MassHealth: The Basics FACTS AND TRENDS

PREPARED BY
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UPDATED OCTOBER 2022

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TABLE OF CONTENTS

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GLOSSARY OF ACRONYMS

ACA	Affordable Care Act
ACS	American Community Survey
ACO	Accountable Care Organization
ARPA	American Rescue Plan Act
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CP	Community Partner
CSP	Community Support Program
D-SNP	Dual Eligible Special Needs Plans
DSRIP	Delivery System Reform Incentive Payment
FBR	Federal Benefit Rate
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FSP	Flexible Services Program
FY	Fiscal Year
HCBS	Home- and Community-Based Services
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
PACE	Program of All-Inclusive Care for the Elderly
PCA	Personal Care Attendant
PCC	Primary Care Clinician Plan
PMPM	Per Member Per Month
SCO	Senior Care Options
SFY	State Fiscal Year (July 1–June 30; for example, SFY22 runs from July 1, 2021–June 30, 2022)
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income
SUD	Substance Use Disorder

INTRODUCTION

INTRODUCTION: THE IMPORTANCE OF MASSHEALTH

MassHealth is Massachusetts' name for its Medicaid program and Children's Health Insurance Program (CHIP). MassHealth is a cornerstone of the health insurance landscape in Massachusetts and critical to our high rates of coverage and ongoing efforts to improve equity. The program is jointly funded and administered by state and federal governments.

COVERAGE

1 in 4 Massachusetts residents are covered by MassHealth, almost 2 million people,* including low-income children, seniors and people with disabilities.

SAFETY NET

Enrollment typically grows during recessions when people are losing jobs. MassHealth helps keep Massachusetts' coverage rates high through crises such as the COVID-19 pandemic.

EQUITY

MassHealth members are representative of the diversity of the Commonwealth, and so the program is positioned to address inequities for people across disability status, racial and ethnic identities, sexual orientation, and gender identities.

EVOLVING

Because MassHealth is jointly funded and administered by state and federal governments, it is sensitive to policy and administration changes at both the state and federal levels.

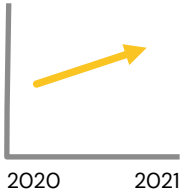
*The analysis throughout this report uses enrollment by State Fiscal Year (SFY). Enrollment in SFY 2021 was just below 2 million people. Monthly caseload data suggest enrollment has continued to grow since then; MassHealth had over 2.2 million members as of April 2022.

MASSHEALTH: THE BASICS
KEY FINDINGS

ENROLLMENT

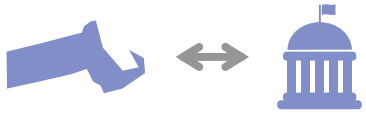
More than half of MassHealth members have **income at or below 86% FPL** ($19,806 per year for a family of three in 2022)

43% of Massachusetts children are MassHealth members

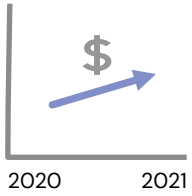


Enrollment grew sharply during the COVID-19 pandemic (between SFY 2020 and SFY 2021)*

SPENDING



Every dollar of MassHealth spending is **reimbursed by at least 50 cents** of federal revenue



Total **MassHealth spending increased as enrollment increased** from SFY 2020 to SFY 2021, but the cost per member decreased on average by 2%

MassHealth is an important source of **revenue for providers** — accounting for almost a fifth of hospital revenue and **over half of nursing facility revenue**

INNOVATIONS

Over half of MassHealth members are in **Accountable Care Organizations (ACOs)**

MassHealth continues to build on recent efforts to **improve the member experience for those with the most complex needs** and to address certain social needs known to impact health

MassHealth is pursuing **new approaches for improving health equity** — including holding providers and ACOs financially accountable for measuring and reducing inequities in health

*State Fiscal Year (SFY) 2020 starts 7/1/2019 and ends on 6/30/2020. SFY 2021 starts on 7/1/2020 and ends on 6/30/2021.

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

TYPICAL COMMERCIAL INSURANCE COVERAGE

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

+

ADDITIONAL BENEFITS

- Long-term services and supports (community- and facility-based)[1]
- Diversionary behavioral health services (to avert hospitalization)
- Enhanced mental health/substance use disorder treatment [2]
- Dental services
- Transportation to medical appointments[1]

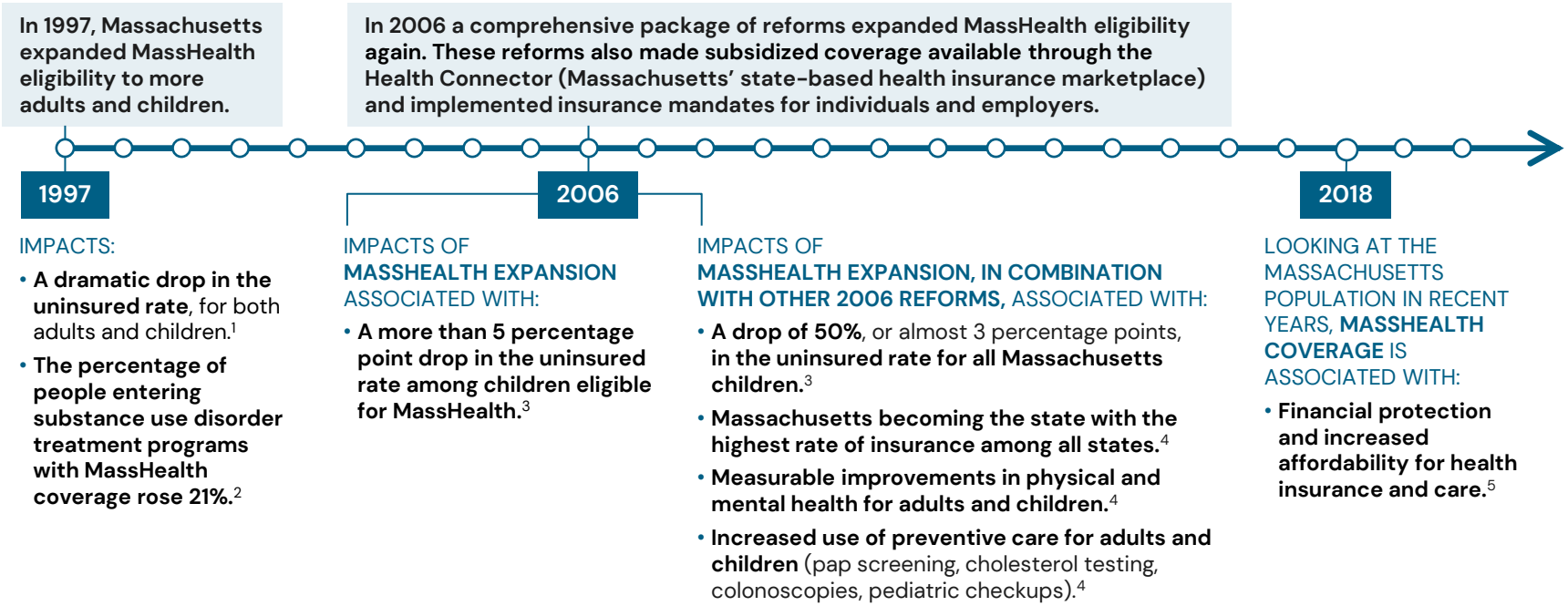
= MassHealth

[1] LTSS and transportation to medical appointments are available to most but not all MassHealth members.

[2] See Massachusetts Division of Insurance, The Catalogue of Carrier Coverage of Inpatient, Outpatient and Community Behavioral Health Services (November 10, 2017), Excel sheet available at https://www.mass.gov/info-details/health-care-access-bureau.

MASSHEALTH IMPROVES ACCESS TO CARE AND HEALTH OUTCOMES

Massachusetts expanded MassHealth over the course of decades. These expansions have given researchers opportunities to study the effects of MassHealth on access to care and health outcomes.



[1] Zuckerman, S., Kenney, G.M., Dubay, L., Haley, J., & Holahan, J. (2001). Shifting Health Insurance Coverage, 1997–1999. Health Affairs, 20 (1).

[2] Zur, J. & Moitabai, R. (2013). Medicaid Expansion Initiative in Massachusetts: Enrollment Among Substance-Abusing Homeless Adults. AJPH, 103 (11).

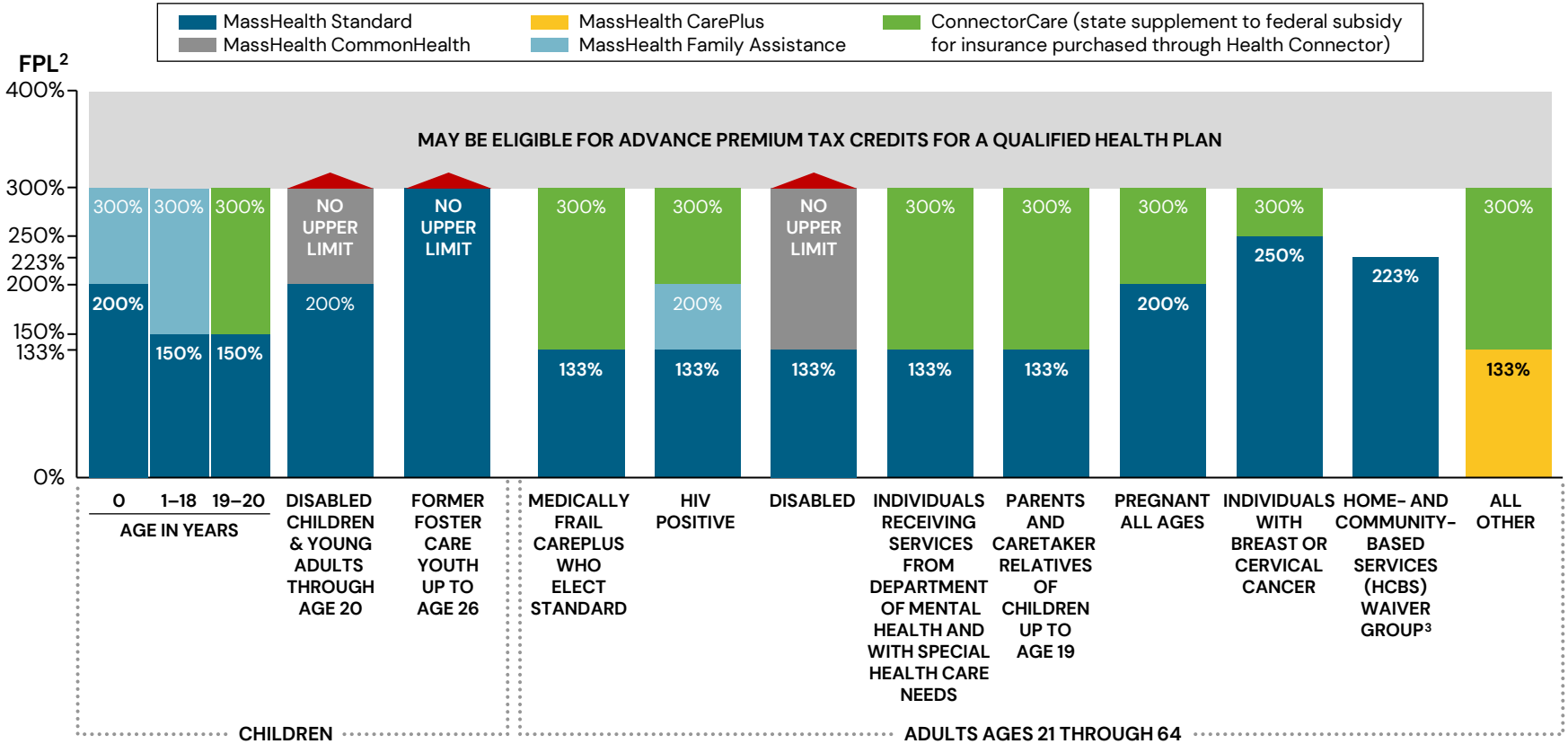
[3] Kenney, G. M., Long, S. K., & Luque, A. (2010). Health reform in Massachusetts cut the uninsurance rate among children in half. Health Affairs, 29 (6), 1242–1247.

[4] Love, K.A. & Seifert, R.W. (2016). 10 Years of Impact: a Literature Review of Chapter 58 of the Acts of 2006. Blue Cross Blue Shield Foundation of Massachusetts; Miller, S. (2012). The Impact of the Massachusetts Health Care Reform on Health Care Use among Children. American Economic Review, 102 (3).

[5] Long, S.K., Aarons, J. (2018). Massachusetts Health Reform Survey. Blue Cross Blue Shield Foundation of Massachusetts.

ELIGIBILITY AND ENROLLMENT

MASSHEALTH INCOME LIMITS VARY FOR DIFFERENT AGES AND ELIGIBILITY GROUPS[1]



[1] MassHealth eligibility includes nuances not included in this chart; MassHealth staff can help determine eligibility. Additional information can be found at https://www.mass.gov/service-details/masshealth-coverage-types-for-individuals-and-families-including-people-with.

[2] FPL = income as percent of federal poverty level; in 2022, 100% FPL for an individual was $13,590 annually.

[3] Eligibility for all Home- and Community-Based Waivers except one (the waiver for Young Children with Autism) is based on 300% of the Supplemental Security Income (SSI) Federal Benefit Rate (FBR). FBR is a metric used by the Social Security Administration and tied to the consumer price index. In 2022, 300% SSI FBR for an individual was $30,277 annually (223% FPL for an individual).

NOTES: MassHealth Limited, not shown in this chart, provides emergency health services to people who, under federal law, have an immigration status that keeps them from receiving more services. Income eligibility for this population is similar 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 ages 21–64.

SOURCES: 130 C.M.R. §505; 130 C.M.R. §519; MassHealth (2022). Member Booklet for Health and Dental Coverage and Help Paying Costs.

ELIGIBILITY FOR SENIORS AGE 65 AND OLDER GENERALLY INCLUDES AN ASSET TEST AND LOWER INCOME THRESHOLDS; MOST SENIORS ALSO HAVE MEDICARE[1]

POPULATION	INCOME/ASSETS[2]	COVERAGE
Living in community, with or without Medicare eligibility, citizen or lawfully present immigrant	≤100% Federal Poverty Level (FPL) ≤$2,000 Assets	Comprehensive coverage through MassHealth Standard or Family Assistance (based on immigration status). For those with MassHealth Standard, MassHealth also pays their Medicare cost-sharing and premiums.
Living in community, certain noncitizens	≤100% FPL ≤$2,000 Assets	MassHealth Limited — Emergency services only.
Living in community, eligible for Medicare	≤130% FPL ≤$16,800 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	>130% and <165% FPL ≤$16,800 Assets	MassHealth Buy-In — Covers Part B premiums only.
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 monthly allowances[3] toward nursing facility care.

[1] MassHealth eligibility includes nuances not included in this chart; for example, parents of minors and seniors who work have different eligibility requirements. MassHealth staff can help determine eligibility.

[2] Certain assets are excluded from the asset test; these include home (in most cases), vehicle, life insurance up to $1,500, and funeral and burial expenses up to $1,500. In certain cases, asset spend-down is available. Income and asset considerations are based in part on federal law.

[3] Allowances include personal need allowance and spousal maintenance allowance, among others.

NOTES: Asset limits listed are for individuals; the amounts for couples are higher. Seniors (age 60 or older) can qualify for MassHealth through the Frail Elder Waiver with income up to 300% of the Supplemental Security Income (SSI) federal benefit rate (FBR) ($30,277 in 2022). Other Home- and Community-Based Services (HCBS) waivers are available as well. Seniors may also be eligible for ConnectorCare and Advance Premium Tax Credits for insurance purchased through the Health Connector.

SOURCES: 130 C.M.R. §519; MassHealth (2022). Senior Guide to Health Care Coverage,

THERE ARE MANY DOORS INTO MASSHEALTH

Individuals apply directly, by phone, on paper form, in person with assistance at a MassHealth Enrollment Center or Health Connector walk-in center, or through the Health Connector website, an integrated eligibility system that allows users to shop and apply for MassHealth and other health insurance programs.

Health care providers assist patients with applications.

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

State agencies facilitate applications.

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

Community organizations and advocacy groups provide health care referrals and access to MassHealth.

- My Ombudsman. This nonprofit organization answers questions, provides information, and works with health plans and MassHealth to ensure members can access their benefits.
- Community action programs
- Community development corporations
- Aging services access points
- Health Care For All
- Other community organizations designated as Enrollment Assisters

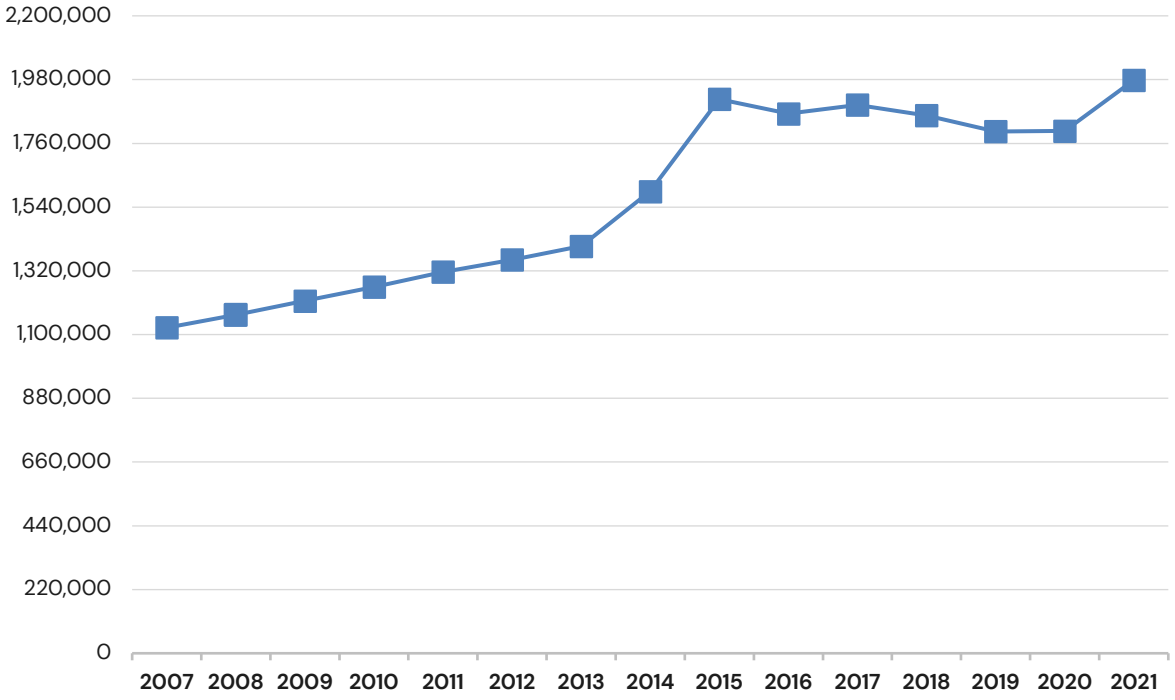
Appeals and Grievances

Typically, if an applicant disagrees with MassHealth's denial of coverage, the applicant can appeal the decision within 30 days using the Fair Hearing Request Form. Applicants and members can also file grievances at any point for any type of problem, including issues with the quality of care, wait times, or customer service. In response to the COVID-19 pandemic, MassHealth has temporarily expanded the window for eligibility appeals. Through the end of the national public health emergency, MassHealth members will have 120 days to request appeals for eligibility-related concerns.*

*Centers for Medicare & Medicaid Services. (2020, March 26). Section 1135 Waiver Flexibilities — Massachusetts Coronavirus Disease 2019.

MASSHEALTH ENROLLMENT SHARPLY INCREASED FROM SFY2020 TO 2021

TRENDS IN MASSHEALTH ENROLLMENT, STATE FISCAL YEARS (SFY) 2007–2021



[1] The analysis throughout this report uses enrollment by State Fiscal Year (SFY). Enrollment in SFY 2021 was just below 2 million people. Monthly caseload data suggest enrollment has continued to grow since then; MassHealth had over 2.2 million members as of April 2022.

[2] Fronstin, P., Woodbury, S. (2020) How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic? Commonwealth Fund.

[3] To help support states and promote stability of coverage amidst the COVID-19 pandemic, the Families First Coronavirus Response Act provides a 6.2 percentage point increase in the percent of a state's Medicaid spending that the federal government reimburses (otherwise known as the Federal Medical Assistance Percentage, or FMAP). A requirement of receiving the enhanced funding is that states must provide continuous coverage for current Medicaid enrollees throughout the federal public health emergency, also known as the maintenance of effort requirement. The federal public health emergency is currently set to expire after January 11, 2023.

SOURCE: MassHealth Budget Office.

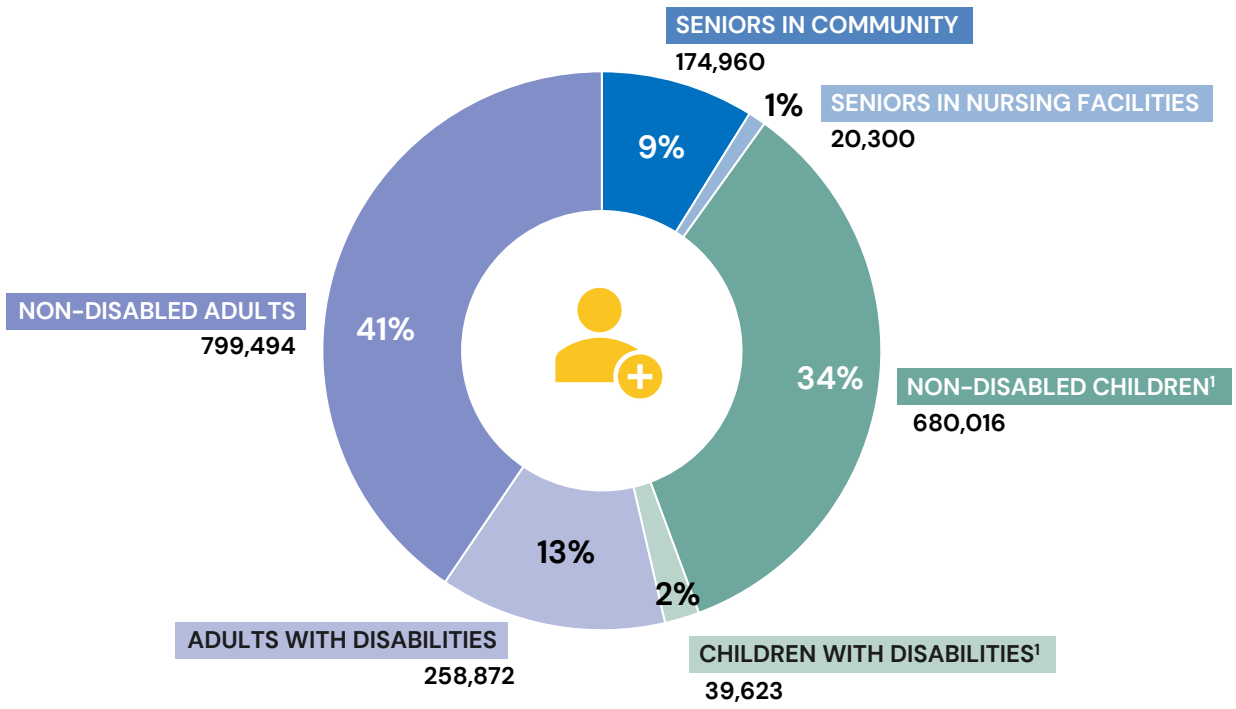
MassHealth enrollment decreased 6% from SFY 2015 to 2020, changing from 1.9 million members to just over 1.8 million members. From SFY 2020 to 2021, roughly coinciding with the start of the COVID-19 pandemic, enrollment grew approximately 10%, increasing to nearly 1.98 million members.[1]

Two factors likely contributed to this growth. The economic downtown associated with the COVID-19 pandemic caused many to lose their jobs and often their employer-sponsored insurance. This may have driven many to enroll in MassHealth.[2]

Additionally, the enrollment spike since SFY 2020 was in part driven by a federal continuous coverage requirement effective throughout the federal COVID-19 Public Health Emergency, which protects most people enrolled in Medicaid from losing their coverage, even if they no longer qualify.[3]

CHILDREN, SENIORS, AND PEOPLE WITH DISABILITIES MAKE UP OVER 59% OF MASSHEALTH MEMBERS

PERCENT OF TOTAL MASSHEALTH ENROLLMENT (1.98 MILLION), SFY 2021



[1] Children defined as under age 21.

[2] In certain instances, MassHealth may be able to provide secondary coverage or supplemental coverage — in the form of additional or augmented covered services — in instances when a member has alternative insurance that may not provide coverage for certain needed services.

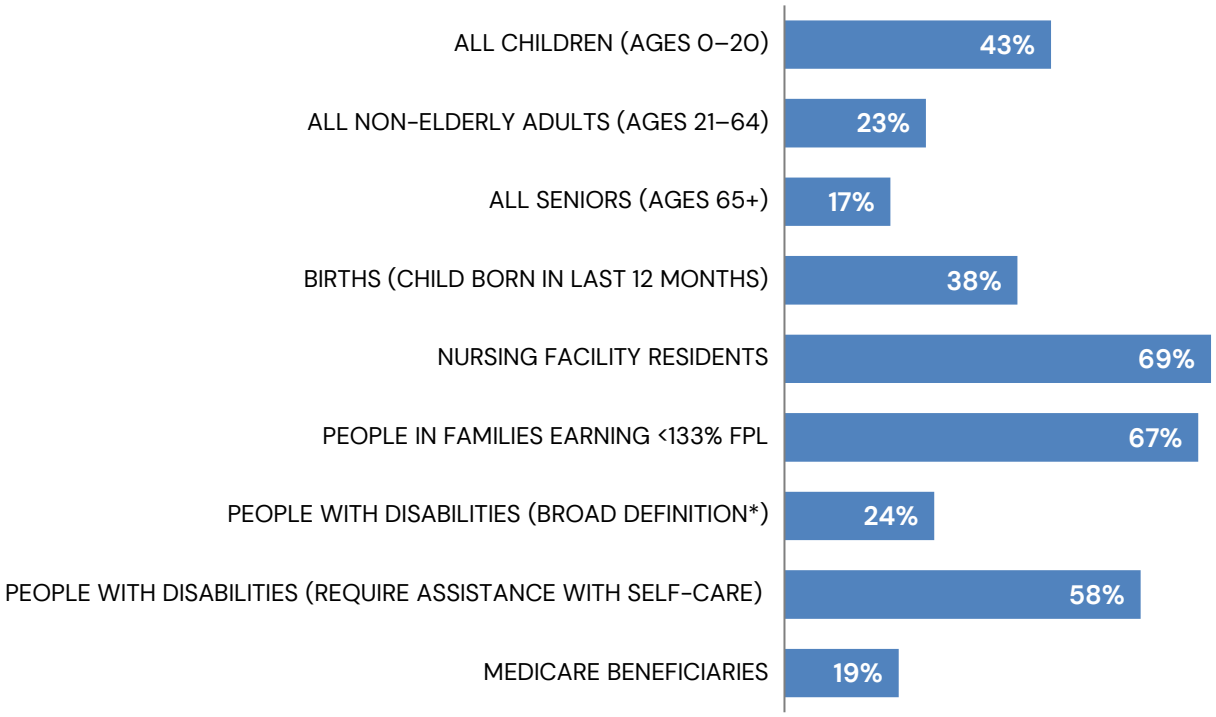
SOURCE: MassHealth Budget Office.

MassHealth members range from the very young to the very old. Children comprise 36% of MassHealth members. Adults with disabilities (under age 65) and children with disabilities represent 15% of membership. One out of 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.

Some MassHealth members (of all ages) have coverage through Medicare, an employer-sponsored plan, or student health insurance (this additional coverage is not shown in the chart). In those cases, MassHealth acts as secondary coverage.[2] In some circumstances, MassHealth also pays members' premiums and cost sharing for their employer-sponsored insurance or Medicare coverage.

MASSHEALTH IS IMPORTANT TO MANY POPULATION GROUPS

PERCENT OF SELECT MASSACHUSETTS POPULATIONS COVERED BY MASSHEALTH



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

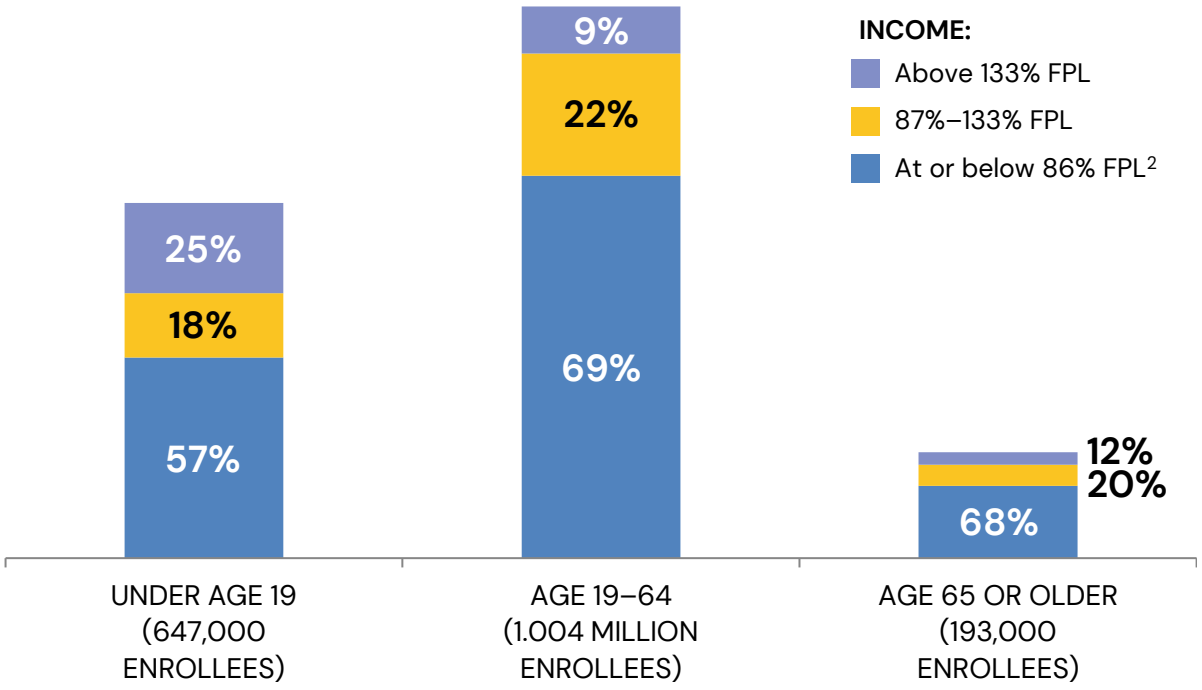
SOURCES: Authors' calculations for "all children," "all non-elderly adults," and "all seniors" calculated using the 2016-2020 American Community Survey (ACS) 5-Year Estimates and data from MassHealth Budget Office. "Nursing Facility Residents" calculation uses Nursing facility data from Massachusetts Center for Health Information and Analysis. Baseline Report: Trends in the Massachusetts Nursing Facility Industry 2013–2017 November 2019), accessed at Massachusetts Nursing Facilities (chiamass.gov)

More than 4 in 10 children in Massachusetts and almost one-quarter of adults under age 65 are MassHealth members. MassHealth is an especially important source of coverage for people with low incomes and people with disabilities.

About three-fifths of people with incomes below 133% of the federal poverty level (about $18,075 annually for a one-person household in 2022) and more than half of all Massachusetts residents with disabilities who need assistance with self-care (dressing, bathing, or getting around inside the home) receive coverage from MassHealth. Almost seven out of 10 nursing facility residents are MassHealth members.

ADULTS ENROLLED IN MASSHEALTH HAVE PARTICULARLY LOW INCOMES — MOST BELOW 86% FPL

INCOME AS PERCENT OF FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP FOR MASSHEALTH ENROLLEES[1]



- Nearly 70% of adults enrolled in MassHealth have an income at or below 86% FPL, which in 2022 corresponded to:
  - $11,687 for an individual
  - $15,747 for a family of 2
  - $19,806 for a family of 3
- Because children's eligibility extends farther up the income scale, a larger share of children enrolled in MassHealth live in families with incomes above the federal poverty level.

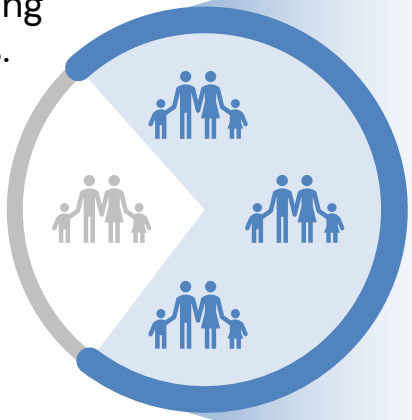
[1] Reflects individuals enrolled in MassHealth as of June 30, 2018. For consistency throughout the slide deck, example incomes are given for FY 2022.

[2] 86% FPL reflects an income eligibility limit that applied to certain MassHealth eligibility categories prior to expansions that have occurred over time. Most enrollees continue to have incomes below this level.

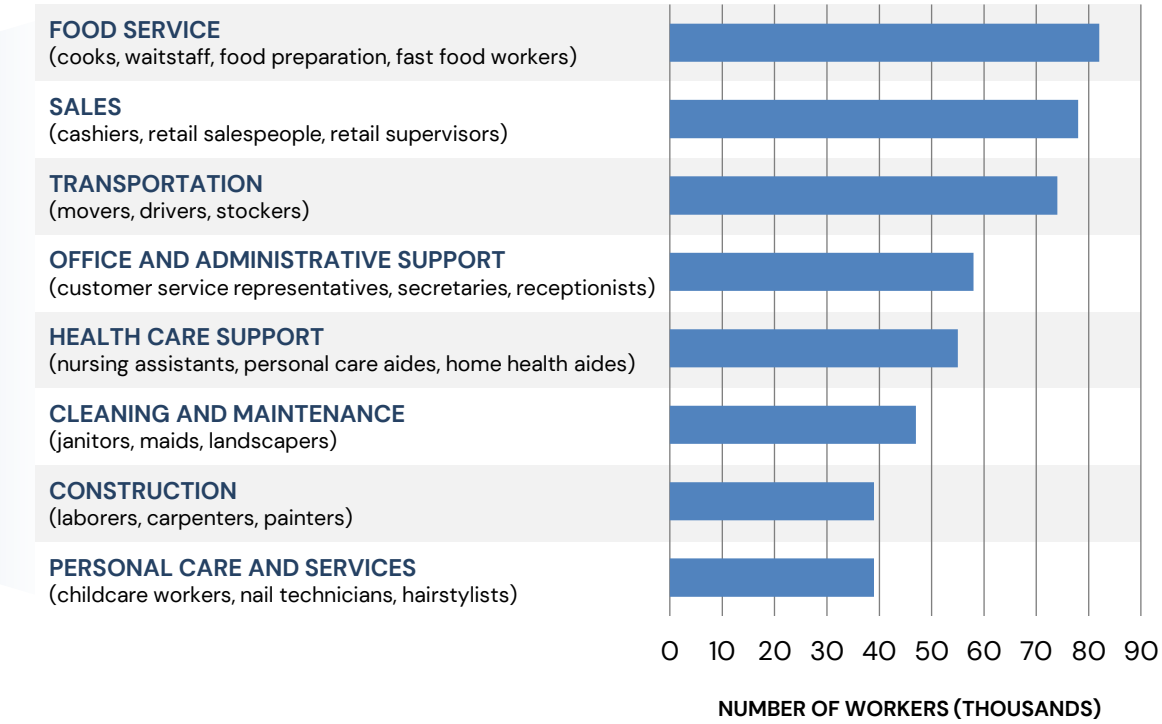
SOURCE: Manatt Health Strategies, LLC (2019). Faces of MassHealth: Portrait of a Diverse Population. Blue Cross Blue Shield of Massachusetts Foundation.

MASSHEALTH PLAYS A KEY ROLE IN SUPPORTING THE LOW-INCOME WORKFORCE

Three quarters of non-elderly MassHealth members live in working families.



MassHealth provides health insurance coverage to low-income workers across a **wide range of industries**:



SOURCES: Authors' calculations using the American Community Survey (ACS) 2019 1-Year Public Use Microdata Samples.
Note: As of the date of this publications, the 2020 ACS 1-year estimates have not yet been released, and the number of low-income workers by industry may have shifted since 2019.
Kaiser Family Foundation. Distribution of the Nonelderly with Medicaid by Family Work Status, 2019. Accessed at: Distribution of the Nonelderly with Medicaid by Family Work Status | KFF.

MASSHEALTH HAS DESIGNED DIFFERENT DELIVERY SYSTEMS TAILORED TO THE NEEDS OF ITS DIFFERENT POPULATIONS

MANAGED CARE PROGRAM[1]	POPULATIONS SERVED	COVERED SERVICES
Accountable Care Partnership Plans and Primary Care ACOs (Model A and Model B ACOs)	MassHealth Standard, Family Assistance, CommonHealth, and CarePlus members under age 65	Medical and behavioral health services are covered through alternative payment methods to the ACO (which vary by model and risk track). LTSS and dental benefits are not included through ACOs but are available through MassHealth fee-for-service payments.[2]
Managed Care Organizations (MCO) and MCO-Administered ACOs (Model C ACO)[3]	MassHealth Standard, Family Assistance, CommonHealth, and CarePlus members under age 65	Medical and behavioral health services are covered through a capitated payment[4] to MCOs. LTSS and dental benefits are not included in the MCO benefit but are available through MassHealth fee-for-service. MCOs can subcontract with MCO-administered ACOs using alternative payment methods.
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 a 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 coverage[5]	Full spectrum of services, including LTSS, dental, and behavioral health, covered through a capitated payment to a single health plan.
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, including LTSS, dental, and behavioral health, covered through capitated payment to a single provider. 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 through a capitated payment to a single health plan (includes LTSS, dental, behavioral health).

[1] For more information on each of these programs, please see these educational materials developed by MassHealth: MassHealth Health Plan Information (ACOs, MCOs, and the PCC Plan), Enrolling and Receiving Care Under Senior Care Options (SCO), One Care website, PACE website. Please also see Blue Cross Blue Shield of Massachusetts Foundation, What to Know About ACOs: The Latest on MassHealth Accountable Care Organizations.

[2] Fee-for-service (FFS) payment: A payment made to providers for each service delivered.

[3] MassHealth will be sunsetting model C ACO's in 2023, according to the 1115 waiver extension approved by CMS in September 2022. For more information, please see Blue Cross Blue Shield of Massachusetts Foundation, The MassHealth Proposed Demonstration Extension 2022–2027: Building on Success, Focusing on Equity.

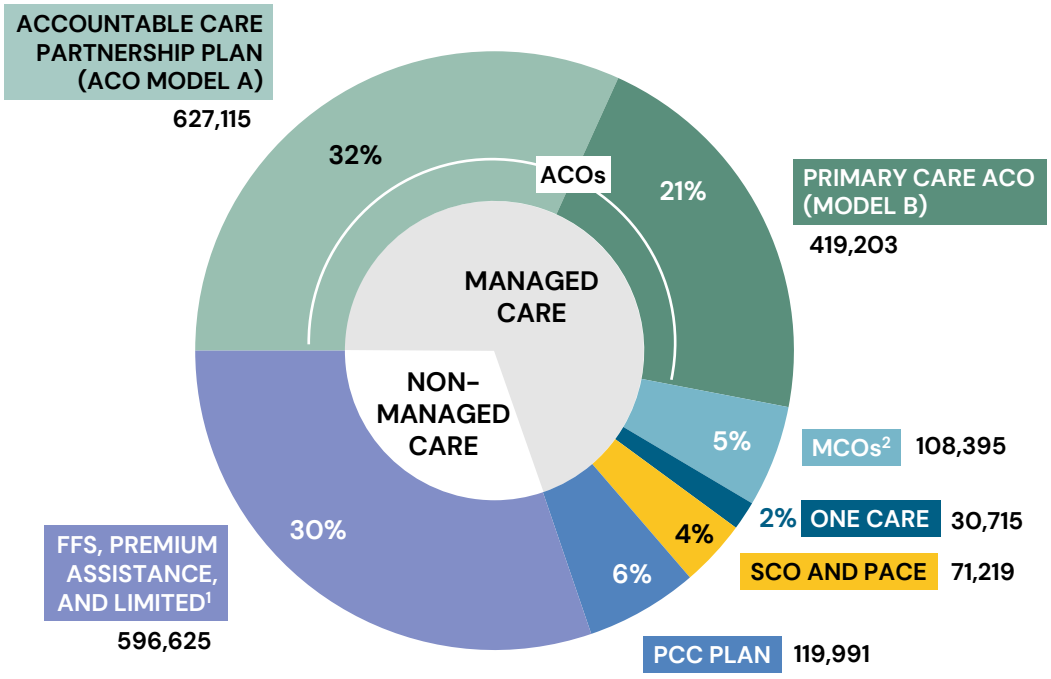
[4] Capitated payment: A monthly payment to a health plan for each enrollee. In return, the health plan must provide or arrange for all medically necessary covered services.

[5] If a member enrolled in One Care turns 65 and is still eligible for MassHealth, they may elect to stay enrolled in One Care.

SOURCES: 130 C.M.R . §450; 130 C.M.R §508.

AMONG MASSHEALTH MEMBERS, 70% ARE ENROLLED IN MANAGED CARE, WITH OVER HALF OF MEMBERS IN ACOs

MASSHEALTH ENROLLMENT BY PAYER TYPE, SFY 2021



[1] Premium assistance includes-premium subsidies from MassHealth for employer-sponsored health insurance. MassHealth Limited provides coverage for emergency medical services for about 168,623 noncitizens (for SFY 2021).

[2] The MCO population includes members who are also enrolled in an MCO-administered ACO (Model C) (about 10,000 members). MassHealth will sunset Model C ACOs in 2023, as indicated in the latest 1115 waiver extension approval.

SOURCE: MassHealth Budget Office.

MassHealth members are enrolled in several varieties of managed care. Members under age 65 can enroll in a MassHealth-contracted Accountable Care Organization (ACO), a MassHealth-contracted Managed Care Organization (MCO) (with the option of an MCO-administered ACO), or the MassHealth-administered Primary Care Clinician (PCC) Plan. Members with disabilities under 65 who have MassHealth and Medicare can enroll in One Care.

Following the full implementation of the MassHealth ACO program in March 2018, more than half of MassHealth members are now enrolled in an ACO.

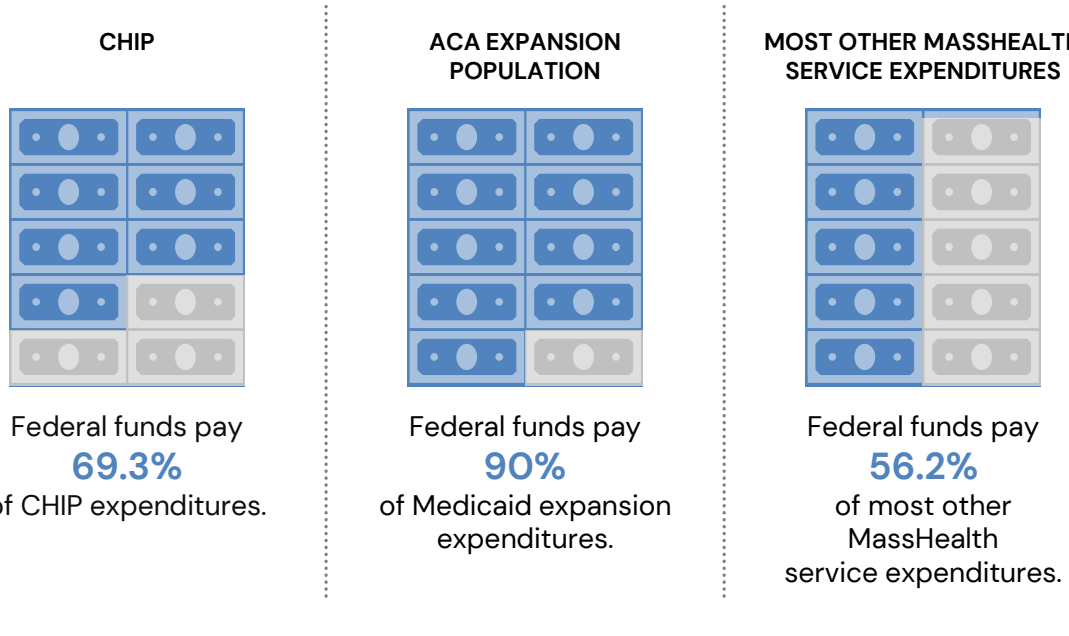
Seniors may enroll in Senior Care Options (SCO) or, if they have significant disabilities, in the Program of All-Inclusive Care for the Elderly (PACE), which is available for members aged 55 and older.

Members not in managed care are in fee-for-service (FFS) plans. 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.

SPENDING AND COST DRIVERS

EVERY DOLLAR IN MASSHEALTH SPENDING IS REIMBURSED BY AT LEAST 50 CENTS IN FEDERAL REVENUE TO THE STATE

FEDERAL AND STATE SHARES OF MASSHEALTH EXPENDITURES, APRIL 2022



The federal government reimburses Massachusetts for a portion of MassHealth spending. Currently, the federal government reimburses Massachusetts for:

- 69.3% of its Children's Health Insurance Program (CHIP) spending;[1]
- 90% of its spending on the ACA expansion population[2]; and
- 56.2% of other MassHealth service expenditure

Federal legislation passed in response to COVID-19 temporarily increased the share of MassHealth expenditures reimbursed by the federal government (known as the "Federal Medical Assistance Percentage" or FMAP) for expenditures in the CHIP program and for most other MassHealth service expenditures.[3] These rates are set to decrease when the federally-declared public health emergency ends.

[1] The CHIP federal matching assistance percentage is currently 69.34%. When the federally-declared public health emergency ends, the matching assistance will decrease.

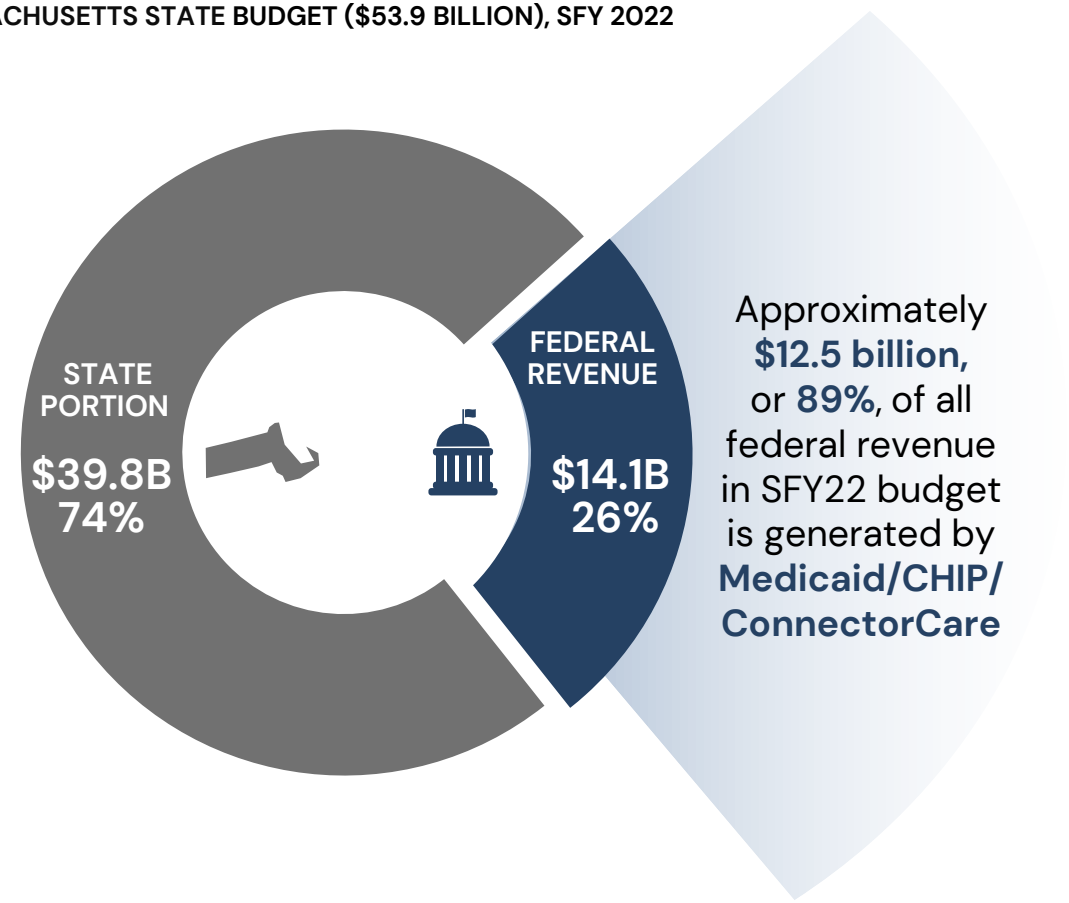
[2] The Affordable Care Act (ACA) gave states the option to expand Medicaid to nearly all adults earning less than 138 percent of the Federal Poverty Level (or about $17,800 per year in 2021). Parents in this income range were already eligible for MassHealth prior to the ACA, so the expansion population is mostly childless adults.

[3] Federal Medical Assistance Percentages (FMAP) for the ACA expansion population is 90%. FMAP for the ACA expansion population is not affected by the temporary FMAP bump in the Families First Coronavirus Response Act. However, most other MassHealth services expenditures do benefit from the temporary 6.2% increase in FMAP funding.

SOURCES: Kaiser Family Foundation. State Health Facts, Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP. Kaiser Family Foundation. State Health Facts, Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier.

THE MAIN SOURCE OF FEDERAL REVENUES TO MASSACHUSETTS IS MASSHEALTH

MASSACHUSETTS STATE BUDGET ($53.9 BILLION), SFY 2022



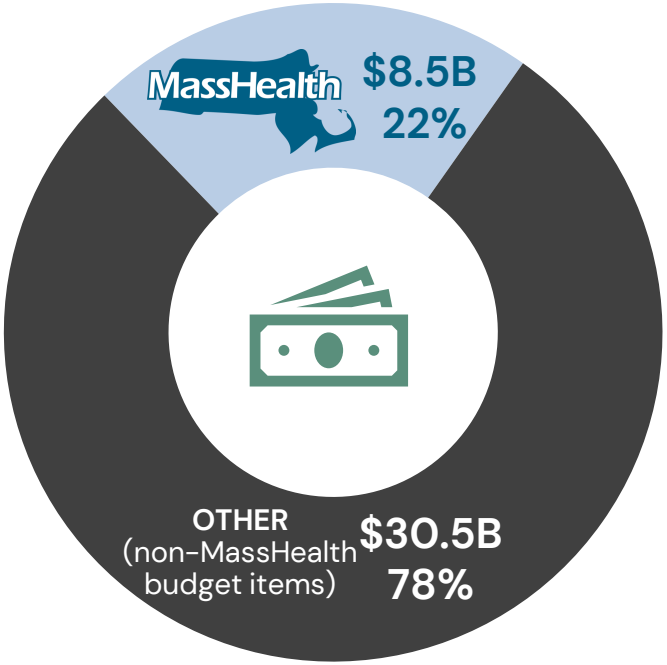
NOTE: Medicaid in this context includes MassHealth, Commonwealth Care (prior to 2014), and ConnectorCare premium and cost-sharing subsidies (post-2014); additional MassHealth 1115 waiver spending; and spending on some programs and facilities that serve people eligible for MassHealth and are administered by the Departments of Developmental Services, Mental Health, and Public Health, and the Massachusetts Rehabilitation Commission.

SOURCE: Massachusetts Budget and Policy Center.

Federal revenues supply about one-quarter of the funding for the state budget, and about 89% of that revenue is generated by Medicaid, CHIP, and ConnectorCare expenditures.

MASSHEALTH ACCOUNTS FOR APPROXIMATELY 22% OF THE STATE BUDGET, NET OF FEDERAL REVENUES

MASSACHUSETTS TOTAL STATE SPENDING NET OF FEDERAL REVENUES ($39 BILLION), SFY 2022



Massachusetts's SFY 2022 budget is approximately $53.9 billion, of which about one-quarter was supplied by federal revenues. Medicaid/CHIP/ConnectorCare generated the vast majority (89%) of those federal revenues (see slide 21). To understand the true cost of MassHealth to the state, it is instructive to look at the expected state spending net of federal revenues; this net state budget totaled $39 billion in SFY 2022. The state's share of MassHealth costs is approximately 22% of the state budget net of federal revenues.

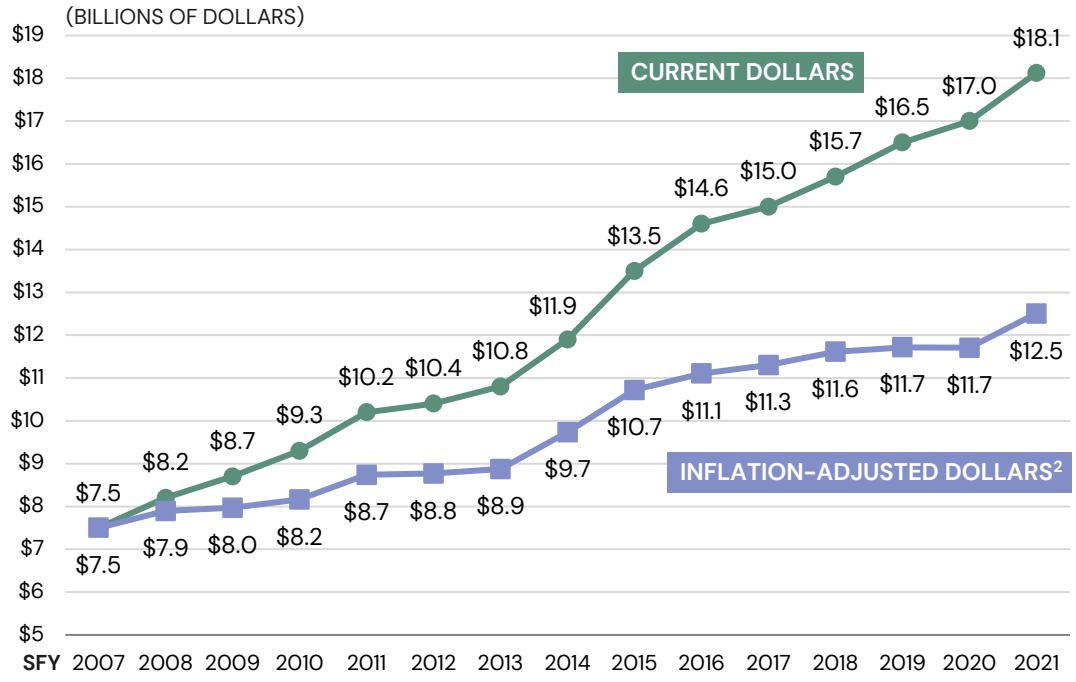
From SFY 2018 to SFY 2022, the total state budget increased by an average of 4% per year, while the MassHealth budget increased by an average of 2.4% per year (not shown in charts).*

*Information based on data provided by Massachusetts Budget and Policy Center staff. The budget amounts are total budgets including federal revenue.

SOURCES: Massachusetts Budget and Policy Center (2022). What is the Actual State Cost of MassHealth in State Fiscal Year 2022? Blue Cross Blue Shield of Massachusetts Foundation. See also: Massachusetts Budget and Policy Center (2019). What is the Actual State Cost of MassHealth in 2019? Blue Cross Blue Shield of Massachusetts Foundation.

TOTAL MASSHEALTH SPENDING HAS RISEN SINCE THE BEGINNING OF THE PANDEMIC, DRIVEN LARGELY BY ENROLLMENT

MASSHEALTH TOTAL PROGRAMMATIC SPENDING, SFY 2007–2021*



*This analysis reflects gross spending amounts which includes both state and federal revenues. The spending amounts include claim and capitation payments for medical benefits provided by MassHealth, and do not include the cost of Medicare or commercial premiums, Medicaid-reimbursable services from other state agencies, administrative spending, or risk corridor payments to managed care plans, or supplemental payments to providers. Note that this slide contains actual programmatic spending data while the previous slide contains budgeted state spending net of federal revenues.

[1] Medical cost inflation refers to the consumer price index specifically for medical care.

[2] Inflation adjustment uses the Medical Consumer Price Index for the Boston area, from the U.S. Bureau of Labor Statistics.

[3] Massachusetts Budget and Policy Center (2022) What is the Actual State Cost of MassHealth in 2022? Blue Cross Blue Shield of Massachusetts Foundation

SOURCES: MassHealth Budget Office and author's calculations.

Total MassHealth program spending has more than doubled in 13 years, from $7.5 billion in SFY 2007 to $18.1 billion in SFY 2021. When adjusted for medical cost inflation,[1] the average annual increase from SFY 2007 to SFY 2021 was less than 4%.

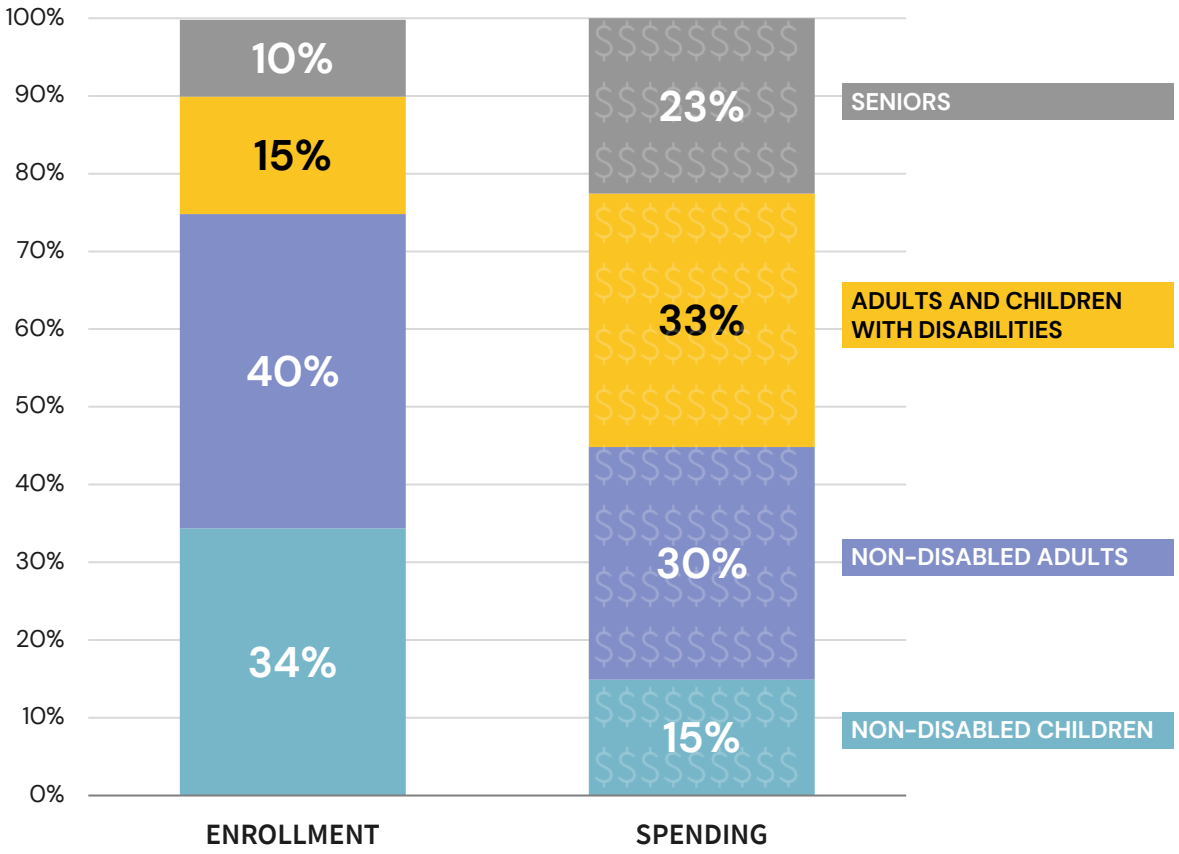
In SFY 2021, roughly coinciding with the start of the pandemic, the inflation-adjusted spending growth increased to 6.6%. This growth in spending was largely driven by increases in enrollment related to the pandemic and the federal continuous coverage requirement effective throughout the federal COVID-19 Public Health Emergency (see slide 12). In addition to pandemic related enrollment, spending was affected by a scheduled increase in ACO and MCO capitation rates that took effect in January 2020.

The increased spending in SFY 2021 was largely offset by the enhanced federal match during the pandemic, reducing the impact on the state budget.[3]

Prior to the COVID-19 pandemic, the most significant annual increases in spending occurred from SFY 2013 to SFY 2015. Most of that growth is attributable to enrollment increases resulting from the ACA expansion.

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

DISTRIBUTION OF MASSHEALTH ENROLLMENT AND SPENDING BY VARIOUS POPULATIONS, SFY 2021

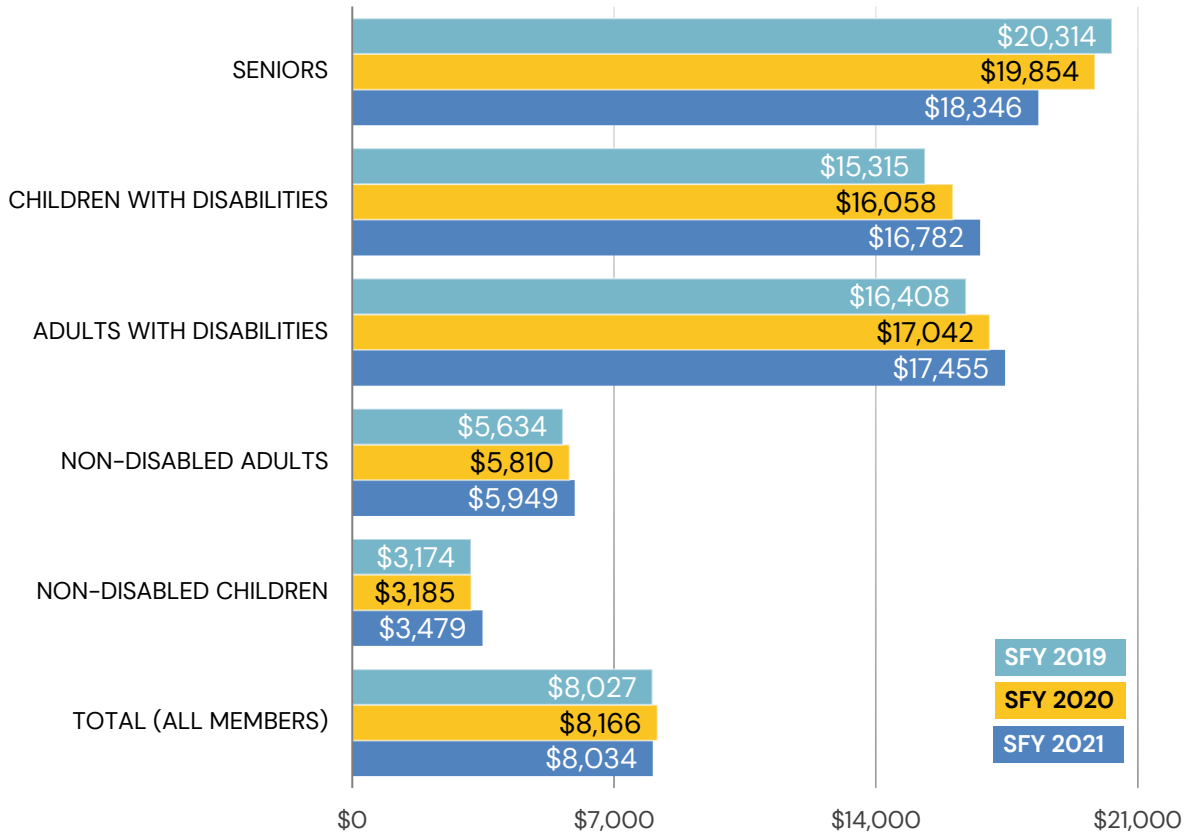


SOURCE: MassHealth Budget Office.

MassHealth spending is not spread evenly across the various categories of members. Approximately 56% of spending in SFY 2021 was for services to people with disabilities and seniors. These groups make up a little over one-quarter (25%) of the MassHealth membership.

TRENDS IN MASSHEALTH SPENDING PER MEMBER VARIED WIDELY ACROSS SUB-GROUPS IN RECENT YEARS

MASSHEALTH PAYMENTS PER MEMBER PER YEAR, SFY 2019-2021[1]



[1] PMPY data for SFY 2020 and 2021 is prior to implementation of risk corridors, which limit the losses or gains of ACOs and MCOs in any given year. PMPY spending for all groups other than seniors in SFY2020 and SFY 2021 will likely be lower once MassHealth has recouped some of the ACO and MCO gains from these years through the risk-sharing process.

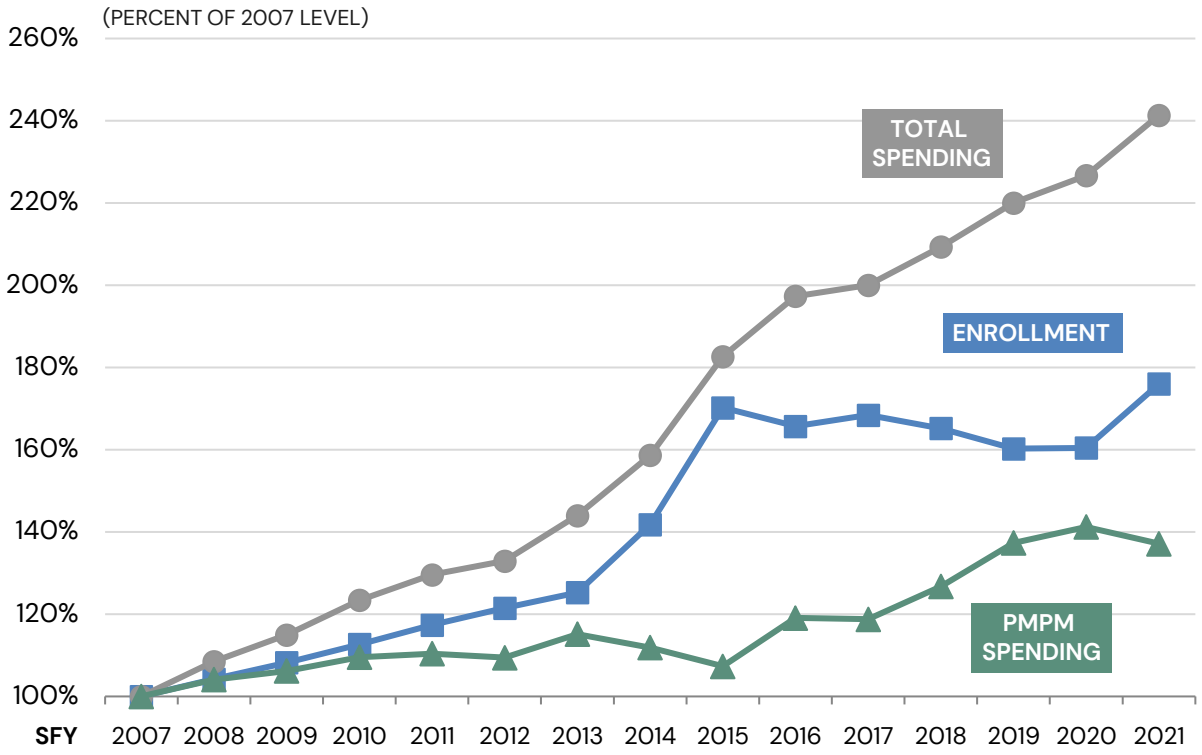
SOURCE: Calculations based on total spending and member months from the MassHealth Budget Office.
Based on date of service spending. Excludes spending and enrollment for the Temporary Medicaid category.

Over a two-year period, from SFY 2019 to SFY 2021, per member spending unadjusted for inflation increased for all population groups except seniors. These increases can be explained by two trends: 1) a significant increase in capitation rates paid by MassHealth beginning midway through SFY 2020, and 2) rebounding utilization in SFY 2021 after the initial COVID-19 lockdown caused a drop in utilization across nearly all service categories (doctors visits, dental care, etc.)

During this same time period, per member spending decreased 10% for seniors (about $1,969). One driver of this decrease was a reduction in nursing facility utilization during the COVID-19 pandemic. Since nursing facility care is high cost, this trend reduced the per member spending of the overall senior population.

WHILE ENROLLMENT AND OVERALL PROGRAM SPENDING INCREASED DURING SFY 2020-2021, AVERAGE SPENDING PER MEMBER DECREASED

GROWTH IN MASSHEALTH TOTAL SPENDING, ENROLLMENT, AND PER MEMBER PER MONTH (PMPM) COSTS[1] AS COMPARED TO 2007 (SFY 2007 = 100%)



From SFY 2020 to 2021, member enrollment increased by 9.7%, while average spending per member decreased by 2%.

The decrease in average spending per member between SFY 2020 and 2021 was driven by two factors: 1) reduced utilization among seniors (see slide 25), and 2) a large increase in enrollment among children and adults without disabilities, who have lower health care costs than seniors or members with disabilities.[2]

This trend is consistent with a historical pattern: spending per member tends to drop when enrollment increases rapidly (as it did during the ACA Medicaid expansion from 2013-2015). Large enrollment increases typically include more members with lower health care costs than the MassHealth population as a whole. From 2015 to 2020, a period of declining overall enrollment and increased spending per member drove the overall spending growth.

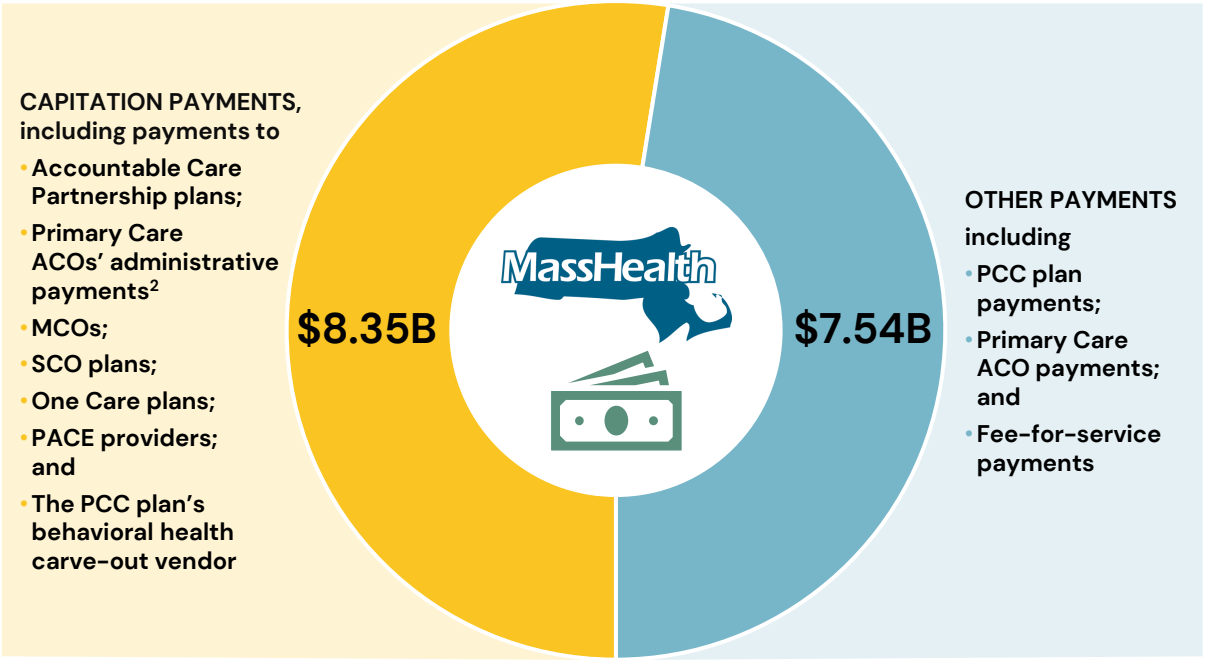
[1] This data include enrollment and spending associated with the temporary Medicaid program that was initiated in 2014.

[2] Blue Cross Blue Shield of Massachusetts Foundation. (2021). SFY2021 Budget for MassHealth and Other Health Reform Programs.

SOURCES: MassHealth Budget Office (total date of service spending and enrollment) and authors' calculations.

NEARLY HALF OF MASSHEALTH SPENDING IN STATE FISCAL YEAR 2021 WAS ON CAPITATION PAYMENTS

TOTAL MASSHEALTH SPENDING = $15.9 BILLION, SFY 2021



MassHealth spent $15.9 billion[1] on services for its members in SFY 2021. Nearly half of that spending ($8.35 billion) was capitation payments to ACOs, MCOs, the PCC plan's behavioral health carve-out vendor, SCO plans, One Care plans, and PACE providers. In SFY 2021, approximately 70% of MassHealth members were enrolled in one of these managed care arrangements.

For members in managed care plans, some services are paid for under fee-for-service arrangements, including the majority of LTSS provided to managed care members. As a result, nearly half of fee-for-service payments went to LTSS and nursing facilities.[3]

[1] This total does not include spending on Medicare premiums. The figures also do not include Medicaid-reimbursable services from other state agencies, administrative spending, or supplemental payments to hospitals.

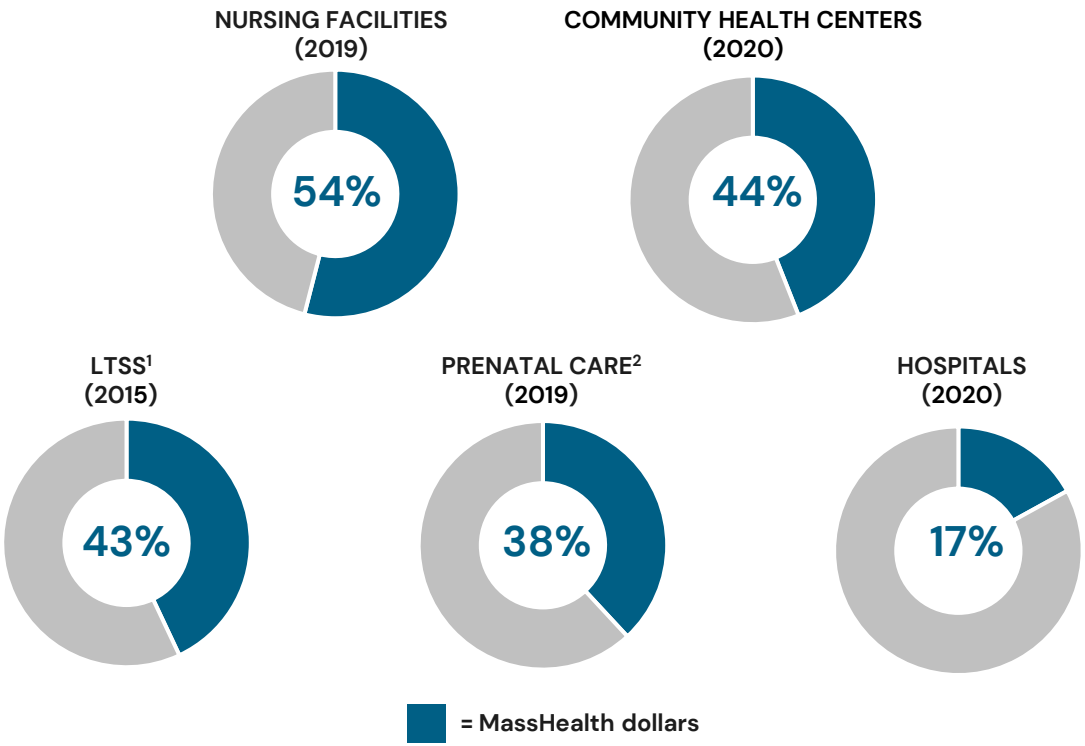
[2] Primary Care ACO administrative payments are made on a per enrollee, per month basis. Primary Care ACOs are primarily paid on a share savings / shared loss model that is not considered to be a capitated payment.

[3] Authors communication with the MassHealth Budget Office.

SOURCE: MassHealth Budget Office.

MASSHEALTH SPENDING IS IMPORTANT TO MANY TYPES OF PROVIDERS

MASSHEALTH REVENUE AS A PERCENTAGE OF PROVIDERS' TOTAL PATIENT REVENUES



[1] Includes spending for home health care, durable medical supplies, Medicaid Home and Community Based Services (HCBS) waivers, and care provided in residential care facilities. The source data also bundles in ambulance services, school health, and worksite health care, which make up a very small piece of these services.

[2] Percentage of births whose prenatal care was paid for by MassHealth

SOURCES: Center for Health Information and Analysis (CHIA) (2021), Massachusetts Hospital Profiles (SFY 2020 data); CHIA HCF-1 Cost Reports (Nursing Facilities — Calendar Year 2019); Health Resources and Services Administration, Bureau of Primary Health Care, Uniform Data System Report (CHCs — federal FY 2020 data) (limited to HRSA-funded CHCs); CMS National and State Health Expenditure Accounts (estimate using MA total and Medicaid spending 2009 and MA total spending 2014); MA DPH; Massachusetts Births 2019, Table 1. Trends in Birth Characteristics.

MassHealth represents a significant portion of health care providers' revenues. This is especially the case for nursing facilities and community health centers, which on average receive more than 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.

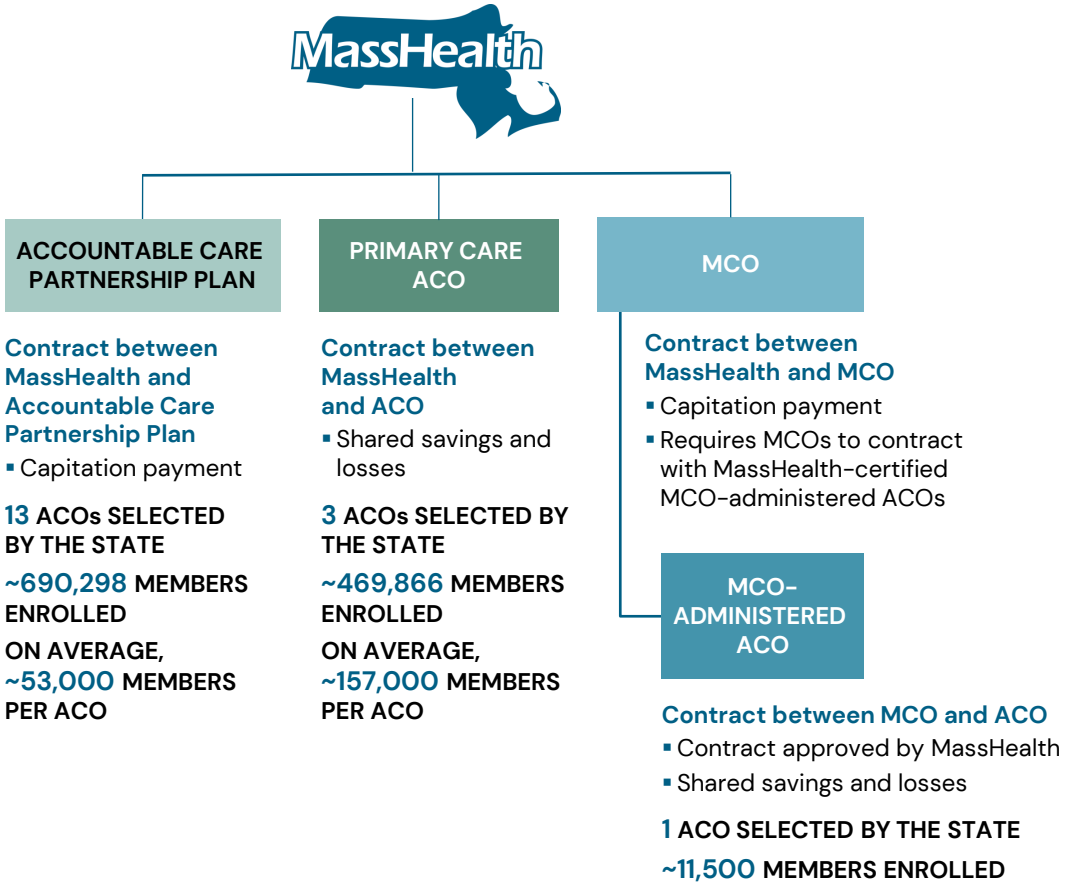
REFORMS

MASSACHUSETTS ADMINISTERS MOST OF MASSHEALTH THROUGH WAIVERS

WHAT IS A STATE PLAN?	Medicaid state plans reflect an agreement between a state and the federal government regarding how the state Medicaid program will operate. Amendments to Medicaid state plans are frequent and available here.
WHAT IS A WAIVER?	States may request approval from the federal government to waive certain parts of federal Medicaid law in order to test program innovations or gain more flexibility in how they deliver and pay for Medicaid services. Waivers allow greater flexibility than Medicaid state plans. MassHealth uses both Section 1115 and Section 1915(c) waivers. 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.
1115 DEMONSTRATION WAIVER	MassHealth operates under the authority of an 1115 demonstration waiver for almost all members. The waiver first took effect in 1997 and has evolved through seven extensions to expand coverage, support the safety net, and provide incentives for delivery system innovations. Through the extension approved in November 2016 and effective through September 30, 2022, MassHealth implemented a new Accountable Care Organization (ACO) program, and new models of addressing member needs using Community Partners and flexible services. In its latest extension, approved in September 2022 and effective through December 31, 2027, MassHealth plans to build on these successful models and make several policy changes to address health equity (see slide 34 for more information).
1915(c) HOME- AND COMMUNITY-BASED SERVICES WAIVERS	Home- and community-based services (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. MassHealth obtains federal matching funds on expenditures made by the state agencies that authorize and oversee the services, such as the Executive Office of Elder Affairs, the Department of Mental Health, and the Massachusetts Rehabilitation Commission. The waiver programs are targeted to specific populations: ▪ Elders aged 60 and over (Frail Elder Waiver) ▪ Adults aged 22 and over with intellectual or developmental disabilities (Community Living, Intensive Supports, and Adult Supports Waivers) ▪ Adults aged 18 and over with traumatic brain injury (Traumatic Brain Injury Waiver) ▪ Adults aged 22 and over with acquired brain injury (Acquired Brain Injury Residential and Non-Residential Waivers) ▪ Adults and elders aged 18 and over who are moving from a facility back to the community (Moving Forward Plan Community Living and Moving Forward Plan Residential Supports Waivers) ▪ Children aged 0 to 8 with autism (Children's Autism Spectrum Disorder Waiver)

SOURCES: 130 C.M.R. §519.007; 1915(c) waiver approval documents; Gershon, R. (2019) Deciphering State Medicaid Programs. Commonwealth Medicine blog. 1115 MassHealth Demonstration ("Waiver") Approval.

MASSHEALTH ACCOUNTABLE CARE ORGANIZATIONS (ACOS)



Accountable Care Organizations (ACOs) are entities held accountable for their member populations' health and health care costs. There are three different types of MassHealth ACOs, with different payment and contracting structures.

MassHealth requires Accountable Care Partnership Plans ("Model A ACOs") to provide and pay for comprehensive health services to enrollees.

For Primary Care ACOs ("Model B ACOs") and the MCO-Administered ACO ("Model C ACO"[1]), MassHealth does not pay Primary Care ACOs to deliver direct services; rather, MassHealth pays for services directly.

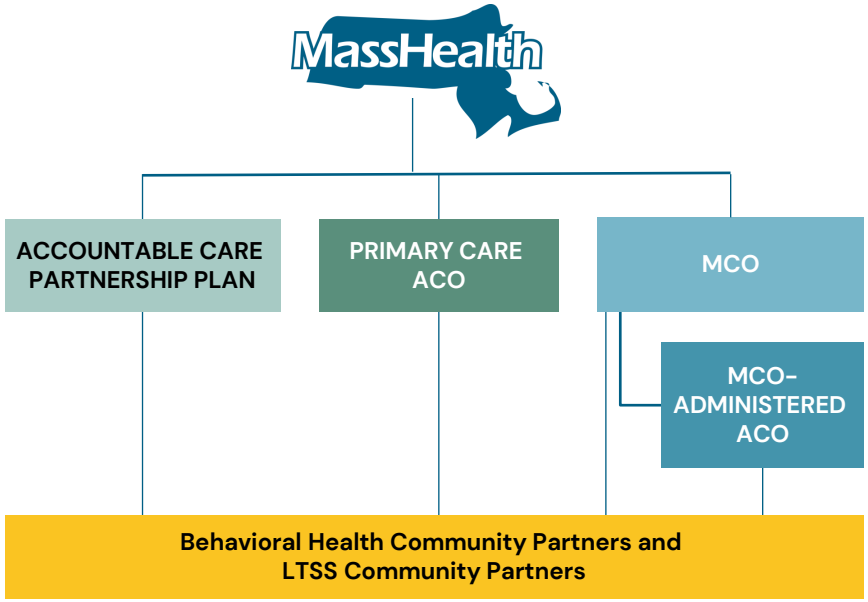
A list of ACO plans and data on enrollment by plan is available in the Foundation's ACO Primer "What to Know About ACOs: The Latest on MassHealth Accountable Care Organizations."

[1] MassHealth will sunset Model C ACOs in 2023, as indicated in the latest 1115 waiver extension approval.

SOURCES: Gershon, et al. (2017). The MassHealth Waiver 2016–2022: Delivering Reform. Blue Cross Blue Shield Foundation; MassHealth. MassHealth Budget Office.

Enrollment data from Delivery System Reform Implementation Advisory Council (February 2022) referencing data from 2/5/2022.

MASSHEALTH COMMUNITY PARTNERS



Agreements between ACOs/MCOs and Community Partners

- Per Member Per Month payment
- Currently funded through time-limited Delivery System Reform Incentive Payment (DSRIP) funding; beginning in April 2023, MassHealth plans to require ACOs and MCOs to pay CPs directly

18 BH CPs SELECTED BY THE STATE
~33,589 TOTAL MEMBERS ENROLLED

9 LTSS CPs SELECTED BY THE STATE
~9,882 TOTAL MEMBERS ENROLLED

MassHealth Community Partners (CPs) work with the most complex members and promote integration of care, improved member experience, and continuity and quality of care for members with complex needs.

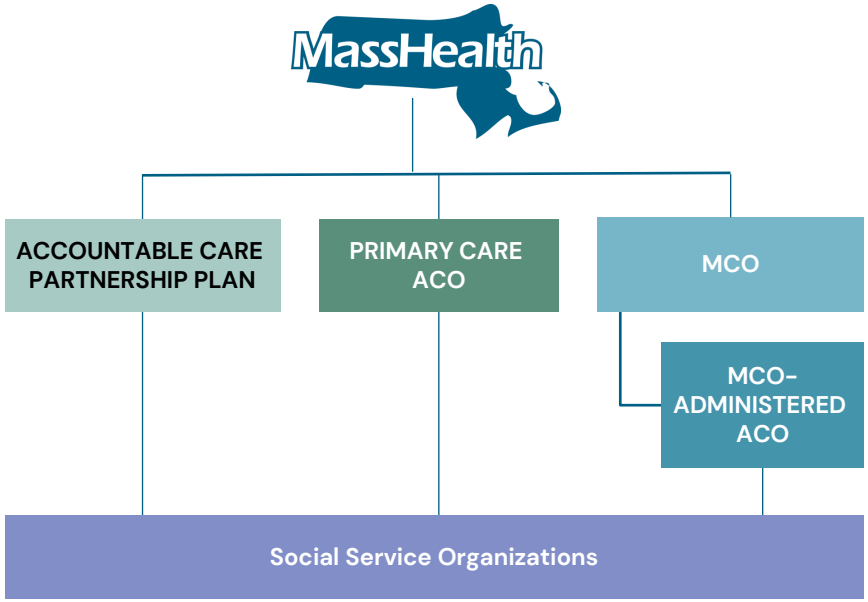
ACOs and MCOs are required to partner with multiple CPs, which make available the capabilities and cultural/linguistic expertise of existing community-based organizations.

CPs are required to perform outreach and engagement, participate in care teams, engage in person-centered treatment planning, coordinate services, support care transitions, provide health and wellness coaching, and facilitate access to social and community supports.

Many CPs are also Social Service Organizations, which partner with MassHealth to deliver flexible services (see next slide).

SOURCES: MassHealth. MassHealth Community Partners (CP) Program: Information for Providers, CP enrollment data from Delivery System Reform Implementation Advisory Council (February 2022) referencing data from 2/5/2022.

FLEXIBLE SERVICES PROGRAM



Partnerships between ACOs and Social Service Organizations to provide FSP

87 FSPs APPROVED BY THE STATE

- **43 NUTRITION FSPs**
- **42 HOUSING FSPs**
- **2 JOINT NUTRITION/HOUSING FSPs**

ALL ACOs HAVE AN APPROVED FSP

SOURCES: MassHealth. MassHealth Care Organization Flexible Services (October 2019).FSP data from Delivery System Reform Implementation Advisory Council (February 2022) referencing data from 2/5/2022.

MassHealth launched its Flexible Services Program (FSP) in January 2020. The FSP provides certain ACO members with services to address their tenancy and nutrition needs; these services are not typically covered by MassHealth. The goal of this program is to try to address certain social needs known to impact health and to potentially reduce an ACO's total cost of care.

ACOs can design specific FSPs to serve members' housing needs, nutrition needs, or both. Examples of housing ("tenancy") supports include housing application assistance, first month's rent, and security deposit. Examples of nutrition assistance includes SNAP application assistance and home-delivered meals. ACOs can partner with Social Service Organizations to provide these services, or they can provide these services directly to their members themselves.

MassHealth stipulates general eligibility criteria for FSP, including 1) behavioral or complex physical health needs and 2) housing- or nutrition-related risk factors. Each ACO further narrows the eligibility for their programs. Because the dollars for FSPs are limited, not every eligible member will receive FSP services.

CMS RECENTLY APPROVED MASSHEALTH'S LATEST 1115 DEMONSTRATION WAIVER EXTENSION

On September 28, 2022, CMS approved Massachusetts' request for a five-year extension of its MassHealth Section 1115 Demonstration waiver. This new waiver will be in effect from October 1, 2022 through December 31, 2027, and addresses the following goals.

CONTINUE AND REFINE PROGRAMS FROM PREVIOUS DEMONSTRATIONS	▪ Continue and build on major elements from current waiver: the ACO program; Flexible Services Programs; and the Behavioral Health and Long-Term Services and Supports Community Partners (CP) programs ▪ Sunset the Model C (MCO-administered) ACO program
INVEST IN PRIMARY CARE, BEHAVIORAL HEALTH INTEGRATION	▪ Invest $115 million per year to enhance primary care, including to support behavioral health integration ▪ Expand coverage for diversionary behavioral health services, which help divert members from inpatient services, to MassHealth fee-for-service members ▪ Strengthen the workforce by offering student loan forgiveness for behavioral health clinicians
ADVANCE HEALTH EQUITY	▪ Invest more than $2 billion dollars (over 5 years) in a new initiative to create incentives for ACO-participating hospitals to measure and reduce health care disparities ▪ Provide 12 months of continuous MassHealth eligibility after release from correctional facilities
CONTINUE TO SUPPORT SAFETY NET CARE HOSPITALS	▪ Continue the structure of the Safety Net Care Pool, a key source of funding for hospitals and other facilities that treat populations with limited access to care, for delivery system innovations in those facilities, and for subsidies to people purchasing care through the Health Connector. ▪ Increase Safety Net Provider Payments from $883 million to $1.5 billion (over 5 years) as more hospitals meet existing criteria for receiving these payments
MAINTAIN NEAR-UNIVERSAL HEALTHCARE COVERAGE	▪ Extend eligibility to three months prior to the date of application for pregnant people and children ▪ Allow members experiencing homelessness to remain enrolled for 24 months regardless of changes in their circumstances ▪ Eliminate the one-time spend-down currently required in CommonHealth for non-working disabled adults

SOURCES: Massachusetts Executive Office of Health and Human Services. 1115 MassHealth Demonstration ("Waiver") Approval.

MASSHEALTH CONTINUES TO PROMOTE SERVICES THAT KEEP PEOPLE OUT OF INSTITUTIONAL LONG-TERM CARE

ISSUE	There is a push nationwide to provide more home and community-based services as an alternative to institutional long-term care. The tragic toll that the COVID-19 pandemic had on many nursing facilities across the country highlighted the importance of strengthening home- and community-based services.
PAST INNOVATIONS	Massachusetts is one of the states with the most use of Medicaid Home- and Community-Based Services (HCBS), services that keep seniors and people with disabilities in their homes and communities as opposed to in institutional long-term care. MassHealth HCBS is provided through several avenues, including a state plan personal care attendant (PCA) service and HCBS waivers offering coverage for home health care, personal care, habilitation, respite, physical and occupational therapy, group adult care, home modification, assistive technology, and other services. [1] More recent innovations include implementation of LTSS Community Partners (see slide 32) and the implementation of Mass Options, a service provided by the Massachusetts Executive Office of Health and Human Services, connecting individuals to aging and disability services through telephone and texting options.[2]
FEDERAL OPPORTUNITY	Under the American Rescue Plan Act (ARPA), states were eligible for higher rates of federal funding for HCBS through an FMAP increase from April 1, 2021 through March 31, 2022. These additional funds may be invested in enhancing certain HCBS and behavioral health services. Massachusetts intends to invest the anticipated federal funding through three rounds of investment through March 2025.[3]
LOOKING FORWARD	In its initial spending plan, Massachusetts proposed implementing three rounds of initiatives with the ARPA funds, supporting three key structural pillars: [3] ▪ Strengthening the HCBS workforce by retaining and building a high-quality network of providers ▪ Improving access to and promotion of HCBS services and supports, including navigation, transitions, and enhanced care models ▪ Updating HCBS technology and infrastructure, to enable more effective care coordination, access, and delivery

[1] Executive Office of Health and Human Services. Home and Community Based Waivers.
[2] Executive Office of Health and Human Services. MassOptions.
[3] Executive Office of Health and Human Services. Strengthening Home and Community Based Services and Behavioral Health Services Using American Rescue Plan (ARP) Funding.

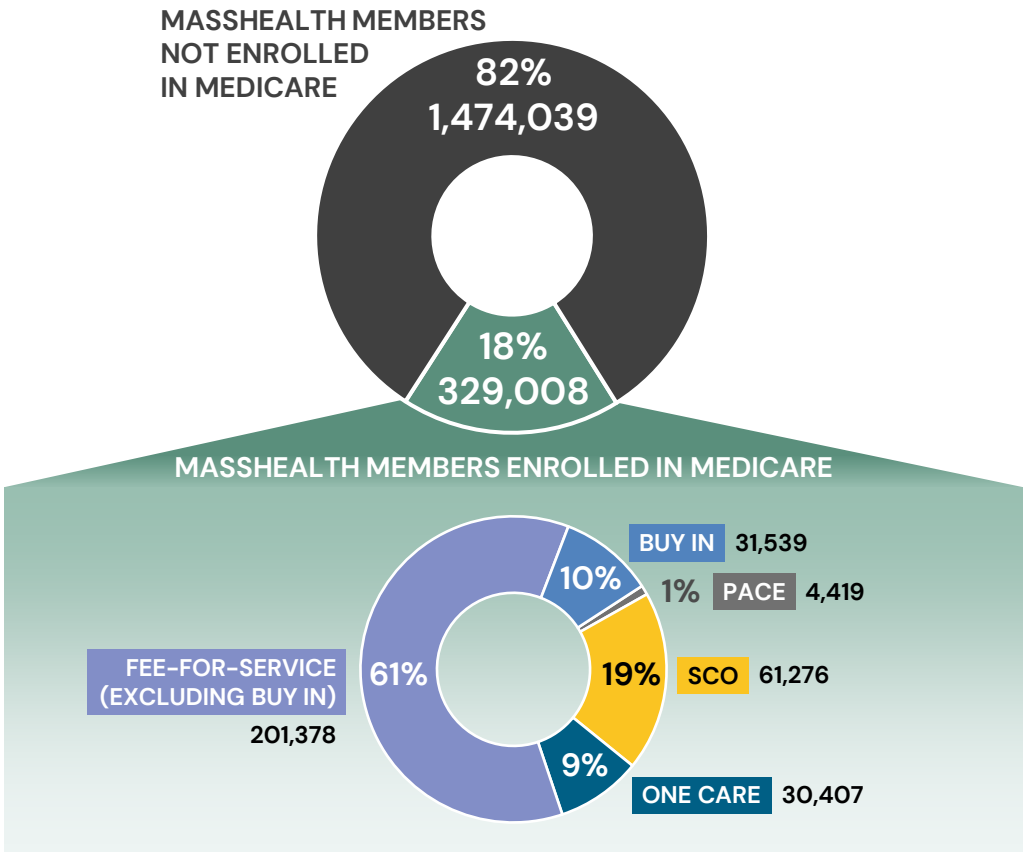
MASSHEALTH EXPANDED COVERAGE FOR PREGNANT INDIVIDUALS

ISSUE	Citing concern about maternal health outcomes nationwide, as well as significant racial inequities in maternal mortality and morbidity, experts have been calling for extended Medicaid coverage for postpartum individuals.[1]
PREVIOUS COVERAGE	Prior to April 2022, Medicaid eligibility based on pregnancy covered individuals at a higher income level than many other eligibility categories. Individuals who are pregnant and who have income up to 200% FPL were eligible for MassHealth coverage during their pregnancy and for 2-3 months postpartum.
FEDERAL RESPONSE	Starting in April 2022, the American Rescue Plan Act allows states to expand coverage for pregnant people for one year postpartum. This option is available to states for five years.[2]
LOOKING FORWARD	In 2022, Massachusetts took up the option to extend postpartum MassHealth coverage from 60 days to 12 months regardless of immigration status. This option became effective on April 1, 2022.[3]

[1] Romulus, Yaminah. Extending Postpartum Coverage Improves Maternal Health Outcomes, Health Care For All.
[2] US Congress (2021-2022). American Rescue Plan Act. Section 9812: Modifications To Certain Coverage Under Medicaid For Pregnant And Postpartum Women.
[3] Massachusetts Executive Office of Health and Human Services. Eligibility Operations Memo 22-07 (RE: Extension of Postpartum Coverage for Eligible Individuals)

MASSHEALTH CONTINUES EFFORTS TO IMPROVE CARE FOR INDIVIDUALS ENROLLED IN BOTH MASSHEALTH AND MEDICARE

SFY 2021



NOTES: The bottom pie chart only shows members who are enrolled in Medicare and Medicaid. In addition, there are SCO and PACE enrollees who are not enrolled in both MassHealth and Medicare. The MassHealth buy-in covers Medicare premiums, co-pays, and deductibles, but does not cover other MassHealth Standard services. Eligibility for the buy-in program was expanded in January 2020, increasing buy-in enrollment.

[1] Massachusetts Executive Office of Health and Human Services. (2022). Information for Organizations Interested in Serving as One Care Plans.

[2] Massachusetts Executive Office of Health and Human Services. (2022). One Care Related Information.

SOURCE: MassHealth Budget Office.

Nearly one in five MassHealth members is also enrolled in Medicare. Most of these members have two insurance cards and must navigate two distinct enrollment processes, provider networks, and sets of covered services. These misalignments can cause confusion, suboptimal care, and poorer health outcomes.

Massachusetts has developed three managed care options — One Care, SCO, and PACE — which each align Medicare and Medicaid services through a single program and provide coordinated care. More than two-thirds of "dually eligible" people remain outside these plans.

In 2018, Massachusetts proposed a new round of reforms, known as "Duals Demo 2.0", that aim to increase enrollment and improve quality of care in One Care and SCO. The future of this proposal is currently in flux, as CMS and MassHealth are working to bring the proposal into compliance with a new CMS rule that changes the guidelines for these types of plans.

MASSHEALTH IS IMPLEMENTING STRATEGIES TO MINIMIZE COVERAGE LOSS WHEN THE PUBLIC HEALTH EMERGENCY ENDS

The Families First Coronavirus Response Act increased federal funding available to help states pay for their Medicaid programs. To receive this funding states had to put in place "continuous coverage requirements" that protect most members from losing their coverage until the federal COVID-19 Public Health Emergency ends. This has led to a substantial increase in MassHealth enrollment since March 2020. MassHealth estimates that about 700,000 current MassHealth members would have been found ineligible or downgraded from their current benefit.[1]

Once the federal public health emergency ends, MassHealth is expected to resume standard eligibility redeterminations for a substantial portion of its membership. Conducting such a high volume of redeterminations is an operational challenge and puts eligible members at risk for unnecessary coverage loss.[2] MassHealth has developed a multi-prong plan to increase outreach to members and streamline the redetermination process to minimize coverage loss.

WHAT IS UNNECESSARY COVERAGE LOSS?

Unnecessary coverage loss occurs when individuals who are still eligible lose Medicaid coverage because they fail to submit required paperwork or documentation to prove their eligibility.

The best way to avoid unnecessary coverage loss is for eligibility to be verified using existing income data sources; no paperwork from the member is needed.

HEALTH EQUITY IMPLICATIONS

Black, Latinx, and other people of color are disproportionately at risk of losing coverage because people of color experience greater instability in employment and housing. These changes make it less likely that their eligibility can be verified using existing data sources and/or more likely that they will miss notices from MassHealth about the redetermination process.[4]

MASSHEALTH'S STRATEGIES FOR REDUCING COVERAGE LOSS

MassHealth's plans include:

- Conducting a multi-lingual, culturally relevant outreach campaign, with the Health Connector & Health Care For All.
- Increasing the number of automated renewals, by allowing for a bigger difference between what an individual reports as their income and the income recorded in the data source.
- Collecting updated contact information before eligibility protections end to increase member response rate.[4]

[1] Executive Office of Health and Human Services. (March 2022). Preparing for the End of the Federal Public Health Emergency Eligibility Protections. Medical Care Advisory Committee Reports to the Legislature

[2] Centers for Medicare & Medicaid Services. (2022). Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program, and Basic Health Program Upon Conclusion of the COVID-19 Public Health Emergency. PDF available at: Unwinding and Returning to Regular Operations after COVID-19.

[3] Serafi, K., Boozang, P. (2022). The End of the Federal Continuous Coverage Requirement in MassHealth: Key Strategies for Reducing Coverage Loss. Blue Cross Blue Shield of Massachusetts Foundation.

[4] Boozang, P., Striar, A. (2022). The End of the COVID Public Health Emergency: Potential Health Equity Implications of Ending Medicaid Continuous Coverage. State Health and Value Strategies.

CONCLUSION

LOOKING TO THE FUTURE OF MASSHEALTH

COVERAGE

As the Public Health Emergency ends, MassHealth will resume eligibility redeterminations, working to minimize the risk of coverage loss for eligible members.

SAFETY NET

MassHealth will play a key role in pandemic recovery even after the end of the Public Health Emergency, by continuing to be cornerstone of a health care system that provides near-universal coverage.

EQUITY

MassHealth is making several policy changes to address health equity, including creating financial incentives for ACOs to measure and reduce health inequities, and providing continuous eligibility for members experiencing homelessness.

EVOLVING

MassHealth is leveraging opportunities at the federal level to improve access to quality care, for example using ARPA funding to enhance and strengthen home- and community-based services.

MASSACHUSETTS

FOUNDATION