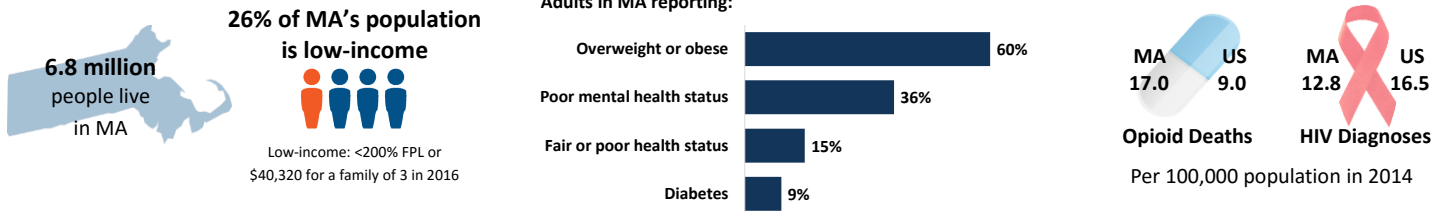


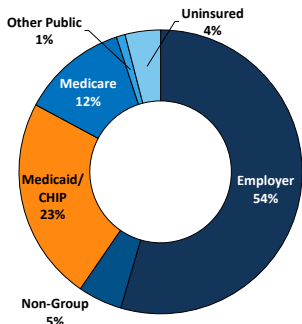
Medicaid and the Children's Health Insurance Program (CHIP) provide health and long-term care coverage to nearly 1.7 million low-income children, pregnant women, adults, seniors, and people with disabilities in Massachusetts. Medicaid is a major source of funding for safety-net hospitals and nursing homes. Federal policy proposals could fundamentally change the scope and financing of the program.

Snapshot of Massachusetts' population

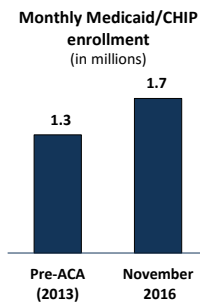


How has Medicaid affected coverage and access?

In 2015, 23% of people in MA were covered by Medicaid/CHIP.



Since implementation of the Affordable Care Act (ACA), Medicaid/CHIP enrollment has increased in MA.



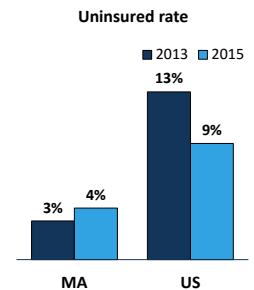
Did MA expand Medicaid through the ACA?



398,300 adults in the expansion group in Q1 of 2016



The uninsured rate in MA has remained low.

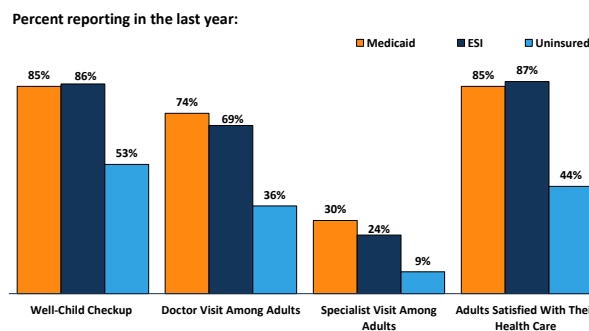


In MA, Medicaid/CHIP covers:



77% of adult and child Medicaid enrollees in MA are in families with a worker.

Nationally, Medicaid is comparable to private insurance for access and satisfaction – the uninsured fare far less well.



Medicaid coverage contributes to positive outcomes:

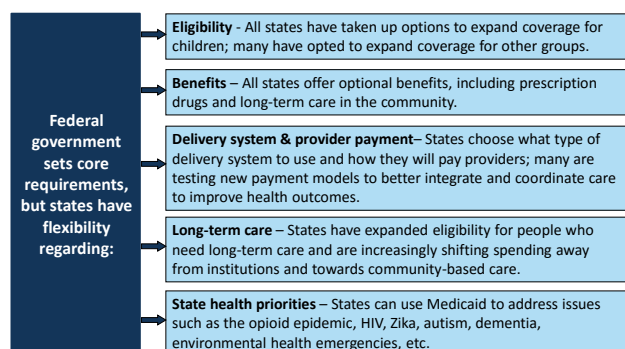
- Declines in infant and child mortality rates
- Long-term health and educational gains for children
- Improvements in health and financial security

And...

>85% of the public would enroll themselves or a child in Medicaid if uninsured.

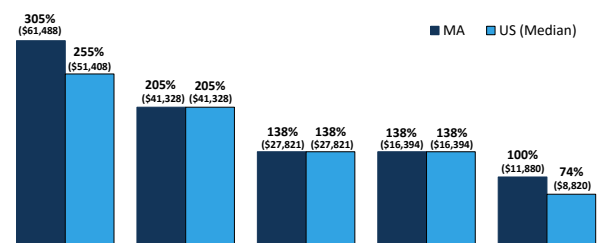
How does Medicaid work and who is eligible?

Each Medicaid program is unique:



Medicaid/CHIP eligibility levels are highest for children and pregnant women.

Eligibility Level as a Percent of FPL, as of January 1, 2017



Eligibility levels are based on the FPL for a family of three for children, pregnant women, and parents, and for an individual for childless adults and seniors & people w/ disabilities. Seniors & people w/ disabilities eligibility may include an asset limit.

# How are Medicaid funds spent and how is the program financed?

Medicaid plays a key role in the U.S. health care system, accounting for:



\$1 in \$6 dollars spent overall in the health care system



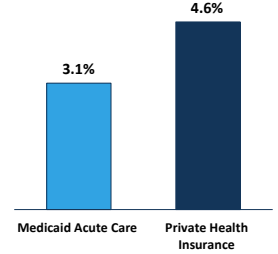
More than \$1 in \$3 dollars provided to safety-net hospitals and health centers



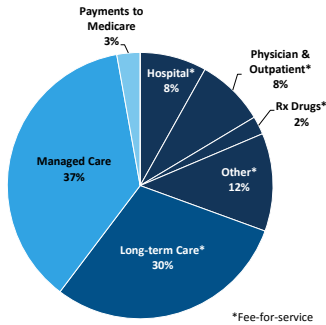
\$1 in \$2 dollars spent on long-term care

On a per enrollee basis, Medicaid spending growth is slower than private health care spending, in part due to lower provider payments.

Per enrollee spending growth in the US, 2007-2013



In FY 2015, Medicaid spending in MA was \$15.6 billion.



0.79

is the Medicaid-to-Medicare physician fee ratio in MA.

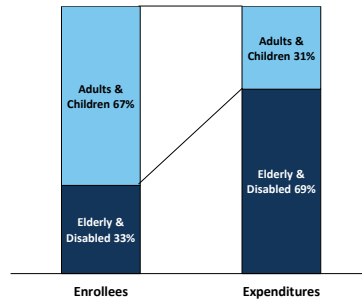
57%

of long-term care spending in MA is for home and community-based care.

54%

of beneficiaries in MA are in managed care plans.

In 2011, most Medicaid beneficiaries in MA were children and adults, but most spending was for the elderly and people with disabilities.



255,100

Medicare beneficiaries (26%) in MA rely on Medicaid for assistance with Medicare premiums and cost-sharing and services not covered by Medicare, particularly long-term care.

41%

of Medicaid spending in MA is for Medicare beneficiaries.

Federal funding to states is guaranteed with no cap and fluctuates depending on program needs.

In MA the federal share (FMAP) is 50%. For every \$1 spent by the state, the Federal government matches \$1.

Expansion states received an increased FMAP for the expansion population. MA received \$2.3 billion in federal funds for expansion adults from Jan 2014 – Sept 2015.



24%

of state general fund spending in MA is for Medicaid.

74%

of all federal funds received by MA is for Medicaid.

## What are the implications of reduced federal financing in a Medicaid block grant or a per capita cap?

Congress may soon debate proposals to reduce federal Medicaid funding through ACA repeal and federal caps.

The March 2016 Budget Resolution would reduce federal Medicaid spending by 41% nationally over the 2017-2026 period.

Total reduction in federal funds: \$2.1 trillion



The impact of a block grant or per capita cap will depend on funding levels, but could include:



Increases in the number of uninsured



Reduced access and service utilization, decreased provider revenues (to hospitals, nursing homes, etc.), and increased uncompensated care costs



Increased pressure on state budgets



Decreased economic activity

A per capita cap could lock in historical state differences or redistribute federal funds across states.

Per capita spending by enrollment group

