MASSHEALTH: THE BASICS

FACTS AND TRENDS

PREPARED BY
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EXECUTIVE SUMMARY

MassHealth is an essential health safety net for nearly 1.9 million of the state's residents:

- MassHealth is Massachusetts' Medicaid and Children's Health Insurance programs. It provides health insurance to more than one in four Massachusetts residents. Implementation of the Affordable Care Act (ACA) brought steep enrollment growth, but enrollment has leveled off in the last two years. More than half of the population with disabilities, more than 40 percent of all children, three-fifths of people in low-income families, and nearly 60 percent of residents of nursing facilities rely on MassHealth to help them pay for health care.
- MassHealth covers services that commercial insurance typically covers, plus other benefits such as long-term services and supports (LTSS) and additional behavioral health care services.

MassHealth covers a broad cross-section of the population:

- Three-quarters of MassHealth members are children and non-elderly adults without disabilities. Seniors (over age 65) make up 9 percent of members, and adults and children with disabilities comprise 16 percent.
- Though they are just one-quarter of members, about 58 cents of every MassHealth dollar is spent for the care of seniors or members with disabilities.
- Implementation of ACA coverage provisions has shifted the makeup of MassHealth membership toward more adults without disabilities.
- Many people with disabilities qualify through MassHealth's CommonHealth program, which offers benefits to persons with disabilities that are not generally available through employers or Medicare. CommonHealth can supplement other private insurance or Medicare to provide benefits that are critical to maintaining independence, such as personal care assistance services.

MassHealth supports workers' access to private insurance:

- For more than one-fifth of its members, MassHealth coverage is secondary to other insurance such as Medicare, employer-sponsored insurance or student health insurance. MassHealth benefits help make employer-sponsored insurance more affordable for eligible low-wage workers and their children by paying for the employee share of the premium and by covering most of the cost of co-payments and deductibles. In addition, MassHealth benefits make it possible for many people with disabilities to work.
- The coordination of public and private sources of coverage allows MassHealth to leverage other funding sources, which is critical to sustainability of the program.

MASSHEALTH: THE BASICS

EXECUTIVE SUMMARY (continued)

MassHealth enrollment continued to grow even as the number of uninsured leveled off, but has slowed recently:

- MassHealth enrollment grew steadily from 1997 to 2013; after a leap following ACA implementation in 2014, enrollment has leveled off in the last two years.
- The number of Massachusetts residents without insurance declined from 2004 to 2010, increased through 2012, and has been stable since.

Nearly 70 percent of MassHealth members receive their health care in a managed care arrangement:

- Forty-four percent of members are enrolled in a MassHealth-contracted private managed care organization and 22 percent with the state-administered Primary Care Clinician Plan.
- Almost 70,000 "dual eligibles" — MassHealth members who also have Medicare — are enrolled in managed care plans: 50,000 in Senior Care Options, and about 17,000 in One Care, for adults with disabilities age 21 to 64.

MassHealth is an important source of income for some provider types:

- Community health centers, nursing homes, and community-based providers of LTSS receive around half of their total patient revenues from MassHealth.

MassHealth spending growth in recent years was driven by membership growth:

- Total MassHealth spending (not inflation-adjusted) has nearly doubled in the last 10 years, reaching $14.8 billion in 2016. Spending accelerated in the last three years, as enrollment grew.
- Per-member spending has grown slowly in the past decade, increasing less than 2 percent per year on average.

MassHealth has been consuming a growing portion of the state budget, and is also an important source of federal revenues to the state:

- Federal and state spending on MassHealth represents nearly 40 percent of the state's budget. The program brings in more than 90 percent of all federal revenues received by the state.

MassHealth has embarked on a comprehensive reform effort to transform the delivery of care and how it is paid for:

- MassHealth is undertaking an initiative to contain costs and improve quality by paying for the value of care rather than the volume.
- Beginning in 2018, accountable care organizations will provide coordinated, comprehensive care to about two-thirds of MassHealth members.
- Massachusetts will receive $1.8 billion in federal funding over five years to support the transformation.

MASSHEALTH OVERVIEW

MassHealth is Massachusetts' name for its Medicaid and Children's Health Insurance (CHIP) programs. MassHealth provides coverage for more than a quarter of the state's residents and has been the centerpiece of state health care reform and an important contributor to the state having more than 96 percent of its people covered by health insurance.

Crucially, MassHealth serves as a safety net — the insurer of last resort — for some of the state's most disadvantaged residents and many with very complex health care needs. MassHealth covers low-income families for whom employer-sponsored coverage is unavailable or unaffordable, people who are affected by economic downturns, and people with physical, behavioral, and intellectual disabilities, among others. It offers assistance with premiums, co-payments, and additional benefits to people who have another source of primary coverage, such as Medicare or an employer plan, but who are challenged by the cost of that coverage.

MassHealth benefits other stakeholders in the health care system. It pays health care providers (primary care physicians, community health centers, hospitals, nursing homes, and others) for treatments that would otherwise go uncompensated or would simply not be provided at all. It provides a valuable service to employers by covering some of the highest cost services for their employees and employees' dependents with disabilities. It brings billions of federal dollars to the state: the program is administered by the state, but funded jointly by the state and federal government. These federal funds help stretch dollars the state spends for health care and long-term care for populations with a high level of need.

MASSHEALTH CHALLENGES

Massachusetts' preeminent challenge today is to bring MassHealth spending under control, while maintaining or improving the quality of service its members receive. MassHealth spending has grown from $7.5 billion in 2007 to $14.8 billion in 2016. Costs can be high because members with low incomes or with disabilities tend to have greater health care needs, on average, than the general population. As is the case with other parts of the health care system, care also is often fragmented and uncoordinated across providers, which can lead to inefficiencies and higher costs.

Historically, a key cost containment strategy for MassHealth has been holding down the rates it pays to providers for services and to managed care organizations (MCO) to deliver comprehensive care to members. Spending has swelled since the implementation of the Affordable Care Act (ACA), which increased MassHealth enrollment by hundreds of thousands of members. Nearly half of MassHealth spending is capitation payments to MCOs. Another fast-growing component — reflecting a successful policy shift away from facility-based care — is for community-based long-term services and supports (LTSS), which exceeded $2 billion in 2016.

MassHealth has now embarked on a more comprehensive strategy to manage costs, while also improving quality and the member experience by better integrating services and basing payments on value rather than volume. MassHealth is currently in contract negotiations with 17 accountable care organizations (ACO), which, beginning in 2018, will be the vehicle for carrying out this strategy.

MASSHEALTH PROVIDES COVERAGE SIMILAR TO COMMERCIAL INSURANCE, PLUS SOME ADDITIONAL BENEFITS

MassHealth

Covers typical commercial benefits, plus:

- Long-term services and supports (facility and community)*
- Diversionary behavioral health services (to avert hospitalization)
- Dental services
- Transportation to medical appointments*

+

Typical Commercial Insurance Coverage

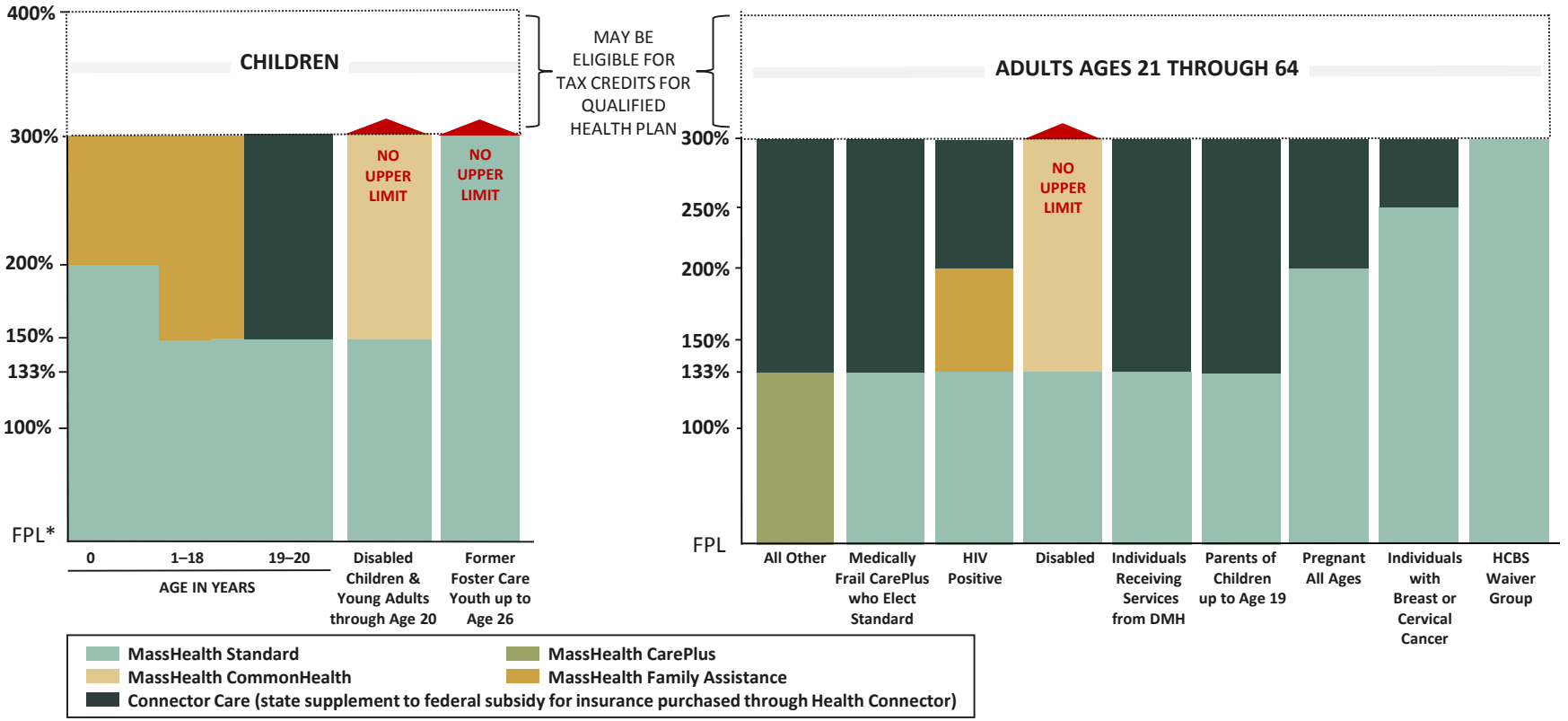
- Hospital services
- Physician services
- Well child visits
- Ancillary services (lab, radiology, etc.)
- Mental health/substance use treatment
- Prescription drugs
- Vision, hearing, medical equipment

* LTSS and transportation to medical appointments are available to most but not all MassHealth members.

WAIVERS

WHAT IS A WAIVER?	States may request approval from the federal government to waive certain parts of federal Medicaid law, to test program innovations or gain more flexibility in how they deliver and pay for Medicaid services. MassHealth has two types of waivers, which are authorized under Sections 1115 and 1915c of the Social Security Act.
1115 DEMONSTRATION WAIVER	The MassHealth program operates under the authority of an 1115 demonstration waiver for all members under age 65, except those who are eligible based on institutional status and a small number of other members. The waiver was first implemented in 1997, and has evolved through six extensions to expand coverage, support the safety net, provide incentives for delivery system innovations, and serve as a platform for health care reform. An important condition of all 1115 waivers is that they be "budget neutral," meaning the federal government will contribute no more to a waiver program than it would to a Medicaid program operating under standard rules. As part of the latest extension approved in November 2016, MassHealth is planning a comprehensive transformation of how care is delivered and paid for, including contracting with newly formed ACOs and moving decisively toward payments based more on the value of services rather than the number of services delivered.
1915c HOME & COMMUNITY-BASED SERVICES (HCBS) WAIVERS	HCBS waivers permit states to provide LTSS in a home or community setting to members whose disabilities qualify them for an institutional level of care. Services include home health care, personal care, habilitation, respite, physical and occupational therapy, group adult care, home modification, assistive technology, and others. MassHealth obtains federal matching funds on expenditures made by the agencies that authorize and oversee the services, such as the Executive Office of Elder Affairs, the Department of Developmental Services, the Department of Mental Health (DMH), and the Massachusetts Rehabilitation Commission. The state must demonstrate that providing the HCBS waiver services does not cost more on average than providing those services in an institution. In addition, the programs have enrollment limits. MassHealth has 10 HCBS waivers, which are an important component of the Commonwealth's "Community First" policy. The waiver programs are targeted to specific populations: ▪ Elders age 60 and over with physical disabilities (Frail Elder Waiver) ▪ Adults age 22 and over with intellectual disabilities (Community Living, Intensive Supports, Adult Supports Waivers) ▪ Adults age 22 and over with acquired brain injuries (ABI) (ABI Residential, ABI Non-Residential, Traumatic Brain Injury Waivers) ▪ Adults and Elders age 18 and over with physical disabilities who are moving from a facility back to the community (Money Follows the Person Community Living and Residential Supports Waivers) ▪ Children age 0 to 8 with autism (Children's Autism Spectrum Disorder Waiver)

MASSHEALTH ELIGIBILITY UNDER ACA



*FPL = income as percent of federal poverty level; in 2016 100% FPL for a family of four was $24,300.

NOTES: MassHealth Limited, not shown in chart, provides emergency health services to people who, under federal law, have an immigration status that keeps them from getting more services. Income eligibility for this population is equivalent to MassHealth Standard: 200% FPL for pregnant women and children up to age 1, 150% FPL for children ages 1–20 years; 133% FPL for adults 21–64. In general, the eligibility level for seniors age 65 and older is 100% FPL and assets of up to $2,000 for an individual or $3,000 for a couple. More generous eligibility rules apply for seniors residing in nursing facilities or enrolled in special waiver programs.

ELIGIBILITY FOR SENIORS AGE 65 AND OLDER IS MORE STRINGENT, THOUGH MOST ALSO HAVE MEDICARE

POPULATION	INCOME/ASSETS*	COVERAGE
Living in community, with or without Medicare eligibility, citizen or lawfully present immigrant	100% FPL <=$2,000 Assets	Comprehensive coverage through MassHealth Standard or Family Assistance (based on immigration status); those with Standard also have coverage of Medicare cost sharing and premiums.
Living in community, undocumented non-citizen	100% FPL <=$2,000 Assets	MassHealth Limited — Emergency services only.
Living in community, eligible for Medicare	100% FPL <=$7,280 Assets	MassHealth Senior Buy-In — Covers Medicare premiums, co-pays, and deductibles. Does not cover other MassHealth Standard services.
Living in community, eligible for Medicare	>100%–135% FPL <=$7,280 Assets	MassHealth Buy-In — Covers Part B premiums only. People who meet a spend-down deductible may also qualify for MassHealth Standard.
Living in or waiting for facility-based long-term care	No specific income limit <=$2,000 Assets	MassHealth Standard — Including LTSS; member must pay income minus a monthly personal needs allowance towards nursing facility care.

NOTES: Seniors (age 60 or older) can qualify for MassHealth through the Frail Elder Waiver with income up to 300% of the SSI benefit rate ($26,400 in 2016). Asset limits listed are for individuals; the amounts for couples are higher. See http://www.mass.gov/eohhs/docs/masshealth/membappforms/saca-1-english-mb.pdf.
*Certain assets — home (in most cases), vehicle, life insurance, and burial expenses up to $1,500 — are excluded.

MANY DOORS TO MASSHEALTH

Individual applies directly, by phone, on paper form, with assistance at a MassHealth Enrollment Center or Health Connector walk-in center or through the Health Connector website (see below)

Health care providers assist patients with applications

- Hospitals
- Community health centers
- Nursing homes
- Other providers

State social services agencies facilitate applications

- Department of Developmental Services
- Department of Mental Health
- Mass Rehabilitation Commission
- Department of Transitional Assistance
- Department of Children and Families
- Other agencies

Community organizations and advocacy groups that provide health care referrals or other services assist clients with applications and follow-up

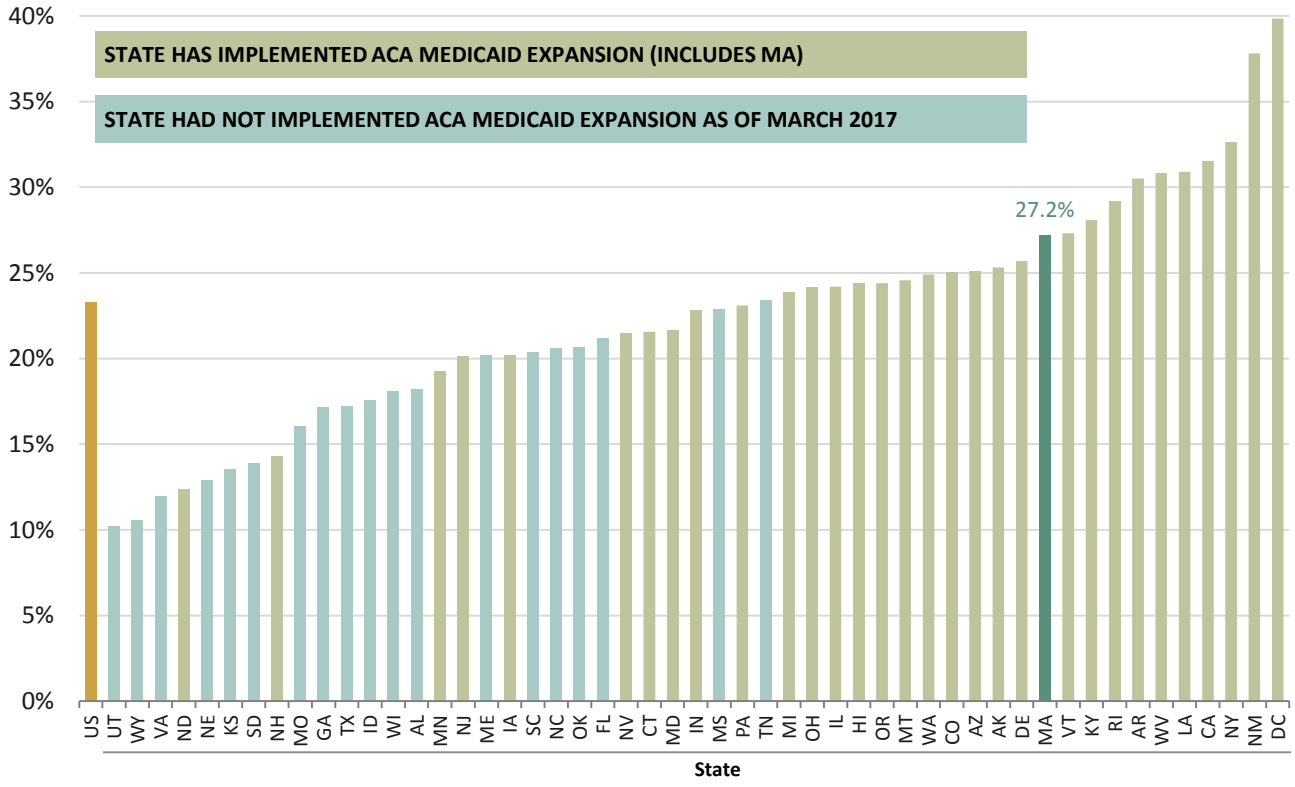
- Community action programs
- Community development corporations
- Aging services access points
- Health Care For All
- Other community organizations designated as Enrollment Assisters

MAHealthConnector.org

An integrated eligibility system that allows individuals to shop and apply for health insurance while determining eligibility for MassHealth and other health insurance programs. (The Virtual Gateway, formerly the online portal for MassHealth applications, is still available to apply for other public programs and provides information on MassHealth eligibility.)

MASSHEALTH PROVIDES COVERAGE TO MORE THAN ONE IN FOUR MASSACHUSETTS RESIDENTS

PERCENTAGE OF POPULATION ENROLLED IN MEDICAID, MARCH 2017



SOURCES: Calculations based on Medicaid enrollment data from the Centers for Medicare and Medicaid Services, "Medicaid & CHIP: March 2017 Monthly Applications, Eligibility Determinations and Enrollment Report"; enrollment includes CHIP. Massachusetts enrollment is as of March 2017 from May 2017 MassHealth Snapshot Report. Population estimates for July 1, 2016 from the U.S. Census Bureau.

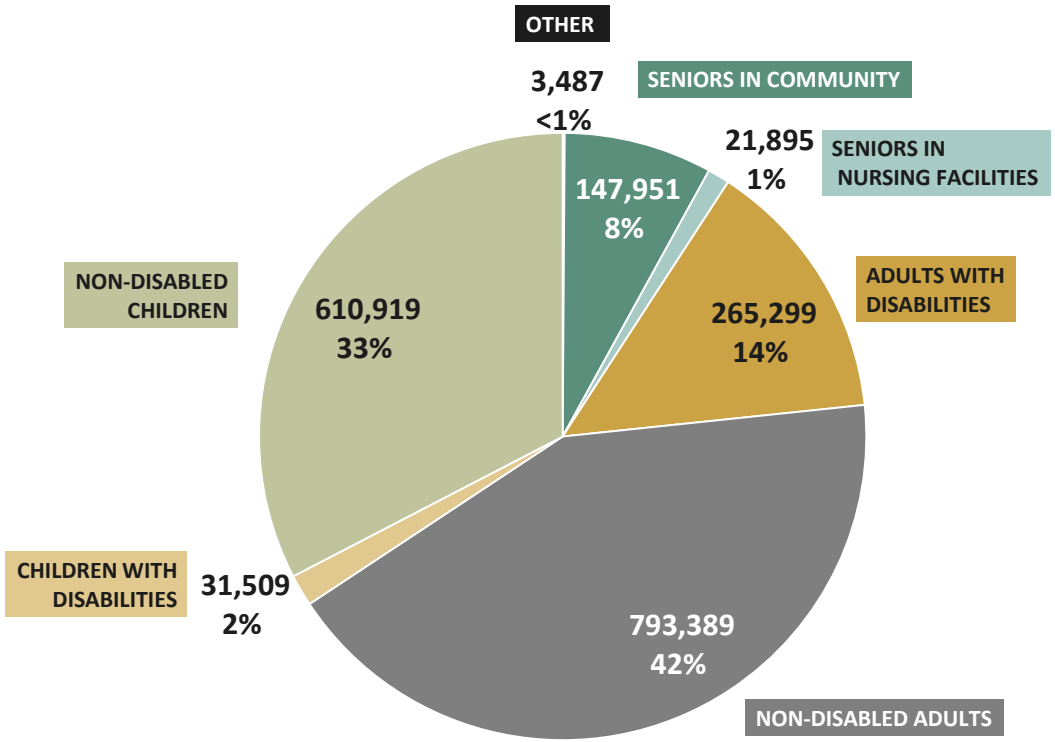
States that exercised the ACA option to expand their Medicaid programs to cover most residents with incomes up to 138 percent of the federal poverty level (FPL) tend to cover a larger portion of their residents in Medicaid than states that did not expand. Massachusetts, which covers more than one-quarter of its people in MassHealth, is among the expansion states.

This high level of MassHealth participation contributes to Massachusetts's lowest-in-nation uninsured rate.

[Note: The Massachusetts bar in this chart uses a different source of data from the rest of the states. Using the same source, Massachusetts would fall between Oregon and Montana, at 24.4 percent.]

MASSHEALTH COVERS CHILDREN, ADULTS, AND SENIORS, AND OFTEN SUPPLEMENTS OTHER INSURANCE

PERCENT OF TOTAL MASSHEALTH ENROLLMENT (1.87 MILLION), MAY 2017



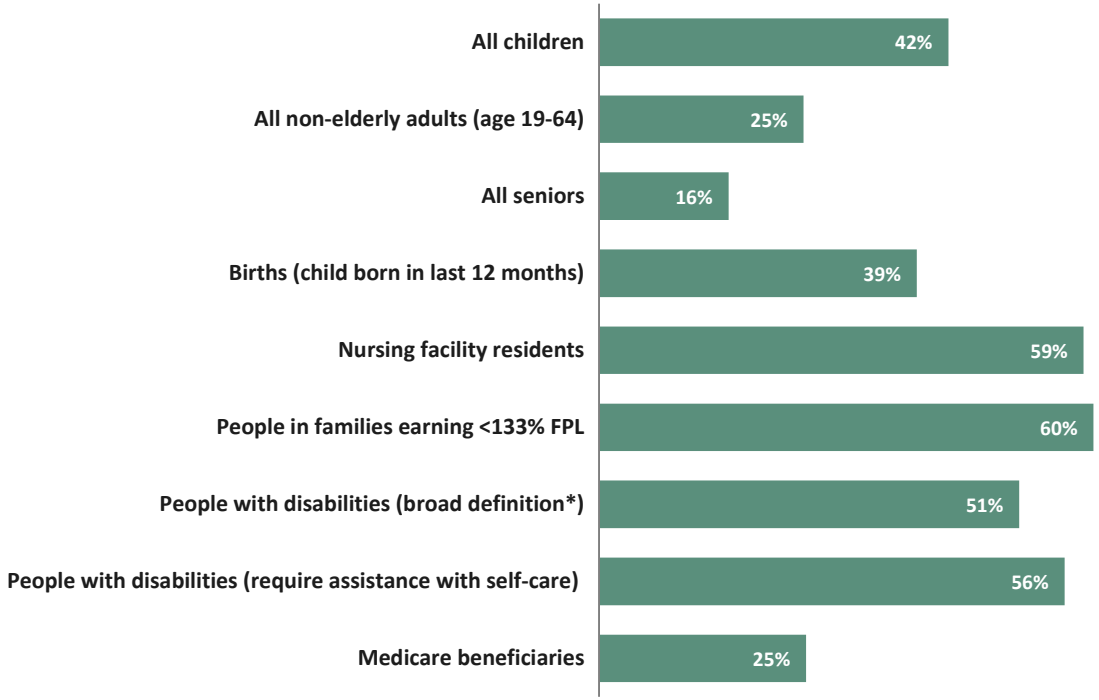
SOURCE: MassHealth, May 2017 Snapshot Report.

MassHealth members range from the very young to the very old. Non-disabled adults under age 65 are now the largest group of members. Children comprise about a third of MassHealth members. Members with disabilities represent 16 percent of membership. Nearly one out of every 10 MassHealth members is age 65 or over. Most of these seniors also have Medicare coverage, and most live in non-facility settings in their communities.

About 23 percent of MassHealth members have coverage through Medicare, an employer, or student health insurance and MassHealth acts as secondary coverage (not shown in chart). In some circumstances, MassHealth also pays members' premiums and cost sharing for their employer-sponsored or Medicare coverage, if it is more economical than paying directly for MassHealth benefits.

MASSHEALTH IS IMPORTANT TO MANY POPULATION GROUPS

PERCENT OF SELECT MASSACHUSETTS POPULATIONS COVERED BY MASSHEALTH, 2015



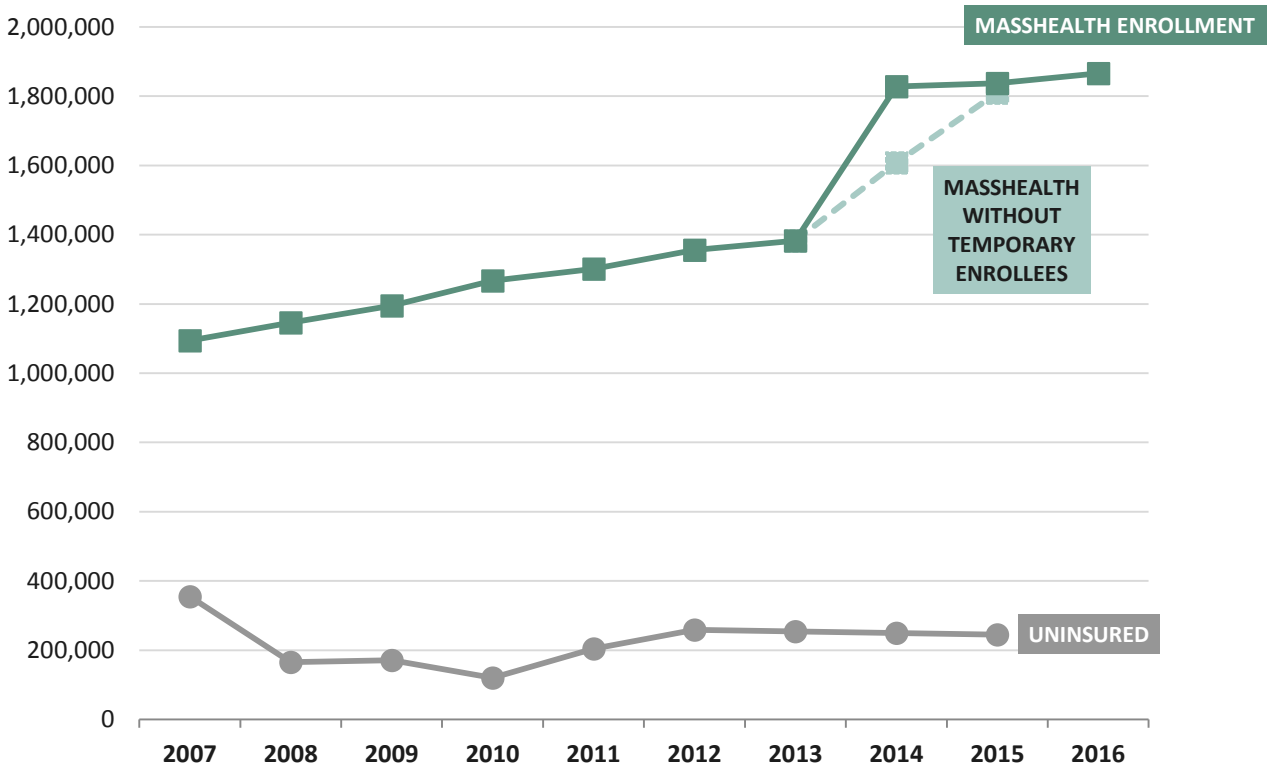
*Deaf or serious difficulty hearing; blind or serious difficulty seeing; cognitive, ambulatory, self care or independent living difficulty

SOURCES: Authors' calculations using the 2015 American Community Survey (ACS). Nursing facility data from MassHealth bed census and payment category data as of July 2015. Data for "all children," "all non-elderly adults," and "all seniors" calculated from 2015 ACS population data and MassHealth Snapshot report, enrollment for 12/31/15, as of May 2017.

More than four in 10 children in Massachusetts and about one-quarter of adults under age 65 are MassHealth members. MassHealth is an especially important source of coverage for people with low income (below 133% FPL), of whom three-fifths are members, and people with disabilities, of whom more than half rely on MassHealth. Six out of 10 nursing home residents are MassHealth members.

MASSHEALTH ENROLLMENT GREW AS THE NUMBER OF UNINSURED LEVELED OFF, BUT HAS SLOWED RECENTLY

TRENDS IN MASSHEALTH ENROLLMENT AND UNINSURED, CY2007–2016



SOURCES: MassHealth figures monthly averages from the Office of Medicaid. Uninsured numbers for 2007–2011 from the Division of Health Care Finance and Policy, from a survey in that year, for 2012–2013 from the ACS, and for 2014–2015 from the Massachusetts Health Insurance Survey, conducted by the Center for Health Information and Analysis (CHIA). Uninsured data from CHIA for 2016 not available.

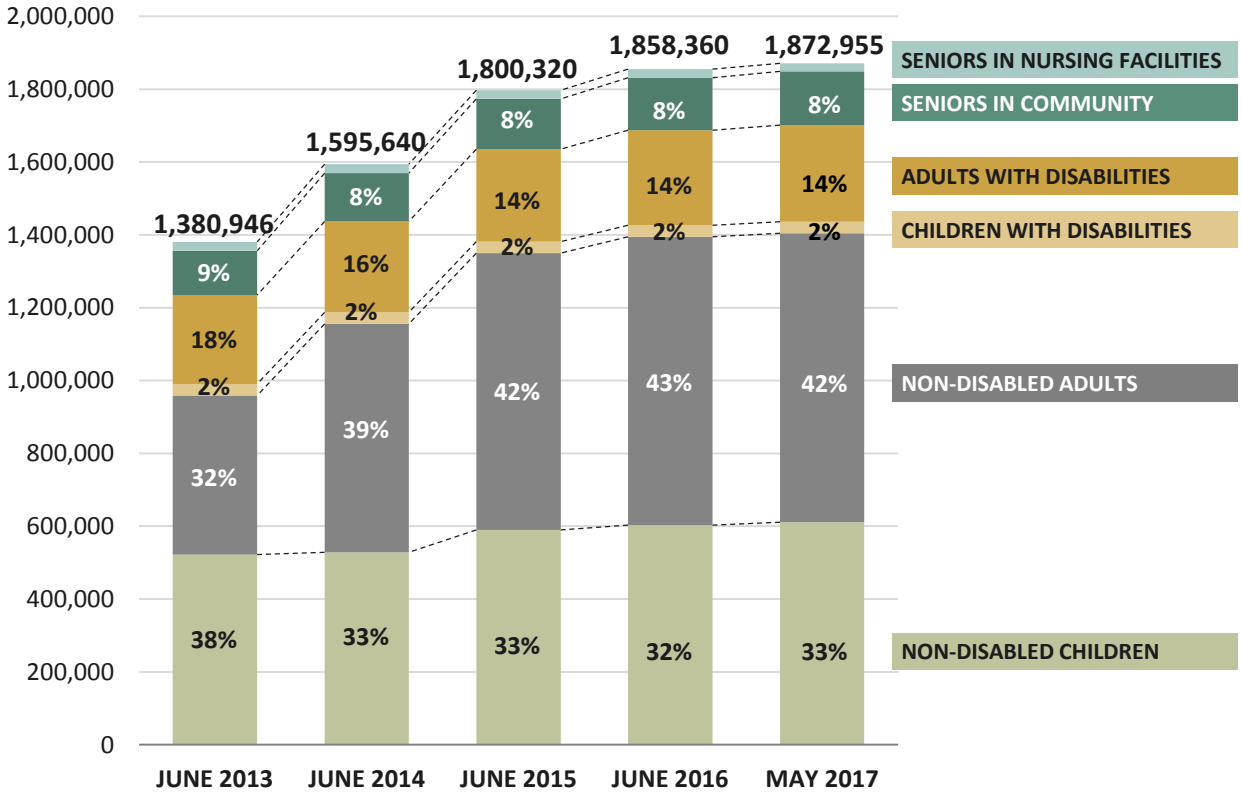
MassHealth enrollment has steadily grown over the past decade, with a large increase in 2014 coinciding with ACA implementation. The trend has leveled off in the past two years, but MassHealth enrollment still grew slightly faster than the overall population.

The number of Massachusetts residents without insurance declined steadily, beginning in 2004 (not shown in chart), through 2010. Commonwealth Care, introduced in 2007 and replaced in 2015 by ConnectorCare, played a role in the decline. The number of uninsured increased between 2010 and 2012 but then stabilized.

[Note: Recent Census Bureau estimates suggest a decline in the number of uninsured in Massachusetts; Census estimates 171,000 uninsured in 2016.]

ACA IMPLEMENTATION HAS DRIVEN RECENT MASSHEALTH ENROLLMENT GROWTH, SHIFTING THE DISTRIBUTION OF MEMBERS TOWARD NON-ELDERLY, NON-DISABLED ADULTS

DISTRIBUTION OF MASSHEALTH ENROLLMENT, 2013–2017
(NUMBER OF MEMBERS)



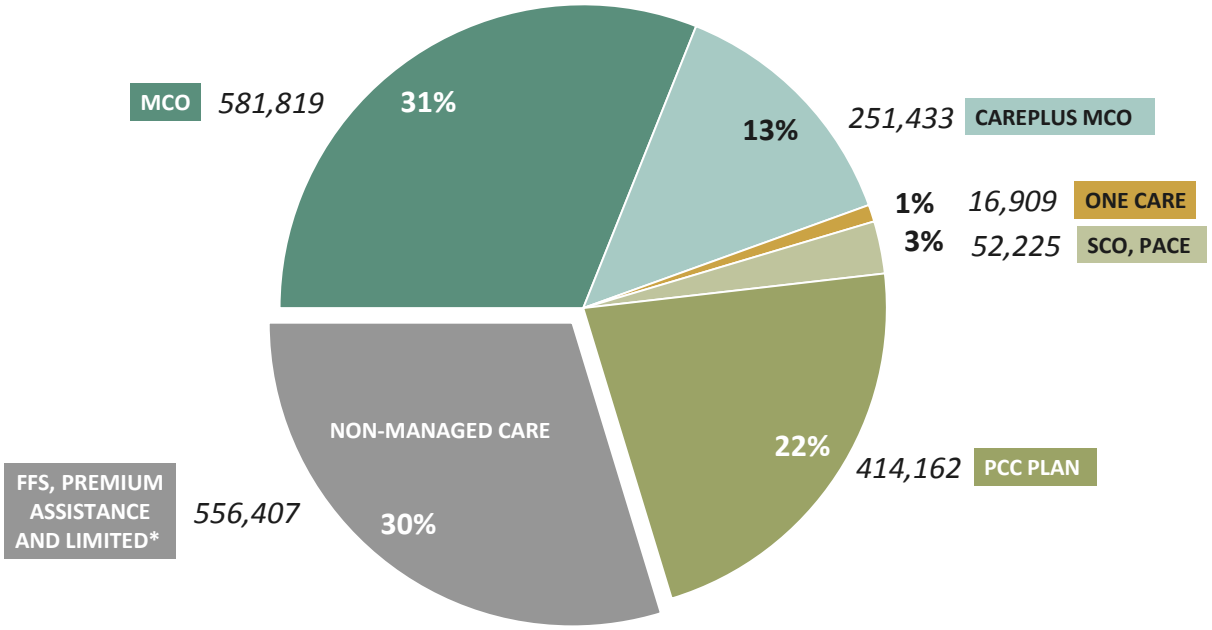
SOURCE: MassHealth, May 2017 Snapshot Report. Figures exclude applicants assigned "Temporary Medicaid" status in 2014. Percentages may not sum to 100 due to rounding.

MassHealth membership grew by nearly 500,000 people over the last four years. Most of that growth (over 70%) occurred among non-elderly adults without disabilities, many of whom became eligible for the first time in January 2014, when the ACA's Medicaid expansion took effect. Non-disabled adults now represent 42 percent of the total MassHealth membership, an increase from 32 percent in 2013.

Other populations whose eligibility was not directly affected by the ACA grew as well: children without disabilities (17%), seniors (16%), and adults with disabilities (9%). Seniors living in the community increased 22 percent, and seniors in nursing facilities declined 11 percent. The number of children with disabilities enrolled in MassHealth has been steady, between 31,000 and 32,000, over the five-year period.

SEVENTY PERCENT OF MASSHEALTH MEMBERS ARE ENROLLED IN MANAGED CARE

MASSHEALTH ENROLLMENT BY PAYER TYPE, MAY 2017



*MassHealth Limited provides coverage for emergency medical services for 157,000 undocumented non-citizens.
SOURCE: MassHealth, May 2017 Snapshot Report.

Members under age 65 have two managed care enrollment options: the MassHealth-administered Primary Care Clinician (PCC) Plan or a MassHealth-contracted private MCO. ACOs will become a new option during state fiscal year (SFY) 2018. People with disabilities under 65 who have MassHealth and Medicare may enroll in One Care. Seniors may enroll in Senior Care Options (SCO) or, if they have significant disabilities, in the Program of All-Inclusive Care for the Elderly (PACE — available for age 55 and older). New enrollees under the ACA are enrolled in CarePlus.

Members not in managed care are in fee-for-service (FFS). They include members with Medicare not enrolled in One Care, SCO or PACE, people with other coverage as primary (e.g., employer-sponsored insurance), people who live in an institution, and people with limited coverage due to their immigration status.

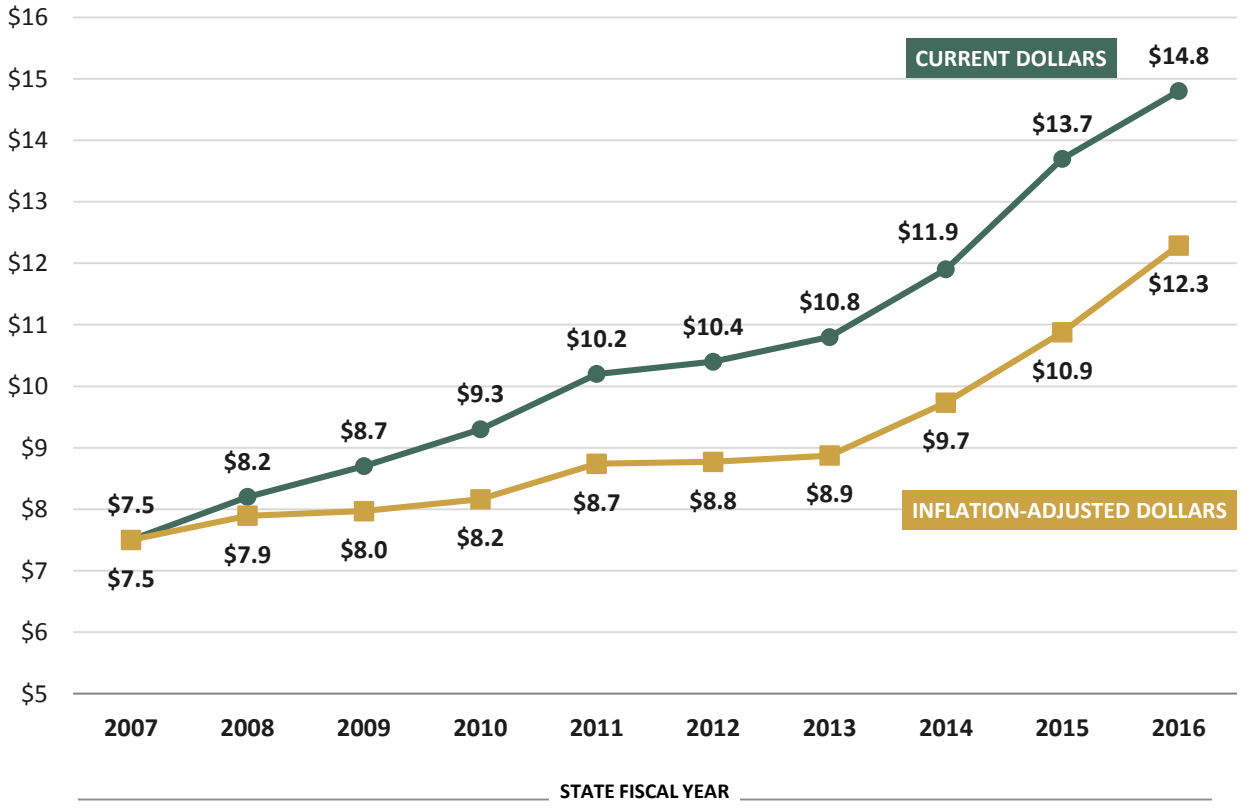
MANAGED CARE: PROGRAM FEATURES

MANAGED CARE PROGRAM	POPULATIONS SERVED	COVERED SERVICES
Managed Care Organizations (MCO)	MassHealth Standard, Family Assistance, and CarePlus members under age 65	Medical and behavioral health services are covered by a capitated payment* to health plans. LTSS and dental benefits are not included in MCO benefit but available through MassHealth Fee-For-Service.** LTSS benefits are not part of the CarePlus benefit package.
Primary Care Clinician (PCC) Plan	MassHealth Standard, Family Assistance, and CarePlus members under age 65	Medical services are paid fee-for-service and are managed by a primary care clinician. Behavioral health services are covered by capitated payment to a behavioral health plan. Dental and LTSS benefits are available and paid fee-for-service.
One Care	Ages 21–64 with MassHealth and Medicare	Full spectrum of services covered by capitated payment to a single health plan (includes LTSS, dental, and behavioral health).
Program of All-Inclusive Care for the Elderly (PACE)	Ages 55+; must meet clinical eligibility for nursing facility level of care	Full spectrum of services covered by capitated payment to a single provider (includes LTSS, dental, and behavioral health). Care is integrated via an interdisciplinary care team with many services provided at an adult day health center.
Senior Care Options (SCO)	Ages 65+ most of whom also have Medicare coverage	Full spectrum of services covered by capitated payment to a single health plan (includes LTSS, dental, and behavioral health).

***Capitated payment:** A monthly payment to a health plan for each enrollee; in return the health plan must provide or arrange for all medically necessary covered services.
****Fee-for-service (FFS) payment:** A payment made to providers for each service delivered.

NOMINAL MASSHEALTH SPENDING NEARLY DOUBLED OVER TEN YEARS; WHEN ADJUSTED FOR MEDICAL COST INFLATION, GROWTH WAS GRADUAL UNTIL 2014

MASSHEALTH TOTAL PROGRAMMATIC CASH SPENDING, SFY2007–2016
(BILLIONS OF DOLLARS)



NOTE: MassHealth spending amounts for some years may differ from amounts reported in earlier versions of *MassHealth: The Basics* due to a change in the approach used to calculate the total spending figure.
SOURCES: MassHealth Budget Office. Inflation adjustment uses the Medical Consumer Price Index for the Boston area, from the U.S. Bureau of Labor Statistics.

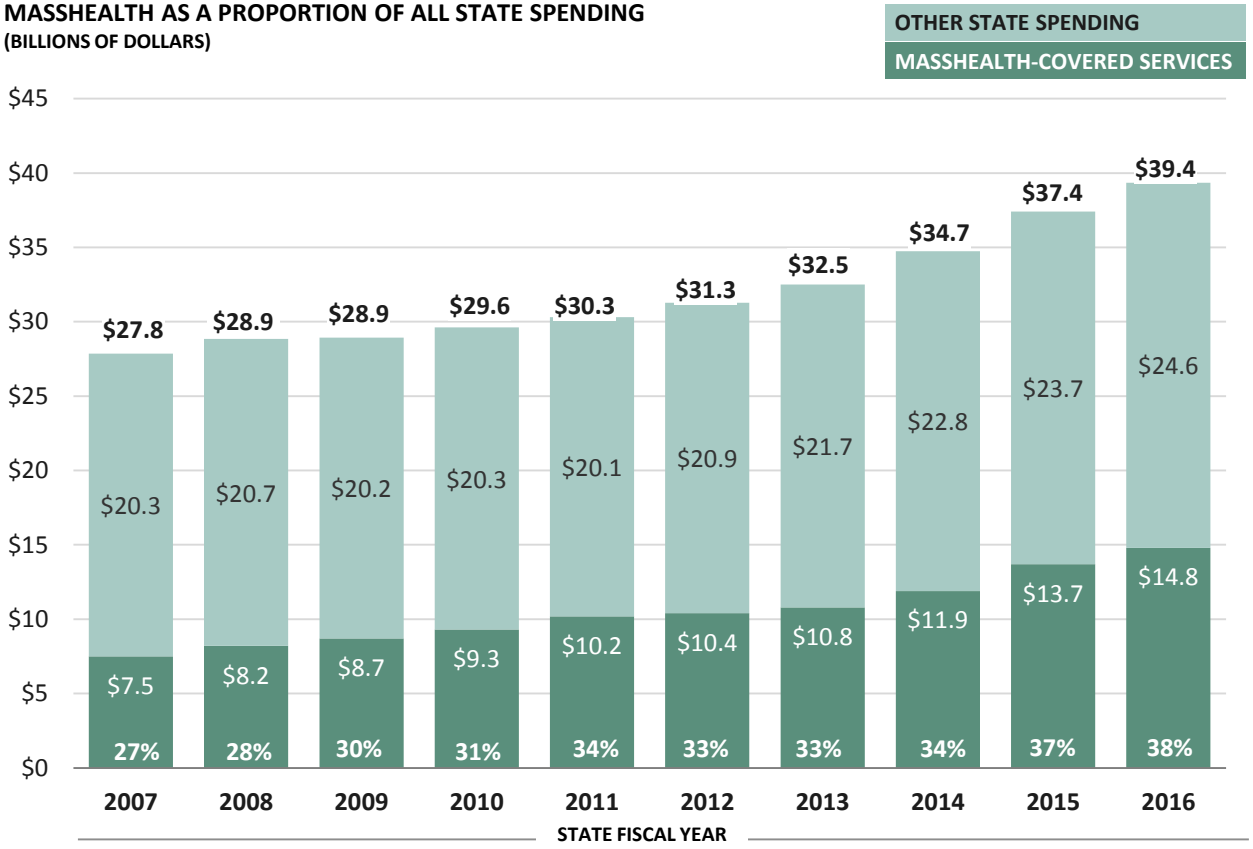
MassHealth program spending has nearly doubled in ten years, from $7.5 billion in SFY2007 to $14.8 billion in SFY2016. Adjusting for medical cost inflation, the average annual increase from SFY2007–2013 was under 3 percent. Annual increases since SFY2013 have been 9.7, 11.8, and 13.0 percent. Most of the recent growth is attributable to enrollment increases resulting from the ACA expansion.

These are gross spending amounts, including both state and federal revenues.

The spending amounts include payment for medical benefits provided by MassHealth, including Medicare premiums, and do not include the cost of Medicaid-reimbursable services from other state agencies, administrative spending, or supplemental payments to hospitals.

STATE AND FEDERAL SPENDING ON MASSHEALTH REPRESENTS NEARLY 40 PERCENT OF THE STATE BUDGET

MASSHEALTH AS A PROPORTION OF ALL STATE SPENDING
(BILLIONS OF DOLLARS)



NOTE: MassHealth spending includes medical benefits provided by MassHealth and other benefits, most notably Medicare premiums. The figures do not include Medicaid-reimbursable services from other state agencies, administrative spending, or supplemental payments to hospitals. MassHealth spending amounts for some years may differ from amounts reported in earlier versions of *MassHealth: The Basics* due to a change in the approach used to calculate the total spending figure.
SOURCES: EOHHS (MassHealth data); Office of the Comptroller, Statutory Basis Financial Reports (other state spending). Mass Budget and Policy Center (calculation of state spending net of federal revenues; SFY2018 estimate).

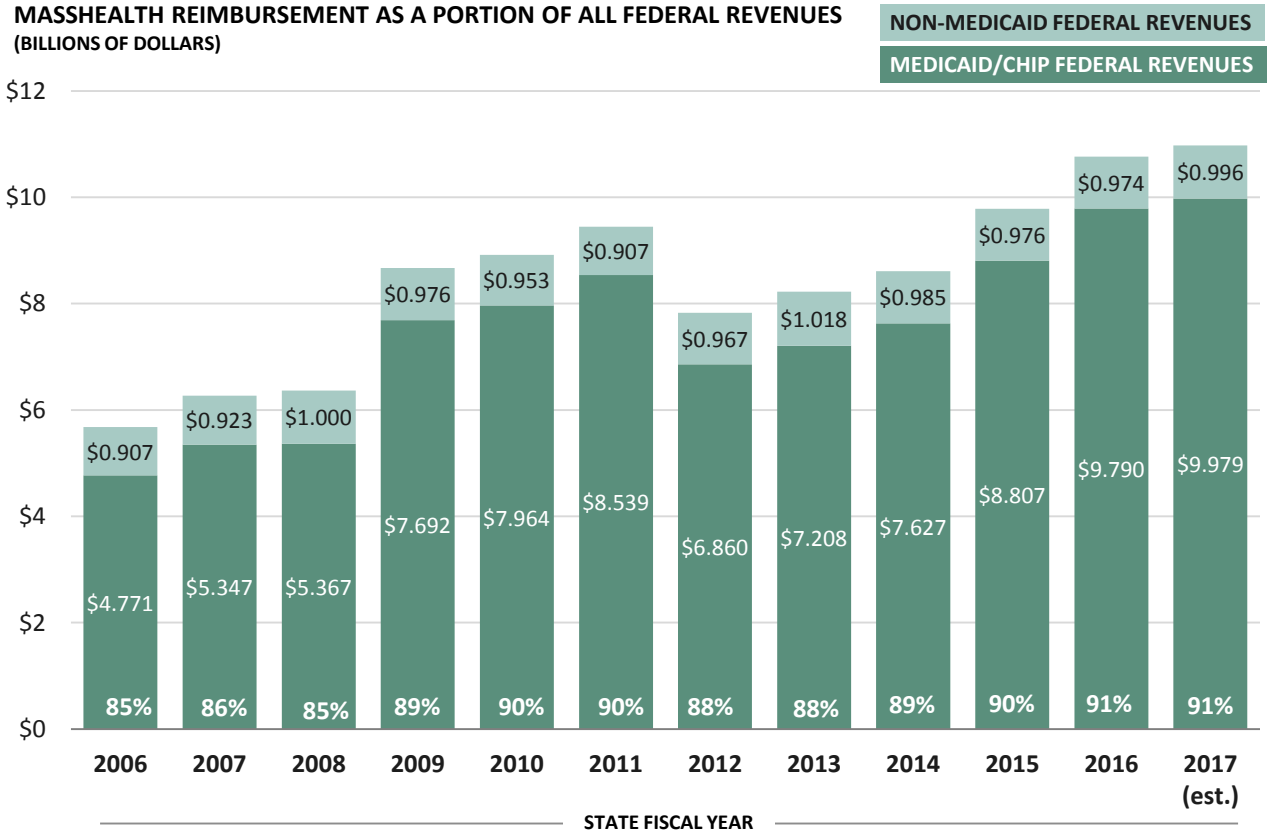
The recent growth in MassHealth enrollment and related spending as a result of the ACA expansion has put more pressure on the state budget. From SFY2014 to SFY2016, other state spending increased by an average of 3.7 percent per year, while MassHealth spending increased by 11.5 percent per year on average. State and federal spending on MassHealth now accounts for 38 percent of the overall state budget.

The federal government reimburses the state's general fund for more than half of its spending on MassHealth.

As a result, state-only spending on MassHealth is estimated to represent 24 percent of the non-federal share of the state budget (data not shown).

MEDICAID IS THE MAIN SOURCE OF FEDERAL REVENUES TO MASSACHUSETTS

MASSHEALTH REIMBURSEMENT AS A PORTION OF ALL FEDERAL REVENUES
(BILLIONS OF DOLLARS)



SOURCE: Massachusetts Budget and Policy Center. SFY2017 estimate as of January 2017.
NOTE: ConnectorCare "wrap" is the additional premium and cost sharing assistance Massachusetts provided to supplement the federal advanced premium tax credits and cost sharing reductions.

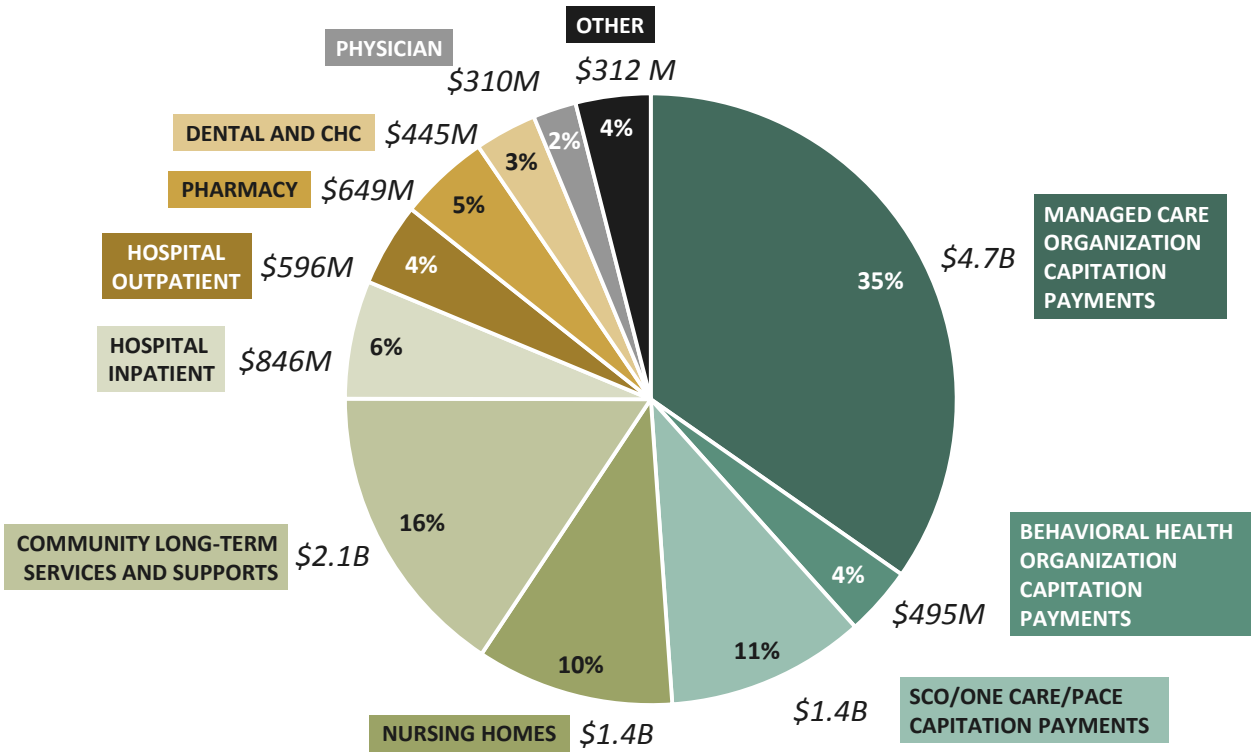
The federal government reimburses the Commonwealth for 50 percent of most Medicaid expenditures and 88 percent of CHIP expenditures. Members made newly eligible under the ACA Medicaid expansion draw an even higher federal match: 75 percent beginning in 2014, increasing to 86 percent in 2017.

Federal revenues supply about one-quarter of the funding for the state budget, and 91 percent of that revenue is generated by Medicaid and CHIP expenditures.

"Medicaid" in this context includes MassHealth, Commonwealth Care (prior to 2014) and ConnectorCare "wrap" (post-2014), additional MassHealth 1115 waiver spending and spending on some programs and facilities administered by the Departments of Developmental Services, Mental Health, Public Health, and the MA Rehabilitation Commission that serve people eligible for MassHealth.

MASSHEALTH SPENDING BY SERVICE TYPE IN STATE FISCAL YEAR 2016

TOTAL MASSHEALTH SPENDING = $13.5 BILLION



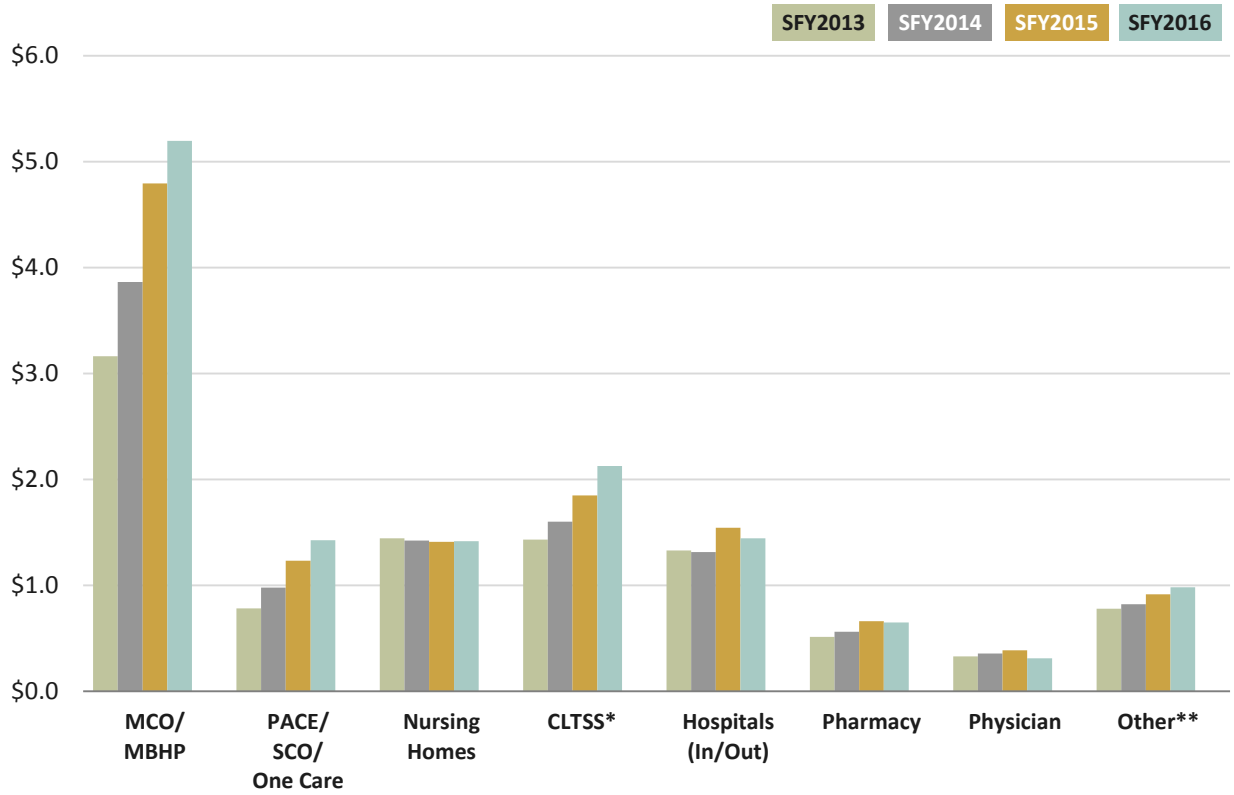
NOTES: These data do not include all of the spending on page 18, most notably Medicare premiums and therefore, the total is lower. "Other" includes transportation and smaller amounts of spending on rest homes, vision care, early intervention, hearing care, family planning clinics, renal dialysis clinics, ambulatory surgery centers, Durable Medical Equipment/Oxygen, imaging/radiation centers, certified independent labs, psychologists, mental health clinics, psychiatric day treatment, substance use disorder services, and Medicare crossover payments.
SOURCE: MassHealth Budget Office SFY2016 "date of service spending," which excludes spending on Medicare premiums. The figures do not include Medicaid-reimbursable services from other state agencies, administrative spending, or supplemental payments to hospitals.

MassHealth spent $13.5 billion on services for its members in SFY2016. Nearly half of spending ($6.6 billion) was capitation payments to MCOs, the PCC Plan's behavioral health carve-out vendor, SCOs, One Care plans, and PACE providers. Nearly 70 percent of MassHealth members are enrolled in one of these managed care arrangements.

Community-based LTSS (e.g., personal care attendants, home health aides, adult foster care) now account for nearly one dollar of every six spent in MassHealth.

TRENDS IN MASSHEALTH SPENDING BY SERVICE TYPE

MASSHEALTH SPENDING TRENDS BY CATEGORY OF SERVICE BETWEEN SFY2013–2016
(BILLIONS OF DOLLARS)



*CLTSS are long-term services and supports provided to people to enable them to live in the community.
**Services included in the "other" category include transportation, dental, community health centers and mental health clinics, among other services.
SOURCE: MassHealth Budget Office date of service spending.

Spending for capitated programs grew by 64 percent (MCO/MBHP) and 83 percent (PACE/ SCO/One Care) from SFY2013 to SFY2016, as more MassHealth members enrolled in these managed care arrangements. This exceeded the overall growth in MassHealth spending of 39 percent in this period.

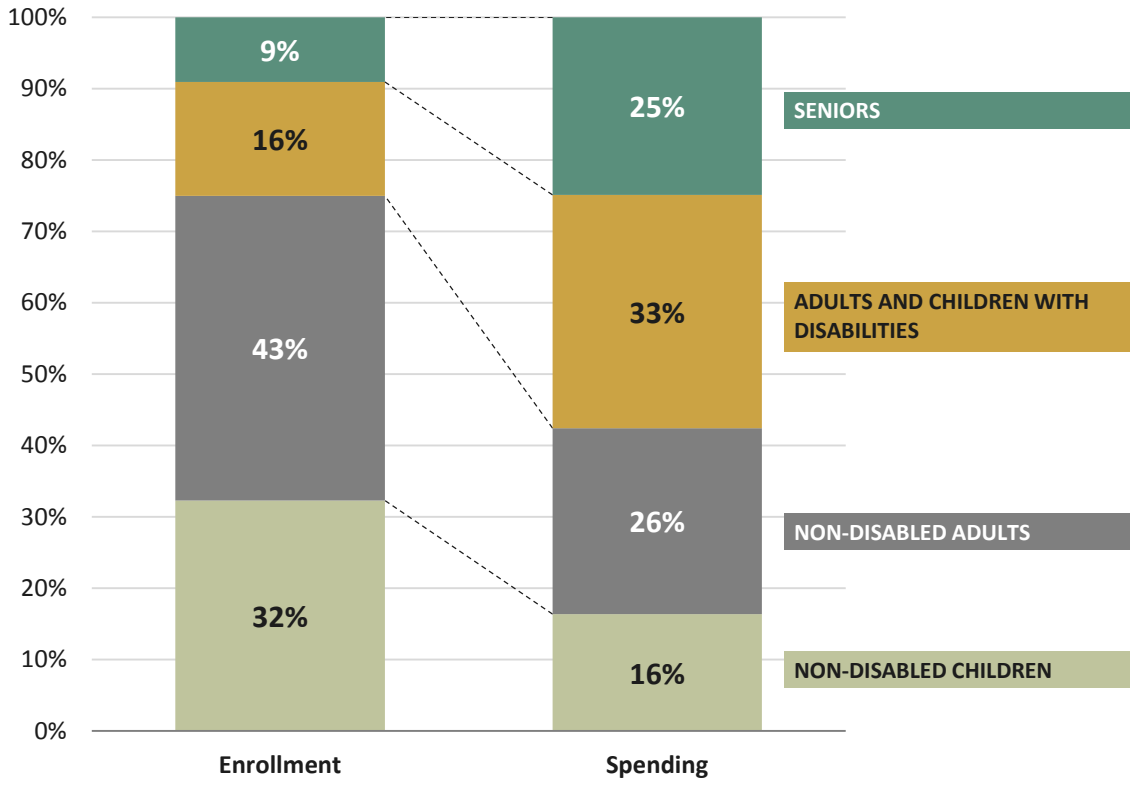
Community-based LTSS also grew rapidly (48%), while nursing facility spending remained level.

Fee-for-service spending for hospital care fell in SFY2016 after a jump in SFY2015. Pharmacy spending also leveled off in the most recent year, after steady growth in the previous two.

The "Other" category grew 16 percent from SFY2013 to SFY2016, driven in large part by spending in "special programs," early intervention, and substance use services.

MOST MEDICAID DOLLARS ARE SPENT ON SERVICES FOR A MINORITY OF MEMBERS

DISTRIBUTION OF MASSHEALTH ENROLLMENT AND SPENDING BY VARIOUS POPULATIONS, 2016

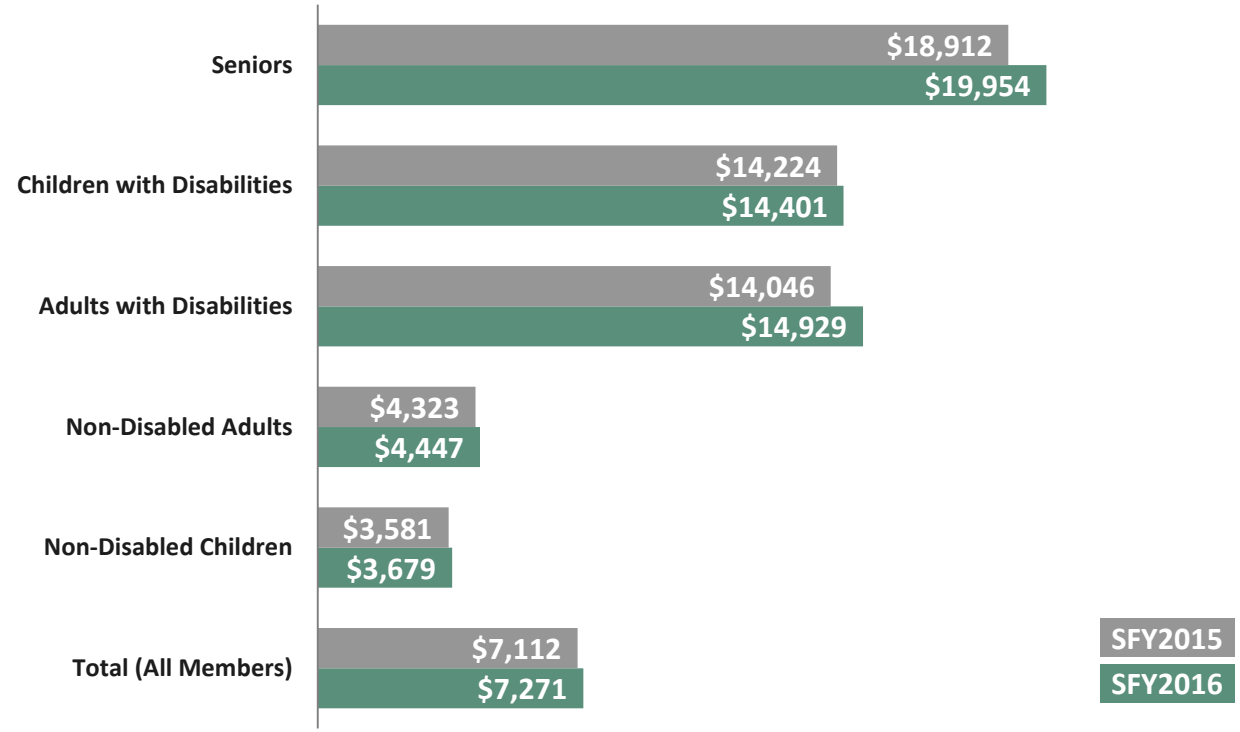


SOURCES: MassHealth Budget Office, SFY2016 date of service spending.

MassHealth spending is not spread evenly across the various categories of beneficiaries. Fifty-eight percent of benefit spending in SFY2016 was for services to people with disabilities and seniors; these groups comprise just one quarter (25%) of MassHealth membership.

MASSHEALTH SPENDS MORE PER ENROLLEE FOR SENIORS AND PEOPLE WITH DISABILITIES

MASSHEALTH PAYMENTS PER ENROLLEE PER YEAR, SFY2015–SFY2016



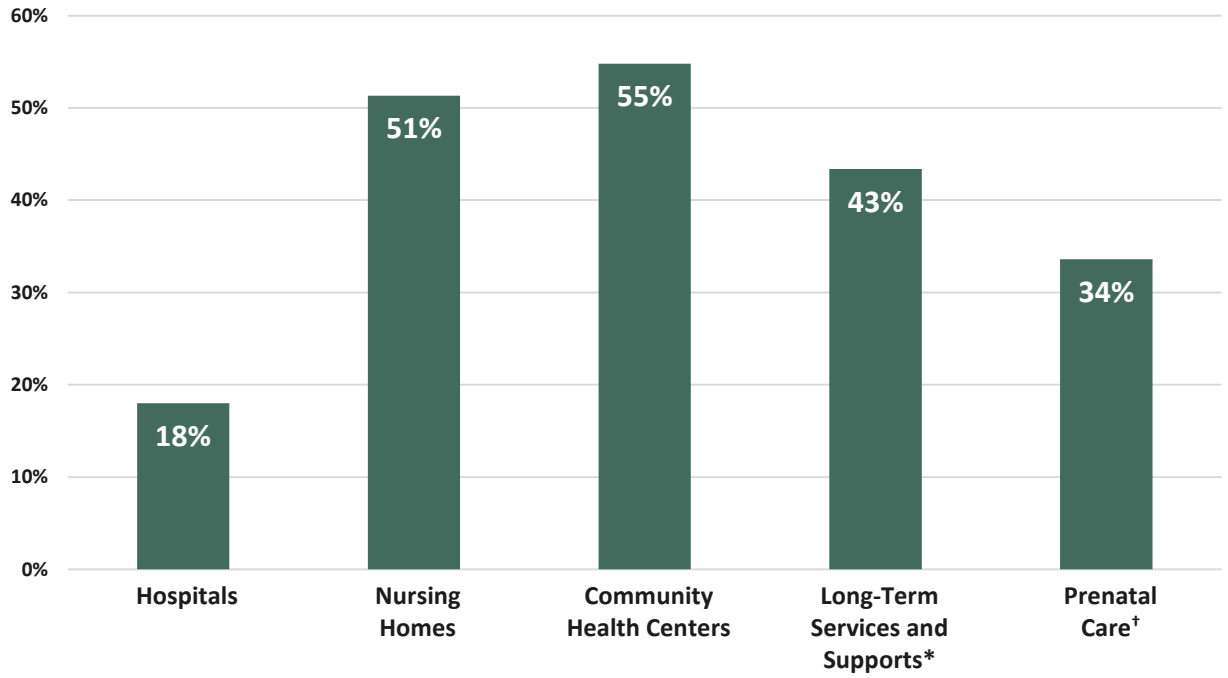
SOURCES: Calculations based on total spending and member months from the MassHealth Budget Office; data as of May 2017. Based on date of service spending. Excludes spending and enrollment for "Temporary Medicaid" category.

Seniors, who are more likely to have chronic conditions and complex health care needs, account for the highest level of MassHealth spending per member per year, followed by adults and children with disabilities. MassHealth members who do not have disabilities have much lower levels of spending.

Per member spending increased most rapidly for seniors and adults with disabilities, both as a rate (about 6%) and in absolute terms (about $1,000 per member per year). For these two groups and for children with disabilities, increases in total spending were influenced more by spending per member than by enrollment increases. In the other two groups, the reverse is the case.

MASSHEALTH SPENDING IS IMPORTANT TO MANY TYPES OF PROVIDERS

MASSHEALTH REVENUE AS A PERCENTAGE OF PROVIDERS' TOTAL PATIENT REVENUES, 2015



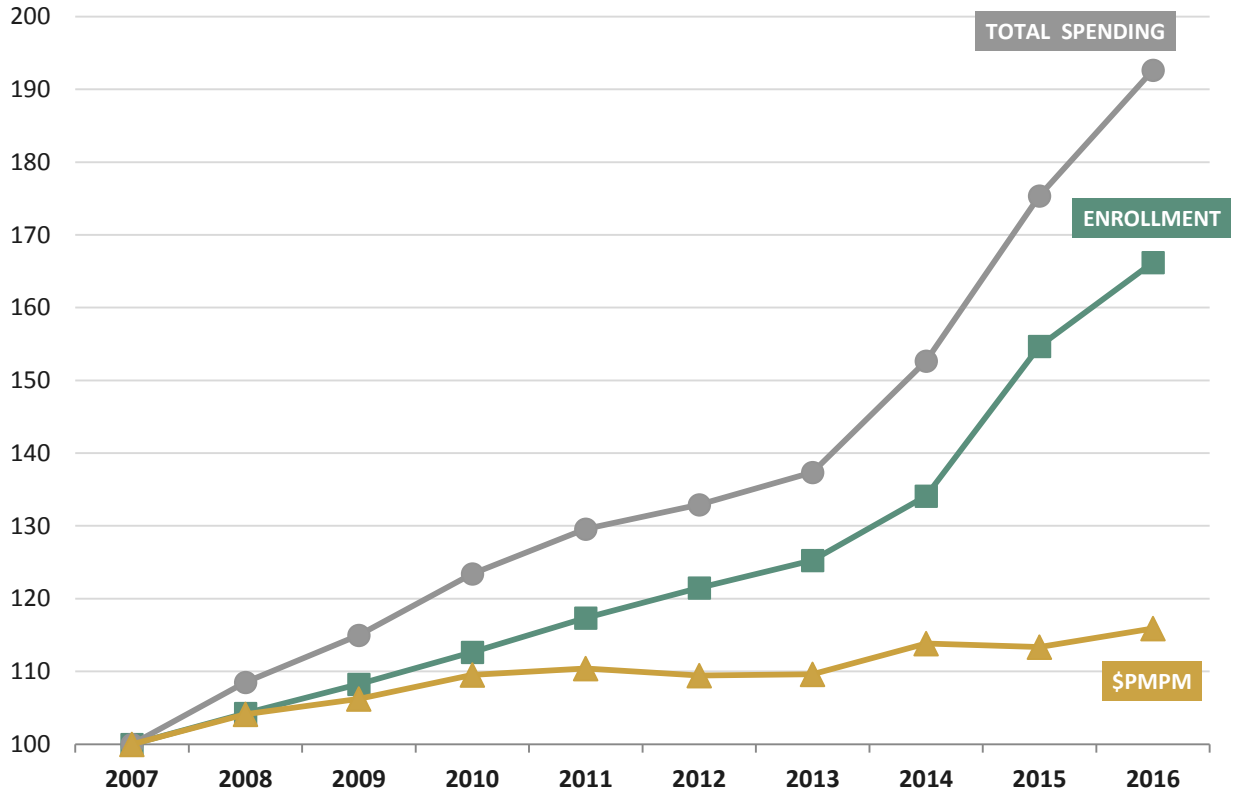
* Includes spending for home health care, durable medical supplies, Medicaid HCBS waivers, and care provided in residential care facilities. The source data also bundles in ambulance services, school health, and worksite health care, which comprise a very small piece of these services.
† Percentage of births whose prenatal care was paid for by MassHealth .
SOURCES: Center for Health Information and Analysis (CHIA), Massachusetts Hospital Profiles, March 2017 (SFY2015 data); CHIA, HCF-1 Cost Reports (Nursing Homes — CY2015); Health Resources and Services Administration, Bureau of Primary Health Care, Uniform Data System Report (CHCs — data from Federal FY2015); CMS National and State Health Expenditure Accounts (estimate using MA total and Medicaid spending 2009 and MA total spending 2014); MA DPH, Massachusetts Births 2015 (percentage of births).

MassHealth represents a significant portion of health care providers' revenues. This is especially the case for nursing homes and community health centers, which on average receive half of their total patient revenues from MassHealth.

MassHealth covers the prenatal care for a third of all births in Massachusetts. Prenatal care is delivered by a mix of providers.

ENROLLMENT, MORE THAN PER MEMBER COST, HAS DRIVEN GROWTH IN MASSHEALTH SPENDING

GROWTH IN MASSHEALTH TOTAL SPENDING, ENROLLMENT AND PER MEMBER PER MONTH (PMPM) COSTS
(YEAR 2007 = 100)



SOURCES: MassHealth Budget Office (total date of service spending and enrollment) and authors' calculations. Excludes spending and enrollment for "Temporary Medicaid" category.

The main driver of MassHealth spending over the last decade has been the increasing number of MassHealth members, not the average amount spent for each member. Not adjusting for inflation, spending per member grew less than 2 percent per year from fiscal year 2007 through 2016. Per member spending grew just 6 percent from SFY2013 to SFY2016, as total spending grew dramatically with the ACA expansion that began in SFY2014. This modest increase in per-member spending was partially driven by the lower acuity of the ACA expansion population relative to the pre-expansion MassHealth membership.

Enrollment grew an average of 5.8 percent per year from SFY2007 to SFY2016, accelerating in recent years with growth of 7.0 percent in SFY2014, 15.3 percent in SFY2015, and 7.5 percent in SFY2016.

MASSHEALTH'S PRIORITIES FOR REFORM

MassHealth has embarked on a comprehensive reform effort to better integrate a complicated, fragmented delivery system and gain better control over program costs.

The centerpiece of the effort is the transformation of the delivery system from a largely fee-for-service model to one based on ACOs, using authority granted through the state's 1115 demonstration waiver, a new extension of which was approved in November 2016.

MassHealth has executed agreements with 17 ACOs. MassHealth also has selected eight entities to participate as LTSS Community Partners (CPs) and 18 as Behavioral Health (BH) CPs, and has begun to negotiate contract terms with them. CPs will coordinate LTSS and BH services for high need ACO members. MassHealth plans to launch the full ACO program in early 2018 (a limited pilot involving six ACOs is currently underway).

Also part of its 1115 waiver extension, MassHealth is proposing major expansions of the treatment continuum for members with substance use disorders.

GOALS OF THE 1115 WAIVER, STATE FISCAL YEARS 2018–2022

- Payment and delivery system reform to promote member-driven, coordinated care and hold providers accountable for the quality and total cost of care
- Integration of physical health, BH, LTSS, and health-related social services
- Maintain near-universal coverage
- Sustainably support safety net providers
- Address the opioid addiction crisis by expanding access to a broad spectrum of recovery-oriented substance use disorder services

ACCOUNTABLE CARE ORGANIZATIONS: PROVIDER ENTITIES HELD FINANCIALLY ACCOUNTABLE FOR THE COST AND QUALITY OF CARE FOR THEIR MEMBER POPULATIONS

Three Varieties of MassHealth ACOs

MassHealth

Accountable Care Partnership Plan

Contract between MassHealth and Accountable Care Partnership Plan

- Capitation payment
- Requires Partnership Plan to provide and pay for comprehensive health services to enrollees

13 selected

Primary Care ACO

Contract between MassHealth and ACO

- Shared savings and losses
- MassHealth does not pay Primary Care ACOs to deliver direct services; rather, MassHealth pays for services itself

3 selected

MCO

Contract between MassHealth and MCO

- Capitation payment
- Requires MCOs to provide and pay for comprehensive health services to enrollees
- Requires MCOs to contract with MassHealth-certified MCO-Administered ACOs

MCO-Administered ACOs

Contract between MCO and ACO

- Contract approved by MassHealth
- Shared savings and losses
- MCO does not pay MCO-Administered ACOs to deliver direct services; rather, MCO pays for services itself

1 selected

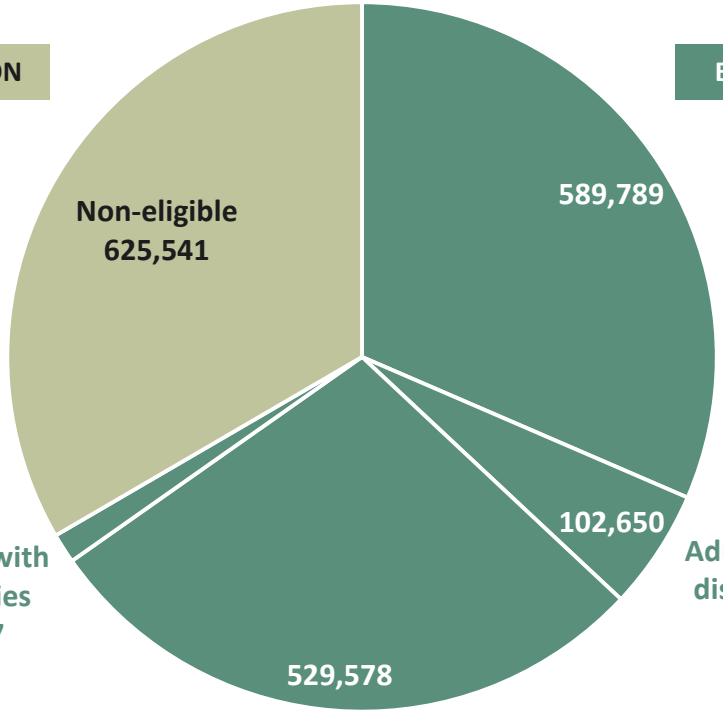
MASSHEALTH MEMBERS ELIGIBLE FOR ACO ENROLLMENT

Total MassHealth Enrollment 1.87 Million (May 2017)

INELIGIBLE FOR ACO: 0.63 MILLION

Ineligible includes:

- Seniors
- People with other insurance including Medicare or private
- MassHealth Limited



ELIGIBLE FOR ACO: 1.25 MILLION

SOURCE: MassHealth, May 2017 Snapshot Report.

COMMUNITY PARTNERS: CONNECT ACO MEMBERS TO COMMUNITY RESOURCES TO MEET BEHAVIORAL HEALTH AND LONG-TERM SERVICES AND SUPPORTS NEEDS

- Community Partners (CPs) promote integration of care, improved member experience, and continuity and quality of care for members with complex needs.
- ACOs are required to partner with multiple CPs, which make available the expertise, capabilities, and cultural/linguistic attentiveness of existing community-based organizations.
- Behavioral Health (BH) CPs perform outreach and engagement, participate on care teams, lead person-centered treatment planning, coordinate services, support care transitions, provide health and wellness coaching, and facilitate access to social and community services.
- Long-term Services and Supports (LTSS) CPs provide disability expert consultation, care planning and choice counseling, care coordination, transition support, health and wellness coaching, and facilitate access to social and community services.

DELIVERY SYSTEM REFORM INCENTIVE PAYMENTS (DSRIP)

- The 1115 waiver agreement includes $1.8 billion to support the transformation:

Objective	Five-Year Funding (% of DSRIP Funding)
ACO Development	$1.065B (60%)
Community Partners: care coordination and capacity building	$546M (30%)
Statewide Investments: student loan repayment, primary care residency training, workforce development, more	$115M (6%)
State Operations and Implementation	$73M (4%)
TOTAL	**$1.8B**

- Up to 20 percent of the ACO and CP payments will be tied to performance, measured by an "accountability score."

ACO IMPLEMENTATION TIMELINE

MassHealth signs contracts with ACOs	August 2017
ACO readiness review	August 2017–February 2018
Community Partners selected	August 2017
First DSRIP payments	September 2017
ACO Program launch; prospective enrollment begins	January 1, 2018
ACOs begin operating	March 1, 2018
Community Partners begin operating	June 1, 2018

SOURCE: MassHealth, "ACO Timeline Update as of 7.13.17" and communication with MassHealth staff.

WAIVER AMENDMENTS (1)

- MassHealth submitted a request to the Centers for Medicare and Medicaid Services (CMS) in June 2017 to amend the 1115 waiver. The amendment would:
  - Discontinue non-emergency transportation as a benefit in CarePlus (which covers non-disabled adults who became eligible with the ACA expansion) to better align it with commercial insurance. There would be an exception for transportation to substance use disorder treatment.
  - Discontinue provisional eligibility for most adults, which authorizes MassHealth to enroll applicants for 90 days when income verification is still needed. Provisional eligibility would still be available for pregnant women, HIV positive adults, and people in the Breast and Cervical Cancer Treatment Program whose attested income is within eligibility limits.

WAIVER AMENDMENTS (2)

- The Baker Administration submitted a second waiver amendment to CMS in September 2017, proposing broader changes intended to put MassHealth on a more sustainable financial path. The proposed amendments address eligibility, coverage, and network issues. Some of its elements are:
  - Enrolling some non-disabled adults with incomes 100–133% FPL in subsidized plans through the Health Connector rather than MassHealth
  - Consolidating coverage of all adults with income below 100% FPL into MassHealth CarePlus
  - Eliminating MassHealth Limited coverage for adults who are eligible for coverage through the Health Connector
  - Adopting a closed formulary for prescription drugs
  - Procuring a narrower provider network for the PCC Plan, to promote enrollment in ACOs and MCOs
  - Waiving the requirement for multiple managed care options in areas of the state where a majority of primary care providers participate in a single MassHealth ACO
  - Relaxing the cost sharing limit (5% of income) for members with income over 300% FPL
- After CMS determines the application to be complete, there will be a 30-day public comment period before CMS can approve the amendment.
- Some changes will require action by the state legislature before they can take effect.
- Further details are available at www.mass.gov/hhs/masshealth-innovations.

FUTURE MODIFICATIONS: WHAT TO WATCH FOR

- The Massachusetts legislature has begun its own process to develop options for MassHealth sustainability. This will be a priority issue for state policymakers through the rest of the fiscal year and beyond.
- Recent efforts to repeal and replace the ACA have foundered, and the federal debate may now turn to improving the law and considering additional reforms. Some proposals have included major changes to Medicaid financing, which would significantly affect how states provide health care access to many of their residents. Analyses of the potential impact of these proposals on MassHealth are available at: www.bluecrossmafoundation.org/publications.

CONCLUSIONS

- MassHealth offers strong support to people who have no other source of affordable health insurance and provides coverage for services and cost sharing not covered by other insurance (Medicare and employer-sponsored insurance) for low-income residents.
- Spending has grown, more rapidly in the last three years, driven mainly by increases in enrollment. Per capita spending has grown by an average of less than 2 percent per year in the past ten years. Managed care capitation payments and community-based LTSS have shown the most consistent spending growth.
- Non-disabled adults have been the fastest-growing enrollment group, owing to the ACA Medicaid expansion. Enrollment among higher cost member groups — people with disabilities and seniors — has grown more slowly.
- MassHealth brings in nearly $10 billion in federal revenues to the state every year.
- Massachusetts has taken advantage of opportunities through the ACA and the federal waiver process to develop innovations that expand access to health care, improve its quality, and transform the way care is organized, delivered, and paid for.
- MassHealth will soon launch a new care delivery and payment reform initiative centered on ACOs and CPs, to realize a vision to improve the value of the care its members receive and better control program spending.