

The Basics of MassHealth

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by Robert Seifert and Stephanie Anthony

Introduction

MassHealth is a pillar of the Massachusetts health insurance landscape that has resulted in over 98 percent of the state having coverage in 2010. MassHealth is the Commonwealth's combined Medicaid and State Children's Health Insurance Program (CHIP) and has long been a central part of its health care safety net. Today it provides health care coverage — a key to accessing care — to 1.3 million of the Commonwealth's neediest, most vulnerable residents. It pays providers such as hospitals, physicians and pharmacies for treatments that would otherwise go largely uncompensated if they were uninsured. It brings billions of federal dollars into the state to help finance physical and behavioral health care for low-income people. It is the financial engine for the publicly subsidized insurance created by the 2006 state health reform law, which greatly expanded coverage in Massachusetts and was, in many respects, a model for the national reform law passed in March 2010.

MassHealth presents challenges as well. Because of its important role and the diverse medical needs of the people it serves, the program demands a great amount of public resources, which are now being squeezed by slowing revenues and other state budget priorities related to the current economic downturn. Much of MassHealth spending is not discretionary, but the state does have some control over the services it pays for, how much it pays for them, who receives them, and how they are delivered. Using any of these policy levers has implications for health care providers and consumers, and for the overall system. MassHealth is also entering a period of change as the federal authorization under which it operates is renewed and the national health reform law goes into effect.

This fact sheet provides an overview of the MassHealth program, describing its basic structure, who receives benefits and what those benefits are, and how enrollment and spending has changed over time. It explains how MassHealth fits into the set of complementary programs created by the 2006 Massachusetts health reform law. It concludes with a discussion of some of the current policy issues and challenges facing the program.

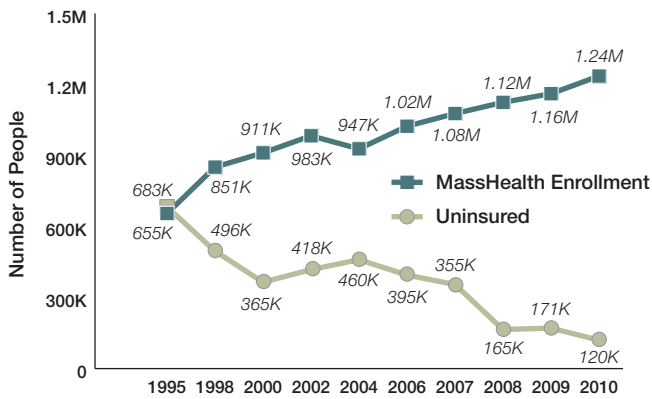
Background

Medicaid is a joint federal-state program, created by Congress in 1965 as Title XIX of the Social Security Act. Medicare, Title XVIII, was passed at the same time. In Massachusetts, MassHealth comprises Medicaid and the State Children's Health Insurance Program (CHIP), Title XXI of the Act, which Congress enacted in 1997 and reauthorized in 2009. Medicaid is a means-tested entitlement, jointly funded by state and federal governments, originally conceived as medical coverage for families and individuals who received cash public assistance. Over the past 15 years, though, Medicaid has been "de-linked" from welfare and, as of 2014, all states will provide Medicaid coverage for all people up to a set level of income, regardless of eligibility for other public programs. States administer their Medicaid programs and establish their benefit packages and provider payments within broad federal guidelines, but there are wide variations in Medicaid programs across states. Massachusetts operates most of its Medicaid program under a federal "research and demonstration" waiver, which allows the Commonwealth more latitude to tailor its program to its population and political circumstances. Though the waiver only applies to people under age 65, its name — MassHealth — is used generically for the entire program.

Who is covered?

MassHealth provides health coverage to many of the poorest, most vulnerable and most intensive users of health care services in the Commonwealth. Since 1997 the Commonwealth has, as a matter of policy, sought to expand MassHealth enrollment among critically underserved groups. The expansion occurred in two phases. The program added over 300,000 members from 1997 to 2002, the first years of the MassHealth waiver. After a contraction following some program cuts in 2002, enrollment climbed again, adding over 100,000 more members from 2004 to 2008. This was coincident with the introduction of an automated enrollment system (the Virtual Gateway) in 2004 and the enactment of state health care reform in 2006. Most recently, MassHealth has served its traditional safety net function, seeing enrollment grow in the past two years as the economic recession reduced the number of Massachusetts residents with private health insurance coverage. As of November 2010, enrollment stands at 1,299,000.

Figure 1. Trends in MassHealth Enrollment and Uninsured, 1995-2010



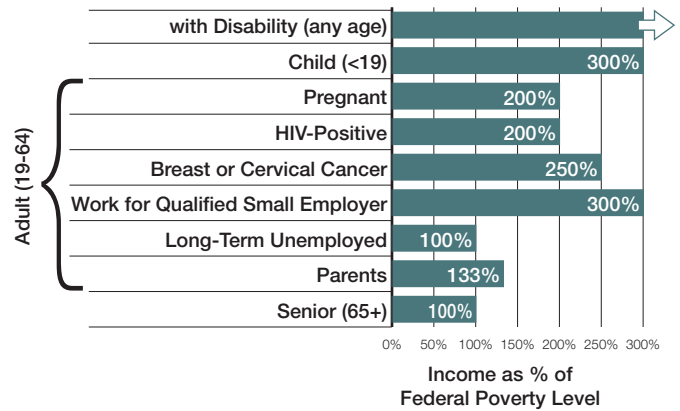
Sources: MassHealth figures are from the Office of Medicaid and are monthly averages, except 1998-2002 which are as of June 30. Uninsured numbers are from the Division of Health Care Finance and Policy, from a survey that year. 1995 uninsured numbers from Blendon et al., "Massachusetts Residents Without Health Insurance, 1995," Harvard School of Public Health.

MassHealth provides or supplements health care coverage for nearly one of every five residents of Massachusetts. Its members include low-income children and families, pregnant women, women with breast or cervical cancer, people with HIV-AIDS, long-term unemployed adults, seniors, and people with disabilities. Eligibility for coverage is different for each of these categories and the rules are complex. Eligibility is determined by a variety of factors, including income relative to the federal poverty level, age, immigrant status and, for some categories of eligibility, assets.

In general, children in families with income up to three times the federal poverty level (FPL for a family of four in 2011 is \$22,050) qualify for some form of coverage. Parents of these children are eligible with incomes up to 133 percent of the FPL. The eligibility limit is 100 percent of FPL (\$10,890 for an individual) for long-term unemployed adults and 200 percent for pregnant women and people with HIV. Women with breast or cervical cancer are eligible up to 250 percent, and employees of certain small employers (for whom MassHealth subsidizes premiums for private coverage) up to 300 percent. Higher income children and adults with disabilities may enroll in MassHealth by paying a sliding scale premium based on their income. People over age 65, most of whom have Medicare coverage, generally must have income at or below the federal poverty level and minimal assets to supplement their Medicare with MassHealth coverage, although they may qualify with higher incomes or assets if they have sufficiently large medical expenses.

When the Medicaid eligibility expansion under the federal health reform law — the Patient Protection and Affordable Care Act (ACA) — takes effect in 2014, Massachusetts, along with all other states, will be required to make MassHealth available to nearly everyone under age 65 with incomes up to

Figure 2. MassHealth Eligibility Standards by Category of Coverage

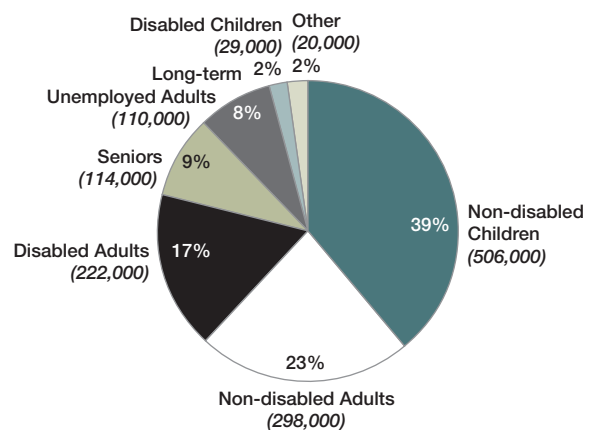


133% of the FPL.¹ As Figure 2 illustrates, this will not require significant changes in Massachusetts' current eligibility rules.

The Commonwealth's 2006 health care reform law introduced Commonwealth Care as a companion program to MassHealth. Most adults up to 300 percent of the FPL who do not qualify for MassHealth are eligible for publicly subsidized coverage through Commonwealth Care. Exceptions are undocumented immigrants and certain other non-citizens, as well as people who have access to affordable coverage through their employer. In short, nearly all Massachusetts residents with incomes below three times the poverty level have access to health insurance at a minimal cost.²

About one-third of the Commonwealth's children (535,000) are MassHealth members, 29,000 of whom have one or more disabilities. Other population groups also rely on MassHealth to a greater degree for their health coverage. MassHealth provides coverage to nearly two-thirds of the Commonwealth's nursing home residents and more than a quarter of non-elderly adults with disabilities.

Figure 3. Distribution of MassHealth Enrollment, November 2010



Source: Office of Medicaid, November 2010 snapshot report.

1 Undocumented immigrants and legal residents who have been in the country for less than 5 years are ineligible for Medicaid under federal law, though they will be eligible for new federal premium subsidies for private coverage beginning in 2014.
 2 People excluded from Commonwealth Care and most MassHealth coverage because of their immigration status may qualify for MassHealth Limited, which provides coverage for emergency services.

What services are covered?

The federal government mandates a set of services that all state Medicaid programs must cover with no more than minimal cost sharing (such as copayments) required of beneficiaries. These services include hospital care (including for mental health treatment), physicians, community health centers, pediatric screening and treatment, and family planning, pregnancy and post-partum services, among others. Services not typically covered in private health insurance plans, such as nursing homes and home health services, are also covered for most MassHealth members.

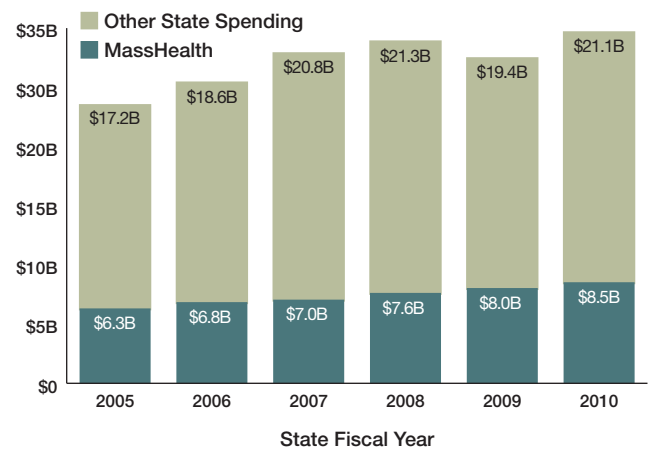
MassHealth also covers most of the services that the federal government agrees to participate in financing but deems optional, including prescription drugs,³ intermediate care facilities for individuals with mental retardation (ICF/MR), personal care for people with disabilities, targeted case management, and others. In recent years, the need to control program spending as recession-driven demand for services grew led to benefit reductions, most notably the elimination of dental services for adults in fiscal year 2011.⁴ Certain groups that are eligible for MassHealth by virtue of the waiver's eligibility expansions (e.g., long term unemployed) have a slightly narrower benefit package; benefits for these groups exclude nursing facilities, other types of community-based long-term care, and non-emergency medical transportation. In general, though, the coverage that MassHealth offers is comprehensive and compares well with private insurance.

When someone who qualifies for MassHealth coverage is also eligible for employer-sponsored insurance or Medicare, MassHealth will "wrap around" that coverage as a secondary payer to cover a MassHealth level of services and cost sharing not covered by the primary insurance. This practice reinforces MassHealth's status as an insurer of last resort and ensures that MassHealth does not pay for duplicate benefits.

What does it cost and how is it funded?

MassHealth is the primary safety net program for an increasingly expensive service, which means it is central to the state budget. MassHealth paid \$8.5 billion in claims and capitation fees to MassHealth providers and managed care organizations for services delivered in state fiscal year 2010. Spending on the program has increased by an average of 6.2 percent per year since 2005, and represented about 29 percent of all state spending in 2010, up from 27 percent in 2005 (see Figure 4).⁵ Still, while MassHealth spending has grown considerably and consumes a large share of the state budget, it imposes a rela-

Figure 4. MassHealth Spending as a Portion of All State Spending



Sources: EOHHS (MassHealth data); Office of the Comptroller, Statutory Basis Financial Reports (other state spending).

tively small burden on the state's overall economy. MassHealth spending accounted for about 2.1 percent of total personal income (a common measure of overall economic activity) for the first part of the decade, through 2006. In recent years, because of a decline in economic activity and an increase in demand for the state's safety net programs, that percentage has grown slightly and reached 2.7 percent in fiscal year 2010.⁶

It can be argued that this is a reasonable investment for a program that provides a critical service to nearly one-fifth of the state's population, though spending increases are a matter of concern for other state budget priorities. The increases are not surprising: in recent years they have been driven almost entirely by an increase in program enrollment, much of that due to the recession and accompanying declines in private health insurance coverage. Since 2005, MassHealth enrollment has grown an average of 5 percent per year. In contrast, average spending per member has remained relatively flat, even in the face of steady rates of medical cost inflation. MassHealth has managed its spending growth in part by holding many of its provider rates flat or allowing only small rate increases during this time period. From 2005 to 2010, MassHealth spending per member increased an average of 1.1 percent per year, while general medical prices were increasing more than four times as fast (see Figure 5).

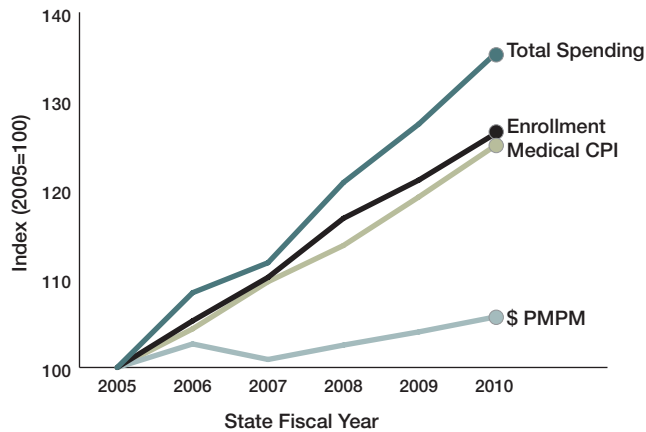
3 As of 2006, about 200,000 elderly and disabled MassHealth members who are also enrolled in Medicare receive their prescription drugs through Medicare.

4 MassHealth covers all other optional benefits for at least some of its members, *except* nurse anesthetist services and religious non-medical health care. (Kaiser Commission on Medicaid and the Uninsured, Medicaid Benefits Database, <http://medicaidbenefits.kff.org/index.jsp>, accessed December 2, 2010.)

5 Data from EOHHS (MassHealth data) and Office of the Comptroller, Statutory Basis Financial Reports (All State Spending)

6 Calculations of MassHealth spending as a share of personal income based on data from Massachusetts Office of the Comptroller, Statutory Basis Financial Reports. Medicaid spending in the SBFR includes spending on other health programs in addition to MassHealth, so these figures are a high estimate of MassHealth's share of the state's economy.

Figure 5. Changes in MassHealth Total Spending, Spending Per Member, and Enrollment, Compared with Medical Inflation



Sources: EOHHS (Total spending and enrollment); U.S. Bureau of Labor Statistics (Medical CPI for the Boston-Brockton-Nashua urban area); authors' calculations (\$PMPM).

The spending trend is tempered by the fact that the federal government plays a large role in financing Medicaid. Ordinarily, Massachusetts receives 50 cents for every dollar it spends on the Medicaid portion of MassHealth (by far the largest piece) and 65 cents on the dollar spent on CHIP.⁷ The state also receives federal financial participation for a number of programs, administered for example by the Departments of Mental Health and Developmental Services, which serve Medicaid-eligible individuals.

As part of the federal stimulus law passed in 2009 (the American Recovery and Reinvestment Act, or ARRA), Massachusetts and all other states have received an enhanced federal Medicaid match, retroactive to the beginning of federal fiscal year 2009 (October 1, 2008). Under the enhanced ARRA match rate, Massachusetts' match rate is about 61.6 percent. This rate began phasing down in January 2011 and will revert to the regular 50 percent rate on July 1, 2011. These additional federal funds have helped to mitigate the effects on the state budget of increased MassHealth enrollment due to the recession, and emphasize Medicaid's role as one of the most important sources of revenue in the state budget, bringing several billion dollars per year to the state's General Fund.

MassHealth spending is not spread evenly across the various categories of beneficiaries. Nearly two-thirds (62%) of benefit spending in FY 2009 was for services to seniors (28%) and children and adults with disabilities (34%), though these groups comprised less than a third of MassHealth membership over the course of the fiscal year (See Figure 6). Average spending per elderly MassHealth member was about \$1,467

per month, and for members with disabilities about \$949 per month, compared with \$568 for all members.

From the perspective of providers, the role of Medicaid in financing health care varies in importance. MassHealth payments account for over half of nursing homes' revenues, about 30 percent of community health centers' revenues (and half of patient billing revenue), and about 12 percent of hospitals' revenues. Of course, the dominance of Medicaid as a payer also varies widely around these averages within provider groups.

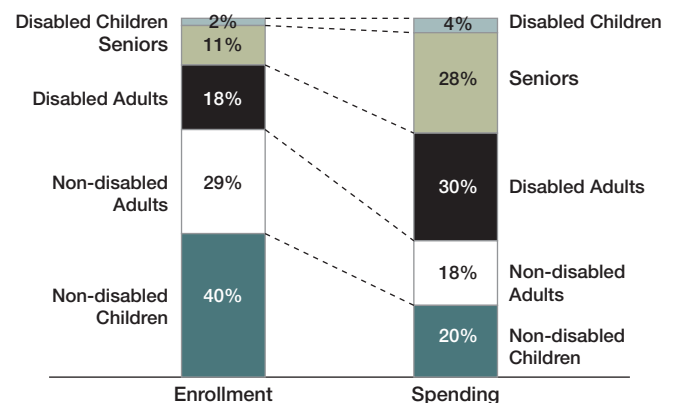
Challenges ahead

Renewing the MassHealth waiver — a shift in focus to cost and quality

Since 1997, the Commonwealth has used the MassHealth waiver to support its health care reform efforts. The waiver secured critical federal funding as the state expanded MassHealth eligibility and services to broader populations, culminating in the 2006 universal health insurance coverage law. The Commonwealth has renewed the MassHealth waiver three times since 1997, each for three-year periods. Past renewal negotiations with the Centers for Medicare and Medicaid Services (CMS) focused on how the state would continue to expand coverage while keeping its federal partner's financial commitment "budget neutral," spending no more federal dollars than it would in a traditional, non-waiver Medicaid program.

On June 30, 2010, the Commonwealth submitted a proposal to renew the waiver for state fiscal years 2012-2014, a period that begins July 1, 2011. The proposal for this renewal shifts its primary focus from coverage expansion to cost containment, with the goals of preserving health care reform coverage gains, ensuring continued affordability of coverage and improving quality of care and patient outcomes. The renewal seeks CMS support for initiatives that promote efficiency in the health care system through improved delivery of primary

Figure 6. MassHealth Enrollment and Spending, FY 2009



Source: Authors' calculations based on data from MassHealth Budget Unit reported in "EHS Results," www.mass.gov/hhs/ehsresults.

⁷ These federal funds are not unlimited: Medicaid funds are restricted by a federal "budget neutrality" requirement in the research and demonstration waiver and CHIP funds are limited by federal appropriation.

care and provider payment reform. MassHealth's initiatives in these areas are part of system-wide cost containment and quality improvement efforts in Massachusetts, and are aligned with the goals and funding opportunities contained in the ACA.

Specifically, the waiver renewal requests CMS authorization and financial support to:

- Help primary care practices that contract with MassHealth to evolve into patient-centered medical homes (PCMHs) that focus on prevention and management of chronic conditions. This is part of a broader multi-payer initiative in the state to develop Accountable Care Organizations (ACOs) that integrate PCMHs, hospitals and other providers.
- Use MassHealth's buying power to begin the transition from fee-for-service to payment systems that promote quality of care and improved health outcomes by launching several pilot projects with hospitals and provider groups to put global and bundled payment systems into practice.
- Increase access to care coordination by allowing formerly excluded populations⁸ to enroll in MassHealth managed care plans, and by developing new models of care coordination that integrate care and financing for individuals under age 65 who are eligible for both MassHealth and Medicare.

As of the date of this fact sheet, the Commonwealth's waiver renewal request is pending with CMS. The waiver makes available to the Commonwealth hundreds of millions of federal dollars per year that support coverage expansions, health insurance premium subsidies, critical safety net providers, and innovative models of care delivery. The Commonwealth faces the challenge of maintaining these successes and having sufficient flexibility to accommodate new models of care that are still being developed. Timely CMS approval of the Commonwealth's request is needed to sustain federal Medicaid funding at a level that supports the system redesign and payment reform initiatives, the 2006 health care reform coverage expansions, and the Commonwealth's safety net providers as they transition to new health care delivery and reimbursement systems.

Balancing costs and need in a time of austerity

The paradox of Medicaid and other public assistance programs is that they are needed most at times when resources to finance them are the scarcest. MassHealth is subject to the same pressures as the rest of the state budget, and must find ways to cut back on spending for the rest of fiscal year 2011 and in 2012. Some steps have already been taken — the elimination of dental benefits for adults, for example, and moderation of rates paid to providers and managed care organizations. Some of the cost containment and delivery system reform

initiatives in the waiver renewal proposal will be helpful in the longer term, but the state's finances are dire and require short-term solutions to balance the books. MassHealth administrators face difficult choices in an effort to balance the needs of the budget makers in the administration and legislature, providers who care for MassHealth members and should receive adequate payment for their services, and the members themselves, who rely on MassHealth to give them access to health care that they would not otherwise have.

Compounding this challenge is the impending loss of the enhanced federal matching funds. From October 2008 through September 2010, the state has received \$2.8 billion in increased federal Medicaid reimbursement: \$1.2 billion in federal fiscal year 2009 and \$1.6 billion in 2010.⁹ These additional funds will continue to flow until July 1, 2011 when they will disappear, effectively increasing the budget deficit the state must close. The state is also constrained in its available remedies by a requirement in the ACA that it maintain its MassHealth eligibility levels as they existed when the law was passed (March 2010) until 2014. However, a state may apply for an exemption from this requirement if it certifies that it is experiencing a budget deficit or will experience a deficit in the following year.

Implementing national health care reform

The 2010 federal health care reform legislation (Affordable Care Act, ACA) is modeled largely on Massachusetts' 2006 reform law. Both plans include an individual mandate, Medicaid expansion, premium subsidies for low-income individuals and families, employer responsibilities, a health insurance exchange or marketplace, and insurance market reforms. The specific provisions vary between the two laws, however, and the Commonwealth must decide how to amend programs or laws to align with the ACA. Because it is the locus of and the financial engine for the public coverage expansions, some of these decisions will affect MassHealth.

The ACA requires states to expand Medicaid coverage to all individuals under age 65 with income up to 133% of the federal poverty level (FPL). Eligibility for public programs in Massachusetts will be affected slightly, though the state already covers much of this population through either MassHealth or Commonwealth Care. Some students will be newly eligible, and some people who currently are ineligible for CommCare because they have access to employer-sponsored insurance will be eligible for premium assistance for their employer coverage through Medicaid. The Commonwealth will also need to move Commonwealth Care members in this income group—who are now covered under the MassHealth waiver—into the traditional, non-waiver MassHealth program. The transition may occur any time before January 1, 2014 and the timing decision will have programmatic and financial implications.

⁸ These populations include participants in Home and Community Based Service waivers, individuals who are institutionalized, children eligible under TEFRA section 134 ("Kaleigh Mulligan" kids), and children receiving Title IV-E adoption assistance.

⁹ <http://www.hhs.gov/recovery/statefundsmfmap-text.html>, accessed December 3, 2010

fact sheet

Additionally, the ACA subsidizes health insurance premiums for individuals at higher incomes than Massachusetts does for Commonwealth Care members (400% FPL versus 300% FPL, respectively), but Massachusetts subsidies are more generous than those authorized by the ACA. The federal premium subsidies will replace state subsidies as of 2014, freeing up state dollars that are now dedicated to the MassHealth waiver. The Commonwealth will need to decide whether to use these state funds to supplement the federal subsidies for this population. In addition to the freed-up subsidy dollars, the ACA will provide the Commonwealth nearly \$2 billion in new federal revenue over ten years through increases in federal Medicaid and CHIP matching rates and a temporary increase in federal Medicaid funding for primary care physician services.

The ACA also includes opportunities for the Commonwealth to advance its “Community First” long-term care policy for elders and people with disabilities, as well as offer support for delivery system redesign through payment reform.¹⁰

There are many ways the Commonwealth can improve MassHealth and the larger health care system using opportunities in the ACA. The challenge is for MassHealth to use its scarce resources strategically so that it pursues support for innovations that are aligned with its priorities and advance the Commonwealth toward its cost containment and system redesign goals.

Conclusion

MassHealth is an essential gateway to health care for a large portion of the Massachusetts population, an important source of revenue for health care providers who serve low-income, medically needy patients, and an integral part of the Commonwealth’s health reform strategy that has now extended coverage to nearly everyone in Massachusetts. It is a large program that lays claim to a significant part of the state budget and presents ongoing management challenges, particularly in a time of state fiscal austerity, the renewal of the research and demonstration waiver, and the impending implementation of national health care reform. These circumstances also present opportunities for MassHealth to develop innovative ways to contain costs and improve the quality of the health care it pays for. Such improvements are critical to the future of MassHealth as a comprehensive safety net for those in Massachusetts who would otherwise struggle to obtain affordable health care.

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¹⁰For a more detailed discussion of the ACA’s impact on MassHealth, please see R. Seifert and A. Cohen, *Re-Forming Reform: What the Patient Protection and Affordable Care Act Means for Massachusetts* (Blue Cross Blue Shield of Massachusetts Foundation, June 2010; <http://bluecrossfoundation.org/-/media/Files/Publications/Policy%20Publications/062110NHRReportFINAL.pdf>) and B. Waldman, *Impact and Opportunities of the ACA on the MassHealth Program* (Massachusetts Medicaid Policy Institute, forthcoming).