassHealth members are not being excessively and/or inappropriately medicated.
   Estimated savings: $20 million

3. **Continue provider rate reductions**
   DMA is in the process of reducing provider rates by up to 5% of payments for almost all providers unless exempt by federal law. Most providers will receive a 3% reduction. Some providers affected by other savings initiatives were not included in these rate reductions. For providers in the first group, rate reductions will take effect no later than April 1, 2003. For the remaining providers, rate reductions will occur in FY'04.
   Estimated savings: $44 million

4. **Reevaluate the clinical eligibility of nursing home patients**
   MassHealth members will be reevaluated periodically to determine whether they meet the new clinical eligibility criteria instead of only on admission or upon transfer to another nursing facility. Residents who do not meet the clinical criteria will no longer be eligible for the MassHealth nursing facility benefit. Providers will no longer be paid for any resident who does not meet the new clinical criteria and will be required to appropriately discharge residents in compliance with all state and federal laws and regulations.
   Estimated savings: $7 million

5. **Coordinate care through the use of contracted physicians (Physicians Access Project) in long-term care facilities**
   This project will assist in the establishment of physician practices in nursing facilities to better manage MassHealth members care.
   Estimated savings: $5 million

6. **Require nursing home beds to be Medicare certified**
   Approximately 40% of nursing home beds in Massachusetts are not Medicare-certified. This project will result in Medicare paying for days that should be covered by Medicare.
   Estimated savings: $10 million

7. **Require all applicants to file for Medicare**
   By law, MassHealth is the payer of last resort. If a MassHealth member is eligible for another type of insurance, including Medicare, it is essential that the member apply for that coverage. DMA believes that some MassHealth members are eligible for Medicare and have not applied.
   Estimated savings: $4 million

8. **Target high cost members for enrollment in care management**
   Care management for high cost members is the management of care for people with chronic diseases who tend to be very high cost.'
   Estimated savings: $15 million

TOTAL estimated savings for new FY'04 DMA/Governor Romney Proposals (No Legislation Required):

$270 million – FY'04 Gross
$134 million – FY'04 Net

IV. Task Force Member Proposals

Eligibility and Benefits

1. **All new residents of the Commonwealth applying for Medicaid benefits shall be eligible for such benefits only after having been a resident of the Commonwealth for a period of twelve months (or eighteen months)**

2. **Modify optional services and optional populations.**

3. **Provide supplemental funding immediately to provide an extension of MassHealth Basic through FY'03**
   The funds could be appropriated from the Tobacco Settlement Fund.

4. **Implementation of a waiver or reduced fee for those individuals unable to pay the Nursing Home Fee**
   The impact of the Nursing Home Fee on families that are not wealthy, but are not eligible for Medicaid is troublesome.

5. **Restore benefits for adult MassHealth beneficiaries (HD 2792)**
   This legislation would restore those benefits that were eliminated through the Governor's 9C cuts. Those benefits include orthotics, prosthetics, eyeglasses, dentures and chiropractic therapy. Additionally, this legislation would restore preventative / restorative dental care to adult MassHealth beneficiaries.

Pharmacy

6. **Program participants should be limited to one doctor for prescriptions and for durable medical equipment (DME)**
   If participants are not limited to one doctor, some participants might "shop" doctors until their needs and wants are met.

7. **Expand the individual packaging of pharmaceuticals for residents of nursing homes**
   Individual packaging would allow the nursing homes to return unused prescription drugs instead of disposing the costly drugs.

8. **Implement a medication return initiative**
   Numerous states including New York require unused, individually packaged medications, ordered for individual patients at long term care facilities, to be returned to the pharmacy for credit. Currently, Massachusetts has a voluntary program to return only eight classes

of medications. Medicaid is paying for the medications for 70% of the nursing home patients in Massachusetts.

9. **Implement provisions of the Massachusetts Prescription Drug Fair Pricing Act (S 55)**
   This legislation would: 1) create the Prescription Drug Fair Pricing Program; 2) require the use of a nonprofit Pharmacy Benefits Manager (PBM) that discloses its revenue sources; 3) enhance savings initiatives at DMA; 4) create the Healthy Massachusetts Discount Card Program; 5) require disclosure of drug company marketing gifts; and, 6) require cooperation and collaboration with other states. The Prescription Drug Fair Pricing Program would, among other things, create a statewide, uniform Preferred Drug List (PDL), create a single purchasing unit to negotiate drug purchasing contracts, implement educational programs for prescribers and consumers and direct all state agencies to participate in the program.

10. **Implement a "Patient Assistance Program" to provide free pharmaceuticals for defined indigent populations**

11. **Implement a psychiatric medication "carve out" for an formulary or preferred drug list requiring prior authorization**

12. **Pursue Medicaid waivers like the "Pharmacy Plus" programs of other states**
    In recent years a number of states have pursued the idea of obtaining federal matching funds through Medicaid for a single benefit and/or coverage for people with incomes above traditional eligibility limits. Beginning in 2000, several states enacted laws and filed Medicaid 1115 waivers seeking approval for this approach to state pharmaceutical subsidy programs.

13. **Review ingredient costs**
    The ingredient cost is the amount the state pays pharmacists for the actual cost of a drug. Recent federal Office of Inspector General reports suggest that states often overpay for these costs. Pharmacists have argued that the federal review methodology is flawed. Massachusetts should do a comprehensive review to assure itself that its payments are appropriate.

14. **Increase enforcement of current pricing rules**
    Pharmacies are required to give MassHealth the best price that they offer to any purchaser. For this "most favored nation" provision to work there must be a credible level of review of pharmacy charges. Administrative enforcement of current pricing rules is often limited by administrative resources. Expanded enforcement could provide financial benefits.

15. **Bulk purchase drugs through a not-for-profit pharmaceutical benefits manager**
    Massachusetts should investigate participating in a multi-state purchasing group which is operated as a non-profit pharmacy benefits manager. The idea is to achieve bulk discounts form manufacturers competing to have their products sold (similar to the

preferred drug list), but also to reduce the ways in which drug companies skew the incentives of commercial pharmacy benefits managers. Massachusetts should also investigate bulk purchasing of medical equipment and supplies.

16. **Increase use of 340(B) pricing**
Safety net hospitals and federally certified free-standing Community Health Centers (federally qualified health centers) have access to greatly discounted drug pricing through a separate federal arrangement with pharmacy manufacturers. In order for patients to be given access to these drugs they must be patients of those institutions. Today, however, only three CHCs in Massachusetts have pharmacies and DMA purchases drugs through a different mechanism. Finding a way to take advantage of these reduced rates for some of the MassHealth population could provide significant savings for the population that is targeted. CHCs are wary of start-up costs and continuing volume. Purchasing drugs through these sites would require integration with other DMA pharmacy initiatives. Significant savings may only be possible if volume is guaranteed through a waiver that restricts consumers to that specific pharmacy for most of their pharmaceutical needs.

17. **Pharmacy case management**
Pharmacy utilizers with certain characteristics such as multiple prescriptions can be targeted for review and case management intervention to review the prescriptions and drug interactions and work with the consumer on medication management. DMA is currently limited in its ability to invest in administrative ideas which save program costs. **DMA would need to be given the flexibility to use programmatic accounts to cover administrative costs.**

18. **Medication costs**
Pharmacies in Massachusetts are allowed to charge nursing facilities according to a variety of pricing structures. There is no consistency across hospitals and nursing facilities as to the cost charged for the same medications. There is no consistency across pharmacies for what they charge to nursing facilities for the same medication. If pharmacies were required to charge nursing homes the same prices as Massachusetts Medicaid pays for the same medications there would be a significant cost savings to nursing facilities.

19. **Suspend current rules until public hearings are held by DMA and other EOHHS agencies on the entire prior approval program**

20. **Require MassHealth to gain approval from the Commissioner of Mental Health for the entire prior approval program in accordance with written procedures, etc.**

21. **Make the prior approval process less cumbersome and more expedient (HD 2777)**

Long Term Care

22. **Continue efforts to shift long-term care expenditures in nursing homes to the more cost-efficient community care settings, including the Community Choices program**

Massachusetts should thoroughly explore federal home and community based waiver options to ensure that the state is maximizing federal revenue and providing enough spaces for qualifying elders. The Community Choices program began last November to offer nursing home eligible seniors on MassHealth a home care service package that enables them to avoid or delay nursing facility placement.

23. **Reduce unnecessary admissions to nursing homes through "pre-screening for long term care services"**
Massachusetts has one of the highest 65+ per capita nursing home utilization levels in the country. The best place to intervene in admissions to nursing homes is at the front door, as elders are being admitted. Currently, the Commonwealth prescreens MassHealth enrollees seeking nursing home care, unless they are being referred by certain "delegated hospitals." These hospital referrals to nursing homes are reviewed by elder affairs subcontractors, but only on an after-the-fact basis. These hospitals often have a financial incentive to move their patients into nursing homes as a way to limit their financial liability under the Medicare Diagnostic Related Grouping (DRG) system. The state could require that all pre-screenings be conducted by the Executive Office of Elder Affairs (EOEA) or its subcontractors, not by hospitals which may have financial incentives to make quick transfers to nursing homes.

24. **Implement "Dollars Follow the Person" legislation**

25. **Change the Medicaid regulations in the Adult Foster Care Program**
Change the regulations in the Adult Foster Care Program to allow, with a physician's consent, a patient more flexibility in regard to the amount of care they receive.

26. **Provide a tax credit for long term care insurance premium payments**

27. **Provide income tax exemptions for families caring for their elderly relatives at home (H 474)**
This proposal could help to reduce spending on long term care as it provides an incentive for families to take care of their elderly relatives in their homes as opposed to costly nursing facilities.

28. **Pursue a 2176 waiver for assisted living and supportive housing**
Develop a waiver program designed to move lower need Skilled Nursing Facility (SNF) patients and some of those applying for SNF entry into Assisted Living and Supportive Housing. The Ruggles' Assisted Living Facility provides a model for how SNF patients who no longer need skilled nursing services may be effectively moved to alternative placements if they are made available. This could provide a direct cost savings to Medicaid by serving people at a more appropriate level of care. Programs like this have been hard to support because federal Medicaid rules cover SNF care but not most of the components of assisted living or supportive housing (the rules prohibit covering room and board). Other funding streams (such as DMH, EOEA and housing agencies) are hard to coordinate. A federal waiver may make it possible to use current non-Medicaid state

dollars for federal match, under the condition that the recipient would otherwise need to be institutionalized.

Care Management

29. **Create incentives for MassHealth members to seek care in the most appropriate and cost efficient setting**
DMA should implement a co-pay scheme for services that would charge members more for services provided at a teaching hospital, for example, and less for services provided at a community hospital or health center. Similarly, co-pays could be increased for non-emergency care that is provided in an emergency room setting. Under federal law, a MassHealth member may be charged a co-payment of up to $3.00 for a covered service that costs more than $50.00. Additionally, DMA should explore the primary care physician (PCP) assignment practices. Data suggests that the yearly health care costs for MassHealth members whose PCP is located at a large teaching hospitals is significantly greater than the yearly costs for MassHealth members whose PCP is located at a community hospital or health center. Modifying PCP assignment practices would require federal review and would need to consider the volume those community hospitals and health centers can support.

30. **Provide early intervention and preventive programs to manage asthma, diabetes, HIV and congestive heart failure**
This short money up-front could save the costly complicated care needed when conditions are not controlled.

31. **Direct public pharmacy managers, physicians and psychiatrists in DMA to oversee pharmacy programs and adjust policies where appropriate**

32. **Implement predictive modeling with care management interventions**
A focus on care management for the most costly DMA consumers has the promise of having the most impact on cost and quality of care. Identifying the most costly group, reaching them and providing supports to them holds real promise. Once these individuals are identified, they are contacted in order to engage them in active care management. This management includes home visits and education. Integration with existing care management efforts is important to implementation and success. In order to initiate a care management approach, DMA should look at products currently available. DMA is currently limited in its ability to invest in administrative ideas which save program costs. **DMA would need to be given the flexibility to use programmatic accounts to cover administrative costs.**

33. **Implement disease management efforts**
Disease management is the focused review and management of patients that present with certain diseases to assure appropriate treatment and on-going management to minimize high cost interventions. Disease management could offer improved health care quality and the prevention of high-cost hospitalizations. Many vendors are available to provide disease management services; integration and coordination of each vendor's management

and education efforts is critical to success. DMA is currently limited in its ability to invest in administrative ideas which save program costs. **DMA would need to be given the flexibility to use programmatic accounts to cover administrative costs.**

34. Implement a planned care model for chronic illness

Planned care is a model for treatment of chronic illness that has four key components: 1) patient training through group sessions with a caregiver to improve self management; 2) case management with a nurse who tracks the client; 3) a patient registry to centralize information on care and clinical testing to monitor patient status; and 4) an information system accessible to providers and patients. Cambridge Health Alliance and six other sites nationwide are pilots for a demonstration project under the Robert Wood Johnson Foundation. This approach is more systemic than current disease management efforts. DMA is currently limited in its ability to invest in administrative ideas which save program costs. **DMA would need to be given the flexibility to use programmatic accounts to cover administrative costs.**

35. Lock-In

Limit MassHealth's consumers' ability to switch MCOs or primary services sites for a minimum period to improve clinical management. Modification to the current 1115 waiver (or additional waivers) would need to be granted by the federal government. However, consumers would still need a reasonable way to switch out of an assigned site if they have problems with access or care. A faster appeals process would need to be developed to assure this. Additionally, this approach would only be successful if MCOs and primary care sites invest in care management.

36. Change MassHealth member assignment practices

MassHealth has relatively high Emergency Department (ED) utilization. Reducing that pattern of use has proven to be difficult. One change that may offer some immediate impact would be to change the assignment patterns so that assignments to tertiary medical centers for primary care are minimized. Modifying assignment would require federal review and would need to consider the volume that non-tertiary primary care providers can support.

37. Reduce day utilization of emergency departments by working with providers and MCOs

Day utilization of EDs remains high. Physical and clinician capacity issues and education must be addressed in order to make progress. A collaborative approach with key providers (including hospitals and CHCs) may yield results.

38. Provider education

Clinicians often receive limited formal training in pharmacology and receive most of their on-going education from drug manufacturers. A number of techniques have been employed in order to counteract inappropriate prescribing practices. Physician profiling could identify physicians who prescribe in a more costly manner than the norm. Clinical pharmacists could consult with psychiatrists to improve appropriate therapeutic regimes. DMA is currently limited in its ability to invest in administrative ideas which save

program costs. **DMA would need to be given the flexibility to use programmatic accounts to cover administrative costs.**

39. **Reduce the number of child/adolescents in hospitals who don't need hospital level of care**
Currently there are approximately 100 children and adolescents being hospitalized on locked psychiatric units who do not need this level of care. Hospitals have proposed the development of alternatives to this expensive and inappropriate care, including the utilization of a resource in western Massachusetts that could provide care to many of these youths. Other ideas include: assess the responsible agencies the difference between the reduced rate and the hospitals' negotiated rate (this would give DSS and DMH incentive to move the youths as well as remove the penalty on the hospitals); enforce the "no-eject" policy on the residences so that they would have to take youths back upon discharge from the hospital; allow out-of-state placements for youth when there is no family involvement; and, require a visit to the hospitalized youth by his/her DSS case worker within one business day of hospitalization.

Administrative Management

40. **Upgrade the computer system at DMA**
The current computer system at DMA is old and inefficient. A newer, more sophisticated system would: allow for cross-checking of each MassHealth applicant with other state and federal agencies to ensure eligibility; perform constant calculations of statistical algorithms to immediately catch and track patterns and schemes of fraud; more easily allow for collection of co-pays and premiums at different levels for different categories of members; provide immediate and understandable explanations of benefits to patients at the time of service; and increase the speed and accuracy of claims processing for providers. The federal government would pay for 90% of the cost of an upgraded computer system.

41. **Implement Explanation of Benefits (EOB) for all patients so they know when and for what services Medicaid is being billed on their behalf (H 719)**
Waste, fraud and abuse associated with provider billing could be reduced by requiring providers to provide EOBs to all MassHealth patients for all services provided.

42. **Ensure that Medicaid is the payer of last resort and that all third party billings are recovered**
Currently, third party billings may not be recovered regularly because DMA's recovery staff is very limited and the computer system does not facilitate the process.

43. **Establish toll-free anonymous "tipster" line**

Review the success of other states that have implemented similar programs, along with a reward for information leading to a conviction (can be a set amount or percentage of savings, with a cap on each).

44. Require all agencies (state purchasing agents) to seek two or more bids from like vendors for the same service

This would assure that DMA (and other agencies) has hired the best company for the job, making it a better business practice.

45. Require that all state purchasing agents show preference in awarding contracts to vendors provide goods and/or services on a contingency fee basis or on a reduced fee plus contingency basis

This "paid-for-performance" type scenario could lead to lower up-front costs to the state.

46. Selectively contract

The state should explore if limited selective contracting for some Medicaid services makes sense for non-MCO populations. Selective contracting means that DMA would purchase some services from a short list of vendors, excluding other vendors from providing those Medicaid services. A new or modified federal waiver would be required.

47. Outsource specialized services

Private companies offer targeted services for radiology, MRI, orthopedics and other claims areas. In addition to disease management their services generally include retroactive claims review for identifying fraud and abuse and inappropriate utilization patterns that can be corrected with prospective medical policies. They also provide clinician education designed to improve utilization of these services. DMA is currently limited in its ability to invest in administrative ideas that save program costs. **DMA would need to be given the flexibility to use programmatic accounts to cover administrative costs.**

48. Claims administration simplification

Providers often complain about the complexity of claims processing both in Medicaid and with other payers. Recent technology may reduce provider frustration and overall administrative expense by offering online claims tracking and easier access to eligibility history. Simplifying certain claims edits could also provide substantial assistance to providers by reducing administrative costs and frustration with the claims process.

49. Encourage entry of new Medicaid managed care organizations (MCOs)

MassHealth MCO coverage has dropped from a high of roughly 33% to 17% at present. Procuring additional MCO services from new vendors could both expand the number of MassHealth recipients under medical management and encourage price and service delivery competition. Expanding managed care coverage may offer financial benefits particularly if new competition with substantial Medicaid experience is introduced.

50. Hospital standards

The State, including the Department of Mental Health (DMH) and the Massachusetts Behavioral Health Partnership (MBHP) should recognize the high quality of care provided by hospitals and also accept the judgment of the Joint Commission on Accreditation of Health Care Organizations (JACHO) and Medicare (CMS) certification. In Massachusetts, both MBHP and DMH apply additional performance standards and regulations that go beyond the JCAHO and Medicare standards. These standards cost the State and the hospitals money through increased staffing and documentation, paperwork and other factors.

51. Streamline approval process for patients who need to be admitted to a psychiatric hospital

Currently, in order for a patient to be hospitalized at a freestanding psychiatric facility a patient usually would be evaluated by four different entities prior to getting onto an inpatient unit. The patient presents at an acute hospital emergency room where he is evaluated; the Emergency Screening Team (ESP) is then contacted to also evaluate the patient; the ESP then evaluates the patient and certifies the admission; the ESP then calls the Massachusetts Behavioral Health Partnership (MBHP) Access Center and review the case to obtain authorization for admission; the patient is then transferred to a psychiatric facility who evaluates the patient and then admits the patient to the unit where care can begin. This process is expensive, redundant, and inconvenient and is not replicated by any other insurer or for any other type of health condition.

52. Increased self-management for providers

The State could reduce the amount of concurrent reviews it conducts for inpatient care. The State, through MBHP has years of data on length of stay for its hospitals. The Commonwealth could manage those hospitals by data, not by daily reviews. There could be monthly or quarterly meetings between MBHP and hospitals to evaluate length of stay performance. Outlier cases could be more closely managed, but for the majority of cases, the care management could be delegated to the hospitals with a retrospective evaluation by the State.

Revenues

53. Maximize potential hospital revenues through Uncompensated Care Pool (UCP)

Federal Financial Participation (FFP) for the Uncompensated Care Pool could be increased by a plan which includes increased pool assessments. The assessment could be used as the state match for FFP. (Some portion of the revenues could also be spent on a hospital rate increase to offset the impact of the hospital assessment and to encourage hospital support for the proposal.)

54. Gain federal match for Community Health Center (CHC) Expenditures in Uncompensated Care Pool (UCP)

$20 million of the UCP is now distributed to CHCs for uncompensated care. These funds could be matched with $10 to $20 million of federal dollars if the expenditures were Medicaid, not Pool expenditures. Uncompensated care reimbursements would need to be converted into Medicaid CHC rate increases.

55. **Maximize federal revenues for payments to Intermediate Care Facilities (ICF)**
An assessment on revenues could be applied to ICFs. Most ICFs are state run and all ICFs are fully dependent on state revenue.

56. **Actively pursue supplemental rebates**
Massachusetts should actively pursue better pricing from drug manufacturers.

57. **Assess employers with 50 or more employees who do not offer health insurance coverage to all employees (full-time and part-time) and use the generated revenue to fund the Uncompensated Care Pool (UCP)**
The annual assessment per uninsured employee would be $2144 (one half the cost of a standard plan, estimated at $4288 in 2003; projected from the most popular plan reported in the Division of Health Care Finance and Policy (DHCFP) employer survey of 2001: $3545 plus 10% increase per year in 2002 and 2003).

58. **Passage of a tax that would specifically be targeted to Medicaid and MassHealth Basic**

59. **Exempt acute care hospitals from any requirement to contribute any amount to uncompensated care pools of any type**

Miscellaneous

60. **Include language to commission a study of health care benefits for state workers that would allow for the accumulation of medical savings accounts to leverage base premium savings**

61. **Tort reform—cap awards for medical malpractice**
Liability insurance premiums have increased dramatically. Insurance is difficult to obtain with only a limited number of companies willing to underwrite nursing facilities.