The Executive Office of Health and Human Services (EOHHS) of the Commonwealth of Massachusetts (MA) is submitting this Close-Out Report in accordance with STC 17.11. There are three components approved in the 2017-2022 1115 Demonstration period that are not continuing into the 2022-2027 Demonstration period. These components are: Student Health Insurance Plan (SHIP), the Accountable Care Organization (ACO) Pilot, and the Public Hospital Transformation and Incentive Initiative (PHTII). The Close-Out Report describes the history, operation, and policy decisions for these components. The required elements of the Close-Out Report are listed under each section.

Per agreement between the state and the Centers for Medicare & Medicaid Services (CMS), EOHHS will submit the Close-Out report for Delivery System Reform Incentive Payment (DSRIP) expenditure authority in August 2023 to account for the additional budget period and subsequent data collection.

I. Student Health Insurance Program (SHIP)

Background and Implementation:

The Commonwealth of Massachusetts (MA) has required students enrolled in higher education to be covered by health insurance since 1989. Pursuant to this requirement, every school in MA must offer a Student Health Insurance Plan (SHIP) to their students, outside of MA's merged individual and small group market. Following Affordable Care Act (ACA) implementation in 2014, fewer students were enrolling in SHIPs, likely due to the availability of insurance options through MassHealth and the Health Connector (the Commonwealth's ACA Marketplace) as students could waive enrollment in SHIP if enrolled in subsidized coverage.

Starting in 2014, the Health Connector worked with representatives from the Massachusetts Department of Higher Education, the Executive Office of Administration and Finance, and Massachusetts public higher education institutions to issue an RFR that resulted in Blue Cross Blue Shield of MA (BCBSMA) becoming the health insurance carrier for all public schools of higher education for Academic Year 15/16. As a result, all public schools of higher education experienced a premium reduction for their SHIP, except for the State Universities.

However, concerns remained regarding the size of the SHIP risk pool and the potential for premium increases, resulting in a proposal to enroll MassHealth-eligible students in SHIPs via the SHIP Premium Assistance (SHIP PA) program. Initial CMS approval for the SHIP PA program was granted in the State Plan Amendment (SPA) No. 16-0011 starting June 1, 2016, with an initial sunset date of December 31, 2017. In addition, CMS approved expenditure authority and STCs for the SHIP PA program under MassHealth Medicaid Section 1115 Demonstration No. 11-W-00030/1 effective November 4, 2016.

Beginning in the 2016-2017 academic year, the MassHealth SHIP Premium Assistance (SHIP PA) program was introduced as a voluntary program to allow MassHealth-eligible students to remain enrolled in SHIPs (Student Health Insurance Plans) at no additional cost to the member, while also accessing MassHealth benefits. Approximately 5,000 MassHealth students enrolled in the SHIP PA program in academic year 2016-2017.

The December 31, 2017 sunset date was removed with State Plan Amendment (SPA) No. 17-022, effective October 1, 2017. Authority for the SHIP PA program was also included in the amended STCs effective July 1, 2017 through June 30, 2022.

At the start of the 2017-2018 academic year, the MassHealth SHIP PA program became mandatory for MassHealth-eligible students enrolled at participating schools in an effort to continue to expand SHIP enrollment.

In addition to expanding SHIP enrollment, another goal of the SHIP PA program was to save Commonwealth resources by enrolling MassHealth-eligible students in SHIP as their primary insurance, making MassHealth a secondary payor.

However, in January 2020, SHIP health insurer BCBSMA released the following proposed rate increases (average overall) for all public schools of higher education:

- ~ 47.1 % with MH SHIP PA program participation; versus
- ~ 10.5 % for non-MHPA students, without MH SHIP PA program participation.

With this proposed increase, the Commonwealth determined that the impact the MH SHIP PA program had on SHIP premium increases for all students (including non-MH students) had become unsustainable. The proposed rate increases within the MH SHIP PA program participation would jeopardize the cost effectiveness of the MH SHIP PA program in Academic Year 2020/2021, and the future participation of all schools. Without participation in the SHIP PA program by all public schools of higher education, the program would no longer be cost effective for the Commonwealth to administer. Due to these dual concerns regarding SHIP premium increases for all students and the cost-effectiveness of the program for the Commonwealth, the Commonwealth decided to end the program at the end of Academic Year 2019/2020.

Though the SHIP PA program ended in August 2020, as discussed with CMS, it remained in the Expenditure Authority and STCs of the MassHealth Medicaid Section 1115 Demonstration No: 11-W-00030/1 through September 30, 2022.

Successes, Challenges and Opportunities for Improvement:

The MassHealth SHIP PA program achieved its goals of significantly expanding SHIP enrollment. It increased SHIP enrollment at the participating schools by approximately 24,000 students to approximately 35,000 students overall.

The program also achieved significant savings for the Commonwealth. For example, in SFY18, the program reduced the Commonwealth's spending by ~$60 million gross or $24 million net, and in SFY19, the program reduced the Commonwealth's spending by an estimated ~$33 million gross or $17 million net.

Ultimately, however, the MassHealth SHIP PA program resulted in significant SHIP premium increases after the first few years of the program, jeopardizing the viability of the program. In Academic Year 2019/2020, after two full years of mandatory enrollment in MH SHIP PA, SHIP premiums increased an overall average of ~20% for public schools of higher education, driven largely by higher acuity of MassHealth-eligible students versus non-MassHealth students. While the SHIP PA program was expected to stabilize SHIP premiums by boosting enrollment, analysis of claims data revealed an unanticipated difference in acuity between MH and non-MH students. As a result, 16 private schools of higher education withdrew from the MH SHIP PA program in AY 19/20 due to the impact of MassHealth students on premium increases for self-pay non-MassHealth students.

In January 2020, BCBSMA released the following proposed rate increases for Academic Year 2020/2021 (average overall) for all public schools of higher education:

- ~ 47.1 % with MH SHIP PA program participation; versus
- ~ 10.5 % for non-MassHealth students, without MH SHIP PA program participation.

These premium increases were not financially sustainable for either the non-MassHealth students, the schools in terms of their participation in the program, or for the Commonwealth from a cost-effectiveness perspective for the program.

The challenges faced by the SHIP PA program have been informative for MassHealth regarding the discrepancy between MassHealth and non-MassHealth students in terms of their care needs. Analysis of claims data suggests that MassHealth students appear to access a higher volume of care than non-MassHealth students, which is a factor that should be considered if the Commonwealth considers a similar program in the future where MassHealth members make up a significant portion of a non-MH risk pool.

Transition Plan:

In April 2020, all students participating in SHIP PA for academic year 2019-2020 received a notice from MassHealth informing them that the SHIP PA Program would no longer be available for academic year 2020-2021. The notice provided contact information for questions on general SHIP PA information, MassHealth Health Plan selection, and MassHealth eligibility. Beginning

in July 2020, SHIP policies began to end and students were transitioned to other forms of MassHealth coverage.

MassHealth-eligible students were sent a Health Plan Selection Package in conjunction with their SHIP policy ending. These students had the option to enroll in their choice of MassHealth service delivery option (ACO, MCO or the PCC Plan).

Students who were no longer MassHealth-eligible remained on MassHealth fee-for-service coverage due to the ongoing COVID-19 Public Health Emergency and the associated continuous coverage requirements.

Through these arrangements, all former SHIP PA students have continued to receive full MassHealth benefits and access to all MassHealth-covered services.

With the impending end of the continuous coverage requirements on April 1, 2023, all former SHIP PA students will undergo the MassHealth renewal process alongside the rest of the MassHealth caseload. The results of that redetermination will determine if they remain eligible for MassHealth coverage.

Budget Neutrality:
Please see the attached Budget Neutrality Workbook dated June 2022 with actual expenditures. However, because SHIP is not explicitly called out in that workbook, please see the Close Out Expenditures workbook that includes how the expenditures for this program were allocated to the waiver groups.

II. Accountable Care Organization Pilot Program

Background and Implementation:

The MassHealth ACO Pilot Program was authorized in the 1115 Demonstration extension that was approved on November 4, 2016. The Pilot program was originally slated to run for one year, from December 1, 2016 through November 30, 2017. When the launch of the full ACO Program was delayed to allow additional time to ensure system readiness, MassHealth in conversation with CMS, extended the Pilot an additional three months to end on February 28, 2018, to align with the launch of the full ACO program on March 1, 2018.

MassHealth used the ACO pilot to gain experience with the following design elements to inform the launch and design of the full ACO program:

1. Evaluate and monitor how effectively Pilot ACOs coordinate and integrate the care of their attributed members;

2. Learn how Pilot ACO models impact the health and well-being of MassHealth members;
3. Determine how MassHealth providers are affected;
4. Study the impact on total cost of attributed member's care; and
5. Analyze how ACOs impact MassHealth operations.

The Primary Care ACO (PCACO) framework that would eventually be launched in the full program, was designed to mirror the ACO Pilot. The Primary Care ACO model relies on MassHealth's internal claims, enrollment, customer service and provider credentialing and attribution systems that have been used historically for members in the Primary Care Clinician (PCC) plan and MassHealth Fee-for-service network. Testing these systems through the ACO Pilot was crucial to the successful launch of the full ACO program. It also allowed MassHealth finance and quality teams to assess their frameworks for evaluation of performance under the full program, and work through the issues of collecting, packaging and distributing member level claims histories to vendors that performed these analyses.

Pilot ACOs were responsible for their members' Total Cost of Care (TCOC) against a benchmark spending target, retroactively risk adjusted, for their population. If an ACO performed within 2% of the benchmark spending target, they were held harmless for losses and did not receive any shared savings payments, but if they exceeded the 2% risk corridor in either direction, they would be required to pay a portion of losses or receive shared savings payments, at 50% of the difference from benchmark. ACOs were also required to submit quality data for their populations, but these quality measures were reporting only for the Pilot.

The Pilot also allowed MassHealth to test a new functionality in our systems that would be used in the full Primary Care ACO program – Referral Circles. Referral Circles allow ACOs to identify a subset of the MassHealth Fee-for-service provider network for whom their members would not need a referral for services when referrals would otherwise be required. Referral Circles were designed as a way for ACOs to incentivize their members to use providers that they had better administrative and care coordination relationships with, enhancing an ACO's ability to effectively coordinate and manage care and thereby reduce total cost.

Likewise, the Pilot ACO was the first time MassHealth performed regular reporting on member attribution and claims data to provider organizations for the purpose of coordinating and managing care. The Pilot required MassHealth to develop reports, data sharing protocols, and data use agreements.

Six provider organizations participated in the ACO Pilot program: Partners Health ACO, UMass Medical Center ACO, Boston ACO, Steward Health, Community Care Cooperative and Children's Hospital ACO, with over 150,000 members enrolled over the course of the Pilot.

As mentioned above, the Pilot was extended an additional 3-month period when the launch of the full ACO program was delayed to March 1, 2018. ACOs in the Pilot were evaluated on both the 12-month original period and the 15-month extended period, and received shared savings or made shared losses payments based on the time period that proved most advantageous to

each individual ACO. Five ACO's TCOC ended up being within the 2% risk corridor so no payments were made or received. Partners Health ACO was required to make a shared losses payment of approximately $400,000 after outspending their TCOC benchmark by 2.2%. All Pilot ACOs except for UMass Medical Center ACO participated in the full ACO program when it launched in 2018.

Successes, Challenges and Opportunities for Improvement:

The Pilot successfully tested MassHealth's internal attribution, claims, credentialing, reporting and customer service systems. Our benchmarks for TCOC proved accurate as well, given that all of the participant ACOs were within 2.2% of our benchmark calculation. All 6 ACOs were able to successfully submit quality data. During the Pilot, we also launched referral circle functionality which continues to operate in our Primary Care ACO program today. The reports that MassHealth developed for the Pilot served as the basic framework for ACO reporting in the full program.

However, during the Pilot, limitations of the member level data provided to Pilot ACOs became clear. Claims data was often too lagged to provide actionable information for care coordination and care management. ACOs compensated by improving their access to real time Admission and Discharge data among hospitals ahead of the ACO launch to better improve the timeliness of care coordination information.

The data also revealed a number of attribution issues related to provider submitted affiliation information in MassHealth's systems. For a long time, MassHealth's primary identifier of a health care practice, the Provider ID Service Location, or PIDSL, was not used by most providers in their day-to-day practice, and they were often unfamiliar with their own PIDSLs, and what information they had submitted to MassHealth was often out of date or incorrect. Working through PIDSL affiliation with the ACOs and their participating practices proved essential for the full ACO program, as MassHealth learned how to communicate about PIDSLs, and ACOs and providers learned to track them and how to update the information associated with them so that members would be correctly attributed to the right practice.

Transition Plan:

When the Pilot ACO program ended, members attributed to an ACO that was participating in the full ACO program were moved into the ACO that their Primary Care Practice was going to be affiliated with, as part of a process called special assignment. For Pilot ACOs that joined the full ACO program, these members continued with ACOs moving into the PCACO model or were moved into the corresponding ACO in the Accountable Care Partnership Plan (ACPP) model. For members in UMass affiliated Primary Care Practices, they remained in the PCC plan, which allowed them to maintain access to their primary care practice of record in our systems. Members were also given a 90-day plan selection period, during which they could change to another ACO or managed care plan for any reason. Since all members in the Pilot ACO were in

a system based on the MassHealth's PCC Plan apparatus, care coordination information, such as prior authorizations and claims histories, were shared with their destination ACO, or preserved in the MassHealth system for those members who were moved to a Primary Care ACO or remained in the PCC Plan.

The Pilot ACO was the first Accountable Care model to operate in Massachusetts Medicaid and CHIP and served over 150,000 members in its time. The experiences of the Pilot ACO directly influenced the design and implementation of the full ACO program that today serves 1.2 million members.

Budget Neutrality:

Please see the attached Budget Neutrality Workbook dated June 2022 with actual expenditures. However, because the ACO Pilot is not explicitly called out in that workbook, please see the Close Out Expenditures workbook that includes how the expenditures for this program were allocated to the waiver groups.

III. Public Hospital Transformation and Incentive Initiative (PHTII)

Background and Implementation (Successes, Challenges and Opportunities for Improvement are described under each initiative):

Cambridge Health Alliance (CHA) is the Commonwealth's only non-state, non-federal public acute hospital and has among the highest concentration of patients participating in MassHealth demonstration programs of any acute hospital in the Commonwealth. The Public Hospital Transformation and Incentive Initiative (PHTII), an incentive-based program established to support CHA's work focused on the MassHealth population, was first authorized in October 2014, during the fifth 1115 Demonstration extension period. The authority for PHTII was renewed in July 2017 and continued through June 2022.

The PHTII program was focused on two areas that aligned with the state's plans for a restructured MassHealth delivery system centered around ACOs and emphasizing the integration of care across physical and behavioral health care, long term services and supports, and health related social services. The two areas of focus for PHTII between 2017 and 2022 were:

a) Participation in an ACO model and demonstrating success on the corresponding ACO performance measures, utilizing the same performance measures as specified for the DSRIP initiative.

b) Continuation and strengthening of initiatives approved through PHTII from the 5th Demonstration period, including but not limited to initiatives focusing on access to

behavioral health services and integration of behavioral health care with physical health care, given CHA's role as a major provider of behavioral health services.

Initiatives:

CHA focused on the following initiatives and demonstrated the following results:

Initiative 1: Integration of Behavioral Health and Primary Care

Overview: To continue the advancement in integrated medical and behavioral health care in the context of population health management and alternative payment models, this initiative leveraged evidence-based practices to advance screening, treatment and improved access to behavioral health care based in the primary care setting for adults, children and adolescents. This suite of initiatives included a focus on population health, quality outcomes, patient engagement and experience of care improvements, coordinated cross-continuum care, and effective care management and follow-up on targeted conditions including depression, anxiety, and substance use disorders. This was enabled through the optimization of screening and follow-up workflows, expansion of evidence-based treatment options, provider and staff training and engagement, building relationships among staff and providers across the system, and building community connections to support patient care.

Results: Cambridge Health Alliance (CHA) expanded and optimized its Primary Care Behavioral Health Integration (PCBHI) program across 12 core primary care sites for patients of all ages and their families. The PCBHI program prioritized behavioral health access in Primary Care, offered in-person and via telehealth, which ensured annual behavioral health screening and follow-up provided by the core Primary Care team. It also allowed for consultation, coordination, coaching and brief treatment support offered via an integrated team of care partners, therapists, and consultant psychiatrists. CHA worked to improve screening workflows, developed and distributed evidence-based tools to assess for and treat high-prevalence behavioral health conditions, and significantly expanded services for patients with addiction disorders.

CHA Primary Care continued to administer annual behavioral health screenings to patients of all ages through in-person visits, including the short-form Adult Wellbeing Questionnaire (AWQ) for adult patients and a set of tools for screening children and adolescents for high-prevalence developmental, behavioral, and emotional concerns. As of the end of the PHTII program, CHA achieved 60% for AWQ screening across clinics, a 13% improvement from the penultimate year of the program, when screening had dropped due to the impact of COVID. CHA developed a workflow for asynchronous behavioral health screening and initiated tablet-based screening during office visits, where three of the four pilot sites achieved at least 70% by the end of the program due to the new workflow. CHA implemented several new Electronic Medical Record (EMR)-based tools for the assessment and treatment of depression symptoms, including an

evidence-based suicide assessment tool for Primary Care Providers (PCPs) to use with patients aged 12+ experiencing suicidal ideation, and a depression smartset for the assessment and management of mild, moderate, and severe depression. The smartset also included patient-facing resources such as behavioral health apps and community providers. CHA also implemented a PCP workflow for ADHD assessment, diagnosis, and treatment, including the Vanderbilt Assessment tool.

The PCBHI program expanded its toolkit of digital behavioral health resources and expanded its toolkits of patient and family-facing app guides to include 15 new tools and distributed to 934 patients. PCPs piloted a new behavioral health app for adult patients with substance use disorders. CHA established 2 new therapy groups focused on disordered eating and ADHD and participated in co-leadership of 10 of 12 groups for Opioid Use Disorder. CHA also updated and distributed patient/family self-management support tools for school registration, special education, and behavioral health resources for children and families. CHA significantly expanded access for patients with substance use disorders, offering Recovery Coaching for patients with substance use disorders at all 12 primary care practices. In the last year of the program, Recovery Coaches saw 163 patients and had 644 encounters. CHA also upgraded its available resources for methadone treatment, integrated a new Office-based Opioid Treatment (OBOT) Nurse Case Manager, and trained Mental Health Care Partners regarding substance use disorders and Recovery Coach services. CHA Primary Care continued the "Joint Operating Clinic, to ensure continued medication treatment for patients with serious mental illnesses, and the "Pain and Addictions Support Service" (PASS), multidisciplinary consultation for complex Primary Care patients experiencing chronic pain and substance use disorders.

Initiative 2: Comprehensive Systems for Treating Mental Health and Substance Use (MHSU) Conditions

Overview: Poor access to appropriate levels of care is a leading barrier to recovery for individuals with mental health and substance use (MHSU) conditions.[1] A comprehensive system for MHSU treatment – offering the right care to the right people at the right time – requires a wide range of services and delivery methods to meet the unique needs of individuals and families. Among others, these services include outpatient counseling (including primary care integration), intermediate care (intensive outpatient, partial hospital), residential and inpatient facilities, support for care transitions, and triage and emergency services. A robust continuum of care helps people access services when they need and want them, improving patient experience and the value of care (quality/cost). A comprehensive treatment system allows individuals and their providers to develop an optimal care plan most likely to help them stay connected to their communities, succeed in daily activities, such as work or school, and engage in family and community supports toward recovery. Individuals who do receive appropriate treatment early in their onset of illness may require less intensive care, experience

[1]American Hospital Association, Trendwatch, Bringing Behavioral Health into the Care Continuum, Opportunities to Improve, January 2012. Available at: http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf.

fewer relapses,[2] and have better long-term health outcomes.[3] New programs offering integrated, person-centered MHSU care show promising results – greater use of community-based outpatient care, fewer hospital and emergency department (ED) admissions, and better health outcomes.[4-5]

Results: To improve the quality of care and overall health of its patient population, CHA pursued numerous initiatives to enhance its systems for treating mental health and substance use (MHSU) conditions. The range of efforts included an overhaul of administrative operations, referral management, greater opportunities for patients to initiate substance use treatment, optimizing our electronic medical record and data systems, growing its volume of outpatient MHSU services, establishing new provider partnerships to expand its network, and developing new approaches for population health and utilization management. By the end of the program, CHA:

- Increased referrals to recovery coaches and Alcohol Anonymous to support patient identified goals around alcohol use;
- Launched a project that is designed to increase the overall social determinants of health screening rate of the MassHealth population, which includes offering non-digital screening and language access to screen patients across Ambulatory settings;
- Increased capacity for Medication-Assisted Treatment (MAT) for patients with opioid use disorder in Primary & Specialty Care, including through the recruitment and hiring of an additional OBAT Case Manager to the treatment team at Everett and Cambridge Primary Care;
- Provided training to therapists in delivering psychological services that help patients to manage physical health problems, which may co-occur with behavioral health symptoms and conditions.

Initiative 3: Referral Management and Integrated Care Management

Overview: Toward the goals of better health and optimal, more coordinated and cost-effective care, this suite of initiatives is aimed at increasing patient access to high-quality care, promote appropriate referrals and access (i.e., the right provider in the right setting) based on the complexity of the patient's needs. Providing integrated care across the continuum of care through effective referral management and care coordination is foundational to the accountable care model and alternative payment arrangements with quality, cost and health care utilization

[2]Institute of Medicine (US) Committee on Quality Assurance and Accreditation Guidelines for Managed Behavioral Health Care; Edmunds M, Frank R, Hogan M, et al., editors. Managing Managed Care: Quality Improvement in Behavioral Health. Washington (DC): National Academies Press (US); 1997. Available from: http://www.ncbi.nlm.nih.gov/books/NBK233235/
[3]Kane JM, Robinson DG, Schooler NR, et al. Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. Am J Psychiatry 2016; 173:362–372.
[4]Krupski A, West II, Scharf DM, et al. Integrating primary care into community mental health centers: Impact on utilization and costs of health care. Psychiatric Services in Advance. 2016:1-7. doi: 10.1176/appi.ps.201500424.
[5]Gilmer TP, Henwood BF, Goode M, et al. Implementation of integrated health homes and health outcomes for persons with serious mental illness in Los Angeles County. Psychiatric Services in Advance. 2016:1-6. doi: 10.1176/appi.ps.201500092.

accountability. This is particularly important for Medicaid and other vulnerable patient populations that often face barriers to care and care fragmentation. This initiative builds and supports systems to maintain a preferred, high value network and simultaneously provide highly coordinated and quality care in four ways: 1) focus on public hospital system access and effective operational improvements in primary care and medical, surgical and behavioral health specialties; 2) encourage public hospital referrals and the use of care within the public hospital system and with clearly defined high value preferred provider networks enabled to coordinate care and redirect referrals from higher cost, lower-value external referrals; 3) build relationships with key community-based partners such as visiting nurse associations (VNAs), skilled nursing facilities (SNFs), and detoxification facilities; and 4) leverage proven technology to improve access and convenience for the patient panel to specialty opinions and care.

Results: CHA continued to advance its approach to referral management and care coordination, improving timely access to high quality specialty care services, and providing integrated care across the care continuum. This initiative also built and supported systems to maintain a preferred, high value network and simultaneously provide highly coordinated and quality care. CHA also continued to improve timely patient access to high-quality specialty care services, leveraging referral management performance data to facilitate actionable improvements to patient care coordination in an effort to support the delivery of care by the right provider, in the right setting and at the right time.

By the end of the program, CHA implemented the following referral management and care management improvements:

- Recruited Specialty providers to expand access for CHA patients which includes full time Vascular Surgeon, Neurologist, and Cardiologist;
- Continued efforts around cross-continuum collaboration for high risk patients via multidisciplinary meetings to discuss strategies to better engage patients in the right level of care within the public health system;
- Identified priority areas with the greatest opportunity to re-direct care and improve access to specialty services to better improve timely access to care; and
- Developing dashboards and metrics that will allow CHA to monitor improvements being made through the referral redesign effort.

<u>Initiative 4: Evidence-Based Practices for Medical Management of Chronic Conditions</u>

Overview: Evidence based medicine (EBM) is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The goal is to improve outcomes, quality, and cost by reducing the variation of care for key conditions and integrate EBM into the health care delivery system across the continuum. Evidence-based patient engagement strategies may include those such as motivational interviewing in chronic health conditions and for substance use disorders, expansion of nursing, pharmacist, and other care team member roles in chronic disease management, and mental health team integration

within primary care. Initiatives may include refining tools, frameworks, analytics, and clinical workforce development in the use of evidence-based guidelines across the care continuum.

Results:

Pharmacotherapy Services identified patients with uncontrolled hypertension to provide patient education, medication reconciliation, home blood pressure monitor validation or identify the need for a home blood pressure monitor utilizing the Electronic Medical Record (EMR) reports. If blood pressure monitors were needed, Pharmacotherapy Services streamlined the process to obtain insurance coverage by utilizing the centralized pharmacy refill team workflow for durable medical equipment requests. Pharmacotherapy Services also created an on-line training module on validating home blood pressure monitors and training documents for Primary Care in how to document patient reported vitals in the EMR for nurses and providers.

Pharmacotherapy Services performed targeted medication reviews (TMRs) for cardiovascular and renal benefit for those with a history of Atherosclerotic Cardiovascular Disease, Chronic Kidney Disease and Congestive Heart Failure. CHA also improved the documentation for these target medication reviews in the EMR. These targeted medication reviews were tracked to determine the efficacy of these reviews.

The CHA Certified Diabetes Care and Education Specialist worked with a clinical team to review discharge orders to standardize the patient discharge process. The Certified Diabetes Care and Education Specialist created an annual competency for all licensed and non-licensed staff at CHA for diabetes. This competency module will be reviewed and updated as needed.

Amount Earned:

For Demonstration Years (DYs) 21 – 23, CHA earned 100% of their total authorized funding. For DYs 24 and 25, CHA has earned nearly 100% of their total authorized funding. At this time, MassHealth does not have final Total Cost of Care (TCOC) scores calculated for DYs 24 and 25. Once these scores are finalized, CHA's payment amounts will likely increase beyond the payment amounts reflected in the table below for those two years.

PHTII Authorized Payment Amounts					
	DY 21	DY 22	DY 23	DY 24	DY 25
Base Payment	$ 293,550,000	$ 230,850,000	$ 108,000,000	$ 85,000,000	$ 80,000,000
Payment Tied to DSRIP Accountability	$ 15,450,000	$ 12,150,000	$ 12,000,000	$ 15,000,000	$ 20,000,000
Total	$ 309,000,000	$ 243,000,000	$ 120,000,000	$ 100,000,000	$ 100,000,000

PHTII Actual Payment Amounts					
	DY 21	DY 22	DY 23	DY 24	DY 25
Base Payment	$ 293,550,000	$ 230,850,000	$ 108,000,000	$ 85,000,000	$ 80,000,000
Payment Tied to DSRIP Accountability*	$ 15,450,000	$ 12,150,000	$ 12,000,000	$ 11,250,000	$ 17,400,000
Total	$ 309,000,000	$ 243,000,000	$ 120,000,000	$ 96,250,000	$ 97,400,000

*DY 24 and DY25 payment amounts do not reflect payments tied to TCOC score

Transition Plan:

As the Commonwealth's only non-state, non-federal public acute hospital with one of the highest proportions of Medicaid patients served, CHA continues its work expanding and improving its behavioral health services. CHA continues to participate in MassHealth's ACO program, and will implement initiatives to improve quality through managed care state directed payments.

Budget Neutrality:
Please see the attached Budget Neutrality Workbook dated June 2022 with actual expenditures.

	DY20 SFY17	DY21 SFY18	DY22 SFY19	DY23 SFY20	DY24 SFY21	DY25 SFY22	Total SHIP Expenditures
Note to legal: The total expenditure amounts are correct, but the allocation to the waiver groups are estimates.							
				Premiums Paid			
BF - Base, Families	$ 1,012,553	$ 15,320,515	$ 16,513,101	$ 18,624,642	$ -	$ -	**$ 51,470,811**
BD - Base, Disabled	$ 123,107	$ 1,870,621	$ 1,968,471	$ 2,293,847	$ -	$ -	**$ 6,256,046**
RC - 1902(R)2, Children	$ 1,031,797	$ 15,412,495	$ 18,189,624	$ 17,877,612	$ -	$ -	**$ 52,511,528**
RC - 1902(R)2, Disabled	$ 5,307	$ 74,871	$ 84,108	$ 105,369	$ -	$ -	**$ 269,654**
HI - 1115 Waiver Expansion, HIV	$ 1,099	$ 23,345	$ 14,368	$ 16,894	$ -	$ -	**$ 55,706**
CH - 1115 Waiver Expansion, CommonHealth	$ 8,503	$ 107,265	$ 157,641	$ 159,676	$ -	$ -	**$ 433,086**
New Adult	$ 2,132,360	$ 31,553,704	$ 35,606,271	$ 39,138,750	$ -	$ -	**$ 108,431,084**
Total	**$ 4,314,725**	**$ 64,362,816**	**$ 72,533,585**	**$ 78,216,790**	**$ -**	**$ -**	**$ 219,427,916**
				Claims Paid			
BF - Base, Families		$ 2,720	$ 8,999	$ 6,683	$ 365,416		**$ 383,818**
BD - Base, Disabled		$ 395	$ 187	$ 490	$ 1,377		**$ 2,449**
RC - 1902(R)2, Children		$ 207,214	$ 1,061,770	$ 641,324	$ 293,144		**$ 2,203,453**
HI - 1115 Waiver Expansion, HIV		$ -	$ 1,875	$ 388	$ 39		**$ 2,302**
CH - 1115 Waiver Expansion, CommonHealth		$ 357	$ 5,546	$ 26,752	$ 3,513		**$ 36,168**
New Adult		$ 142,463	$ 832,568	$ 531,085	$ 277,541		**$ 1,783,657**
Total		**$ 353,149**	**$ 1,910,946**	**$ 1,206,722**	**$ 941,030**		**$ 4,411,847**

Note to legal: The total expenditure amounts are correct, but the allocation to the waiver groups are estimates.

	Pilot ACO expenditures Dec 2016 to Nov 2017	
BD - Base, Disabled	$	529,649,149
BF - Base, Families	$	202,562,462
BP - Base Childless Adults (CarePlus)	$	98,434,048
CH - 1115 Waiver Expansion, CommonHealth	$	30,640,369
HI - 1115 Waiver Expansion, HIV	$	1,306,480
RC - 1902(R)2, Children	$	21,953,186
RD - 1902(R)2, Disabled	$	15,711,777
RT - 1902(R)2, BCCTP	$	1,469,909
New Adult	$	133,652,371
Total	**$**	**1,035,379,751**

	DY19 SFY16	DY20 SFY17	DY21 SFY18	DY22 SFY19	DY23 SFY20	DY24 SFY21	DY25 SFY22	PHTII Total
SNCP-PHTII	130,391,551	163,997,778	309,000,000	243,000,000	120,000,000	96,250,000	97,400,000	1,160,039,329

The expenditures above are reported in the BN workbook under SNCP-PHTII

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1148 (CMS-10398 #56)**. The time required to complete this information collection is estimated to average **7.5 hours** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Budget neutrality is a Federal policy that governs the Federal expenditures for1115 demonstrations. It is assured by placing an upper limit on the amount of Federal Financial Participation (FFP) the state can receive during the demonstration. The upper limit represents what the state could have received in the absence of the 1115 demonstration.

The Budget Neutrality workbook will assist in collecting standardized data in order to determine financial performance for the demonstration in terms of budget neutrality.

The workbook has two major groups of tabs: the first group collects and calculates Without Waiver (WOW) numbers, and the second group calculates With Waiver (WW) numbers. Data is collected per each demonstration Medicaid Eligibility Group (MEG), by demonstration year (DY). A Medicaid section 1115 demonstration is considered budget neutral if the Federal title XIX match, or funding received by the state (i.e., "with waiver" expenditures) do not exceed what the state would have (or could have) received without the demonstration (i.e., "without waiver" expenditures). The workbook provides the ability to evaluate any variance between WW and WOW calculations.

The workbook consists of 15 tabs which contain different types of data and calculations. The following color schema is applied to the tabs:

Blue	Information populated in the Budget Neutrality workbook template based on the demonstration's approved STC
Red	Information populated by states on a quarterly basis or per the reporting requirements defined in the STC
Green	Information automatically populated based on the input from other worksheets

Note: Overview and Dropdowns tabs are read-only, no data entry is required. The Dropdowns tab displays the values used to build the dropdowns menus thoroughout the workbook, including the list of active waivers for the demonstration.

Data Entry	Within the tabs where a State User populates information (C Report, Total Adjustments, WW Spending Projected, MemMon Actual, MemMon Projected, and Summary TC tabs), yellow highlighted cells denote where data entry may be needed (depending on DY being updated).

Pre-populated values in the downloaded Budget Neutrality workbook template

The original workbook entries are based on the STCs and other demonstration approval documentation. These entries are made on the DY Def, MEG Def, WOW PMPM & Agg, Program Spending Limits, and Summary TC tab (Phase-Down Percentage and Cumulative Target Percentage fields).

The MEG Def tab defines MEGs as Medicaid populations (core demonstration populations), Hypothetical populations (when a demonstration has separate budget neutrality agreements) and Tracking Only populations (for example, "pass-through" populations). The MEG Def tab also defines how expenditure numbers are calculated for a MEG (Per Capita vs. Aggregate) and the applicable scenarios (WOW, WW, or both). Also, the tab contains indicators defining MEG characteristics such as expenditure caps or applicability of savings phase-down calculations.

Calculating With Waiver (WW) numbers

WW numbers for each active DY of a demonstration are calculated based on a combination of actual WW expenditures, projected future expenditures, and any adjustments entered by a State User. The actual WW expenditures are copied from the Schedule C of the MBES CMS-64 report to the workbook (C Report tab). These numbers are automatically transferred to the C Report Grouper tab, where waiver expenditures are grouped by MEGs. The numbers are also transferred to the WW Spending Actual tab, which factors in adjustments entered on the Total Adjustments tab to calculate total actual WW expenditures. The WW Spending Total tab displays the actual WW expenditures plus future projected expenditures (transferred from the WW Spending Projected tab). Finally, the total WW actual and projected numbers are transferred to the Summary TC (Total Computable) tab (into the With-Waiver Total Expenditures section).

Calculating Without Waiver (WOW) numbers

WOW numbers can be obtained either one of two ways: using Aggregate or Per Capita calculations. If total projected expenditures for a MEG is known and the expenditure calculation type is defined as 'Aggregate' on the MEG Def tab, the total projected expenditure amount is entered for each active DY. However, if the expenditure calculation type is defined as 'Per Capita', total projected expenditures are derived by multiplying per member per month (PMPM) costs by the actual number of member months.

Both Aggregate and PMPM numbers are populated on the WOW PMPM & Agg tab. The number of actual member months (number of beneficiaries times the number of months enrolled) are entered by a State User on the MemMon Actual tab for each DY. On the MemMon Projected tab, State User enters projected numbers. The totals for actual and projected member months are calculated on the MemMon Total tab. WOW aggregate, PMPM and member month data is then moved to the the Without-Waiver Total Expenditures section of the Summary TC tab, where final calculations are performed.

Based on information from all tabs, the WW and WOW numbers are compared to determine the budget neutrality status of the demonstration.

Below are the definitions for the tabs of the workbook which require data entries from State User.

On top of the C Report tab, enter data in the following highlighted cells:

'Data Pulled On:' - enter the date the source file used to enter data on this tab was pulled
'For the Time Period Through :' - enter the date through which the source file data was pulled
Reporting DY' - enter the Demonstration Year (DY) for which data is being reported. Entered DY value must align with DYs from the DY Def tab.
Reporting Quarter' - enter a number of the quarter (values 1 through 4) for which data is being reported.

Notes:
- Dates must be entered in the following format: mm/dd/yyyy
- Reporting DY and Reporting Quarter entries affect which portion of the 'Medicaid Aggregate' and 'Medicaid Aggregate - WOW only' amounts for a DY will be calculated as Actuals, and which will be calculated as Projected
- Entry for each of these four fields is required for the workbook submission. If any field is not populated, you will receive an error and the document will not be uploaded to the system.

State User enters information on the following tabs:

C Report Tab

Open Schedule C of the CMS 64 Expenditure Report. Under your state, locate expenditure data for the specific demonstration.
From this location on the CMS 64 Expenditure Report, copy expenditure data cells for all DYs (active and non-active). On the C Report tab, paste the data into the correct cell/row. Repeat the copy and paste process for MAP Waivers section (Total Computable and Federal Share) and ADM Waivers section (if applicable). Verify that the pasted numbers are correctly aligned with the Waiver Name values.

Total Adjustments tab

When adjustments are relevant for a demonstration, enter the actual numbers of total contributions to the reported expenditures, per each MEG, for the reporting quarter. Add new reported adjustments to any existing numbers for previous quarters for the reported DY.
Note: Any adjustments that reduce expenditures must be entered as negative numbers (for example, -$10,000).

WW Spending Projected tab

Enter projected annual expenditures for each MEG for the active DYs of a demonstration.
For each reporting quarter, update the projected numbers so they reflect only future quarter projections. Please see the example for the MemMon Projected tab.

MemMonth Actual tab

For each MEG, calculate the actual number of member months for the reported quarter and add this number to the previously entered number for the same DY. For example, for Q3 reporting period, add Q3 member months to the existing number for the same MEG and DY and enter the result into the same cell.

MemMonth Projected tab

For each MEG, enter projected (future) annual member months for all active DYs of the demonstration. Adjust future DY numbers as needed.
For the current DY, enter only the number that reflects future quarters. For example, for Q3 reporting, only enter the projected number for Q4. There should be no projected numbers for completed (actual) DYs.

Summary TC tab

In the Net Variance section, for each DY, enter estimated numbers in row '1115A Dual Demonstration Savings (state preliminary estimate)'.
In the next row, '1115A Dual Demonstration Savings (OACT certified)' enter certified numbers.
Both estimated and certified numbers must be negative, as dual demonstration savings numbers reduce the Net Variance amount.

Demonstration Years Definitions

DY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Start Date	07/01/1997	07/01/1998	07/01/1999	07/01/2000	07/01/2001	07/01/2002	07/01/2003	07/01/2004	07/01/2005	07/01/2006	07/01/2007	07/01/2000	07/01/2000	07/01/2000	07/01/2011	07/01/2012	07/01/2013	07/01/2014	07/01/2015	07/01/2016	07/01/2017	07/01/2018	07/01/2019	07/01/2020	07/01/2021
End Date	06/30/1998	06/30/1999	06/30/2000	06/30/2001	06/30/2002	06/30/2003	06/30/2004	06/30/2005	06/30/2006	06/30/2007	06/30/2001	06/30/2001	06/30/2001	06/30/2001	06/30/2012	06/30/2013	06/30/2014	06/30/2015	06/30/2016	06/30/2017	06/30/2018	06/30/2019	06/30/2020	06/30/2021	06/30/2022

Enter any general comments / notes:

MEG Definitions

	MEG Name	MEG Description	Savings Phase-Down	Expenditures Subject to Cap?	Hypothetical Populations Included in Calculations?	Start DY	Start Date	End DY	End Date
	Medicaid Per Capita								
1	Base Families	Eligible non-disabled individuals enrolled in MassHealth Standard, as well as eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only)	Savings Phase-Down	No	N/A	*1*	*07/01/1997*	*25*	*06/30/2022*
2	Base Disabled/MCB	Eligible individuals with disabilities enrolled in Standard, individuals enrolled in CommonHealth who spend down to eligibility, as well as eligible disabled individuals enrolled in Limited (emergency services only)	Savings Phase-Down	No	N/A	*1*	*07/01/1997*	*25*	*06/30/2022*
3	1902 (r) 2 Children	Medicaid expansion children and pregnant women who are enrolled in MassHealth Standard, as well as eligible children and pregnant women enrolled in MassHealth Limited (emergency services only)	Savings Phase-Down	No	N/A	*1*	*07/01/1997*	*25*	*06/30/2022*
4	1902 (r) 2 Disabled	Eligible individuals with disabilities enrolled in Standard with income between 114.1 percent and 133 percent of the FPL, as well as eligible individuals with disabilities enrolled in MassHealth Limited (emergency services only)	Savings Phase-Down	No	N/A	*1*	*07/01/1997*	*25*	*06/30/2022*
5	1902 (r) 2 BCCDP	Individuals eligible under the Breast and Cervical Cancer Demonstration Program who are enrolled in Standard	Savings Phase-Down	No	N/A	*1*	*07/01/1997*	*25*	*06/30/2022*
6	Base Families 21 RO	Base Families costs if CHIP allotment exhausted	Savings Phase-Down	No	N/A	*1*	*07/01/1997*	*25*	*06/30/2022*
7	1902 (r) 2 RO	1902(r)(2) costs if CHIP allotment exhausted	Savings Phase-Down	No	N/A	*1*	*07/01/1997*	*25*	*06/30/2022*
	Medicaid Per Capita - WOW only								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate - WOW only								
1	DSH	Diverted Disproportionate Share Hospital funding	N/A	Yes	N/A	*1*	*07/01/1997*	*25*	*06/30/2022*
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate - WW only								
1	e-Family Assistance	Eligible children receiving premium assistance or direct coverage through 200 percent of the FPL enrolled in Family Assistance.	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
2	e-HIV/FA	Eligible individuals with HIV/AIDS with incomes from 133 through 200 percent of the FPL who are enrolled in Family Assistance	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
3	SBE	Subsidies or reimbursement for ESI made to eligible individuals	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
4	SNCP-DSRIP	Expenditures for Delivery System Reform Payments (DSRIP) for the period July 1, 2017 through June 30, 2022	N/A	Yes	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
5	SNCP-DSRIP-ACO	Expenditures for the Accountable Care Organization payments associated with the DSRIP for the period July 1, 2017 through June 30, 2022.	N/A	Yes	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
6	SNCP-DSRIP-CP	Expenditures for the Community Partner payments associated with the DSRIP.	N/A	Yes	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
7	SNCP-DSRIP-SWI	Expenditures for the Statewide Investment payments associated with the DSRIP.	N/A	Yes	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
8	SNCP-DSRIP-Operations	Expenditures for the allocated portion of DSRIP associated with statewide operations, implementation, and oversight.	N/A	Yes	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
9	SNCP-PHTII	Expenditures authorized under the Public Hospital Transformation and Incentives Initiative	N/A	Yes	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
10	SNCP-DSH-HSNTF	Expenditures authorized under the Health Safety Net program as referenced on Attachment E item 4.	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
11	SNCP-DSH-IMD	Expenditures authorized under the SNCP for IMD services, as referenced on Attachment E item 5, excluding expenditures reported under STC 91(f)(30).	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
12	SNCP-DSH-CPE	Expenditures for State owned non-acute hospitals operated by the Department of Public Health and the Department of Mental Health, as referenced on Attachment E items 6 and 7.	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
13	SNCP-UCC	Expenditures authorized under the Uncompensated Care Pool	N/A	Yes	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
14	SNCP-OTHER	All other expenditures authorized under the SNCP, including Public Services Hospital Safety Net Care Payments and Safety Net Provider Payments, as referenced on Attachment E items 1 and 8.	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
15	DSHP-Health Connector Subsidies	Expenditures for premium subsidy wrap under the demonstration.	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
16	DSHP-CSR	Expenditures for cost sharing subsidy wrap under the demonstration.	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
17	Provisional Eligibility	Expenditures for amounts spent on individuals found not eligible for Medicaid benefits under this authority consistent with STC 24.	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
18	TANF/EAEDC	Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children.	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
19	End of Month Coverage	Beneficiaries determined eligible for subsidized QHP coverage through Massachusetts Health Connector but who are not enrolled in a QHP.	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
20	Continuous Eligibility	Expenditures for continuous eligibility period up to 12 months for those enrolled in a student health insurance program.	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
21	SUD	All expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table D of Section V.	N/A	No	N/A	*21*	*07/01/2017*	*25*	*06/30/2022*
	Hypothetical 1 Per Capita				Hypothetical Test 1				
1	CommonHealth	CommonHealth Adults - Expenditures for health care-related costs for: a. Adults aged 19 through 64 who are totally and permanently disabled and not eligible for comprehensive coverage under the Massachusetts state plan. b. Adults aged 65 and over who are not eligible for comprehensive coverage under the Massachusetts state plan, with disabilities that would meet the federal definition of "permanent and total disability" if these adults were under the age of 65. CommonHealth Children - Expenditures for health care-related costs for children from birth through age 18 who are totally and permanently disabled with incomes greater than 150 percent of the Federal poverty level (FPL) and who are noteligible for comprehensive coverage under the Massachusetts state plan.	N/A	No	Yes	*1*	*07/01/1997*	*25*	*06/30/2022*
2	CommonHealth XXI	Title XXI-eligible higher income children with disabilities enrolled in title XIX CommonHealth after allotment is exhausted	N/A	No	Yes	*1*	*07/01/1997*	*25*	*06/30/2022*
			N/A						
	Hypothetical 1 Aggregate								
			N/A						
			N/A						
			N/A						
	Hypothetical 2 Per Capita				Hypothetical Test 2				
1	Out-of-state Former Foster Care Youth	Expenditures to extend eligibility for full Medicaid State Plan benefits (MassHealth Standard) to former foster care youth who are under age 26, were in foster care under the responsibility of a state other than Massachusetts or a Tribe in such a state when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends, and were enrolled in Medicaid under that state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they aged out.	N/A	No	Yes	*1*	*07/01/1997*	*25*	*06/30/2022*
			N/A						
			N/A						
	Hypothetical 2 Aggregate								
			N/A						
			N/A						
			N/A						
	Hypothetical 3 Per Capita				Hypothetical Test 3				
1	New Adult Group	Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act	N/A	No	No	*1*	*07/01/1997*	*25*	*06/30/2022*
			N/A						
			N/A						

Hypothetical 3 Aggregate	
	N/A
	N/A
	N/A
Tracking Only	

WOW PMPMs and Aggregates

		21	22	23	24	25
Medicaid Per Capita						
Base Families	1	$753.10	$781.72	$811.42	$842.25	$874.26
Base Disabled/MCB	2	$1,647.49	$1,713.39	$1,781.93	$1,853.21	$1,927.34
1902 (r) 2 Children	3	$597.02	$618.51	$640.78	$663.85	$687.75
1902 (r) 2 Disabled	4	$1,284.97	$1,331.23	$1,379.15	$1,428.80	$1,480.24
1902 (r) 2 BCCDP	5	$4,928.56	$5,105.99	$5,289.81	$5,480.24	$5,677.53
Base Families 21 RO	6	$753.10	$781.72	$811.42	$842.25	$874.26
1902 (r) 2 RO	7	$597.02	$618.51	$640.78	$663.85	$687.75
Medicaid Aggregate - WOW only						
DSH	1	$680,109,699	$695,930,159	$710,007,363	$720,822,506	$731,802,391

		21	22	23	24	25
Hypothetical 1 Per Capita						
CommonHealth	1	$776.08	$813.33	$852.37	$893.28	$936.16
CommonHealth XXI	2	$776.08	$813.33	$852.37	$893.28	$936.16

		21	22	23	24	25
Hypothetical 2 Per Capita						
Out-of-state Former Foster Care Youth	1	$350.41	$365.48	$381.19	$397.58	$414.68

		21	22	23	24	25
Hypothetical 3 Per Capita						
New Adult Group	1	$561.68	$585.83	$611.02	$637.29	$664.70

Program Spending Limits

								TOTAL
Program Name and Associated MEGs	**19**	**20**	**21**	**22**	**23**	**24**	**25**	
Spending Cap								
SNCP-DSRIP			$425,000,000	$425,000,000	$400,000,000	$325,000,000	$225,000,000	$ 1,800,000,000
Expenditures Subject to Cap								
SNCP-DSRIP-ACO *SNCP-DSRIP-CP* *SNCP-DSRIP-SWI* *SNCP-DSRIP-Operations*								
Variance			$425,000,000	$425,000,000	$400,000,000	$325,000,000	$225,000,000	$ 1,800,000,000
Over or Under	.	.	.	.	.	.	.	.

								TOTAL
Program Name and Associated MEGs	**19**	**20**	**21**	**22**	**23**	**24**	**25**	
Spending Cap								
SNCP-UCC			$ 212,000,000	$ 100,000,000	$ 100,000,000	$ 100,000,000	$ 100,000,000	$ 612,000,000
Expenditures Subject to Cap								
SNCP-UCC								
Variance			$212,000,000	$100,000,000	$100,000,000	$100,000,000	$100,000,000	$ 612,000,000
Over or Under	.	.	.	.	.	.	.	.

								TOTAL
Program Name and Associated MEGs	**19**	**20**	**21**	**22**	**23**	**24**	**25**	
Spending Cap								
SNCP-PHTII			$309,000,000	$243,000,000	$120,000,000	$100,000,000	$100,000,000	$ 872,000,000
Expenditures Subject to Cap								
SNCP-PHTII	$130,391,551	$163,997,778	$309,000,000	$243,000,000	$120,000,000	$96,250,000	$70,000,000	
Variance	($130,391,551)	($163,997,778)				$3,750,000	$30,000,000	$ (260,639,329)
Over or Under	Over	Over	.	.	.	.	.	Over

Data Pulled On:	09/01/2022	Reporting DY	25
For the Time Period Through:	06/30/2022	Reporting Quart	4

Paste all information related to the demonstration from Schedule C of the CMS 64 Waiver Expenditure Report.
1. On the Schedule C Report, locate rows relevant to all expenditures for a specific demonstration.
2. Complete two rounds of copy/paste starting from the cell in column A (Waiver Name)
- MAP Waivers/ Total Computable section – into cell A100
- MAP Waivers/ Federal Share section – into cell A200
3. If ADM waivers are applicable to the demonstration, complete two more rounds of copy/paste starting from the cell in column A (Waiver Name)
- ADM Waivers/ Total Computable section – cell A300
- ADM Waivers/ Federal Share section – cell A400

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09
1115 BPHC	0	0	0	0	0	0	0	0	0	0
1115 CMHLTH	0	0	0	0	0	0	0	0	0	0
1115 CPHC	0	0	0	0	0	0	0	0	0	0
1115 LIMITD	0	0	0	0	0	0	0	0	0	0
1115 STNDRT	0	0	0	0	0	0	0	0	0	0
1115-BASIC	0	34,412,171	127,659,803	46,079,527	0	0	0	0	0	0
1115-BPHC	0	3,287,934	168,674,714	138,512,847	0	0	0	0	0	0
1115-CMHLTH	0	13,155,552	29,807,739	20,811,960	0	0	0	0	0	0
1115-CPHC	0	1,399,172	60,536,845	58,728,469	0	0	0	0	0	0
1115-IRP	0	0	751,961	436,730	0	0	0	0	0	0
1115-LIMITD	0	3,052,304	8,987,168	4,244,188	0	0	0	0	0	0
1115-MHSPY	0	6,114	259,466	70,818	0	0	0	0	0	0
1115-MSP	0	9,708,204	8,227,360	1,724,253	0	0	0	0	0	0
1115-STNDRD	0	727,736,079	1,314,307,410	613,253,830	0	0	0	0	0	0
115-STNDRD	0	0	397,237,576	0	0	0	0	0	0	0
1902(r)(2) Children	0	0	0	0	0	(808)	408	13,661	1,898,971	49,012,288
1902(r)(2) Disabled	0	0	0	0	0	(4,601)	15,036	155,368	6,151,729	62,693,624
Base Childless Adults (19-20)	0	0	0	0	0	0	0	0	0	0
Base Childless Adults (Care Plus)	0	0	0	0	0	0	0	0	0	0
Base Childless Adults (Standard ABP)	0	0	0	0	0	0	0	0	0	0
Base Disabled	0	0	0	0	0	707,476	388,868	1,671,804	192,729,141	1,544,511,841
Base Families	0	0	0	0	0	12,197	18,950	472,232	90,387,621	1,858,065,692
Base MCB	0	0	0	0	0	(2,105)	(76)	12,445	244,738	1,777,702
BASIC	0	7,425	1,259,991	101,070,563	161,753,971	12,710,563	0	0	0	0
BPHC	0	0	0	23,391,802	221,736,018	6,669,798	0	0	0	0
CommCare-133	0	0	0	0	0	0	0	0	0	0

[illegible]

C Reoort Grouser

MAP Waivers Only

Total Computable

MEG Names		C Reoort Waiver Names	DEMONSTRATION YEARS (DY) 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Medicaid Per Capita																											
Base Families	1	Base Families					$12 197	$18 950	$472 232	$90 387 621	$1 658 065 692	$1 950 432 163	$2 099 630 570	$2 215 557 457	$2 403 134 261	$2 346 599 383	$2 515 038 962	$2 542 350 612	$2 609 362 814	$2 926 851 268	$2 967 818 807	$2 865 313 197	$2 929 388 898	$2 988 081 000	$3 081 966 072	$3 539 697 037	$3 737 718 017
Base Disabled/MCB	2	Base Disabled					$707 476	$388 868	$1 671 804	$192 729 141	$1 544 511 841	$1 666 269 426	$1 792 204 044	$1 886 678 743	$1 927 983 302	$2 270 456 995	$2 118 047 021	$2 153 546 645	$2 264 315 788	$2 440 269 945	$2 412 653 017	$2 444 577 757	$2 446 176 835	$2 619 136 014	$2 668 522 845	$2 863 030 115	$2 875 463 655
1902(r) 2 Children	3	1902(r)(2) Children					($839)	$406	$13 681	$1 896 871	$46 012 268	$61 439 644	$43 895 783	$38 574 860	$44 927 208	($16 192 539)	$35 470 735	$39 390 389	$70 087 243	$66 008 954	$117 709 687	$141 916 629	$66 111 748	$78 885 195	$74 982 535	$104 988 817	$116 94 1 729
1902 (r) 2 Disabled	4	1902(r)(2) Disabled					($4 831)	$15 036	$155 368	$6 151 729	$82 693 624	$48 183 994	$43 957 808	$57 951 950	$52 179 985	$52 587 197	$49 658 869	$51 173 267	$52 391 558	$46 440 458	$53 769 595	$58 814 966	$55 827 299	$60 241 888	$62 816 443	$70 075 090	$76 057 239
1905 (a) 2 SCTP	5	MassHealth-ECTP							$458 757	$3 115 056	$4 168 585	$4 811 446	$3 985 474	$4 195 858	$4 561 175	$4 755 486	$5 201 051	$5 503 595	$5 541 687	$5 875 464	$5 403 585	$6 076 704	$6 700 364	$7 105 847	$7 458 790	$8 214 870	$8 474 451
Base Families 21 RO	6	Base Fam XXI RO																									
1902 (r) 2 RO	7	1902 (r)(2) XXI RO																									
Medicaid Aaoreaate - WW only																											
aFamily Assistance	1	a-Family Assistance							$7	$40 956	$3 103 365	$3 919 045	$4 009 464	$4 864 368	$4 677 674	$4 439 464											
a-HIV/FA	2	a-HIV/FA					$15 818	$1 332	($7 824)	$874 100	$14 500 059	$16 346 143	$18 350 702	$19 735 876	$23 747 195	$24 881 045	$24 463 693	$26 098 717	$18 355 909	$8 083 523	$7 691 151	$8 151 752	$9 629 813	$11 732 401	$11 210 206	$11 783 925	$13 757 008
SBE	3	SBE-FA																		$810 248			$22 687	59 192			
SNCP-DSRP	4	SNCP-DSRP																					$289 823 537	$285 379 587	$204 984 685	$68 408 514	$53 947 117
SNCP-DSRP-ACO	5	SNCP-DSRP-ACO																									
SNCP-DSRP-CP	6	SNCP-DSRP-CP																									
SNCP-DSRP-SW	7	SNCP-DSRP-SW																									
SNCP-DSRP-Operations	8	SNCP-DSRP-Operations																									
SNCP-PATE	9	SNCP-PATE																									
SNCP-DSH-HSNTF	10	SNCP-HSNTF														$41 781 976	$77 698 623	$128 214 687	$156 211 424	$169 210 251	$149 688 790	$144 717 613	$239 621 717	$238 157 666	$241 584 300	$253 903 311	$118 923 801
SNCP-DSH-MRT	11	SNCP-MRT																			$130 391 551	$163 997 778	$309 000 000	$243 000 000	$120 000 000	$96 250 000	$70 000 000
SNCP-DSH-CPE	12	SNCP-CPE																			$136 988 216		$155 093 217	$164 302 366	$187 347 081	$153 385 409	$155 987 192
SNCP-CPE	13	SNCP-CPE																									
SNCP-OTHER	14	SNCP-Other															($41 531)	$3 113	($4 947 550)	$157 412 572	$301 778 502	$22 116 742					
DSHP-Health Connector Subsidies	15	DSHP-Health Connector subsidies																		$31 385 699	$98 682 856	$110 987 289	$108 917 889	$132 576 163	$144 480 079	$111 173 265	$11 782 323
HealthTrio	16	DSHP-CSR																				$20 052 098	$14 147 543	$14 754 769	$14 415 518	$30 180 457	$50 181 854
Provisional Eligibility	17	Provisional Eligibility																									
TANF/E4ADC	18																										
End of Month Coverage	19	DSHP-Temporary Coverage														($1 146)	($588)		$162 178 153	$478 093 137	$615 371						
Continuous Eligibility	20	Continuous Eligibility																									
SUR	21	SUD																									
Hvoothetical 1 Per Capita																											
CommonHealth	1	1115-CMHLTH																									
CommonHealth	1	1115 CMHLTH																									
CommonHealth	1	1115-CMHLTH																									
CommonHealth	1	COMMONHEALTH	$21 129	$1 271 439	$42 334 215	$78 265 367	$12 547 914																				
CommonHealth	1	Mass Health Commonhealth	($1 351)	$21 257	$182 205	$2 682 462	$49 660 916																				
CommonHealth	1	MassHealth- CommonHealth				$501 026	$16 999 320	$80 274 968																			
CommonHealth	1	MassHealth-CommonHealth				$160 935	$488 309	$50 123 321	$131 231 034	$132 491 136	$109 818 022	$96 428 950	$89 839 385	$87 197 017	$72 429 915	$78 417 273	$76 521 528	$83 146 677	$92 468 150	$92 216 505	$101 222 460	$110 664 637	$117 655 822	$131 752 414	$139 219 849	$134 206 500	$133 167 579
CommonHealth	1	MassHealth-CommonHealth				$501 526	$16 504 054																				
CommonHealth XXI	2	CommonHealth XXI																									
Hvoothetical 2 Per Capita																											
Out-of-state Former Foster Care Youth	1	FFCY																									
Hvoothetical 3 Per Capita																											
New Adult Group	1	Base Childless Adults (19-20)																	$56 607 092	$58 175 862	$88 541 831	$97 151 822	$110 019 336	$121 105 605	$135 603 340	$117 307 939	$135 647 685
New Adult Group	1	Base Childless Adults (Care Plus)																	$1 051 349 385	$1 189 546 904	$1 823 460 579	$1 764 148 817	$1 884 438 101	$1 814 761 023	$1 780 227 596	$2 446 466 963	$2 588 284 587
New Adult Group	1	Base Childless Adults (Standard ABP)																	$39 616 970	$56 470 962	$140 945 616	$220 664 885	$268 935 375	$455 653 119	$277 556 605	$354 100 954	$441 664 719
TOTAL			$13 275 330	$31 100 435	$83 328 380	$82 314 235	$155 536 865	$130 822 883	$133 943 019	$426 697 962	$3 646 373 458	$3 847 621 823	$4 086 579 930	$4 308 155 979	$4 542 117 659	$4 814 643 738	$4 922 800 043	$5 046 517 882	$6 568 006 618	$7 787 832 148	$8 301 785 062	$8 406 355 836	$8 680 570 456	$9 319 940 338	$9 306 298 229	##########	##########

Adjustments made to the reported expenditures

Enter total adjustments made to the expenditure numbers, including adjustments to the previous reporting periods.
Positive adjustments increase expenditures, and negative adjustments decrease expenditures.
Enter adjustments for every MEG for which adjustments were made or are planned.
Helpful Hint: Remember to enter total adjustments as positive or negative (for example, -$10,000 reflects a decrease in expenditures).

		21	22	23	24	25	Description (type of collection, time period, CMS-64 reporting line, etc.)
Medicaid Per Capita							
Base Families	1	-$128,577	-$376,448	-$425,545	-$416,789	-$526,571	Subtracted FFCY expenditures
Base Disabled/MCB	2						
1902 (r) 2 Children	3						
1902 (r) 2 Disabled	4						
1902 (r) 2 BCCDP	5						
Base Families 21 RO	6						
1902 (r) 2 RO	7						
Medicaid Aggregate - WW only							
e-Family Assistance	1						
e-HIV/FA	2						
SBE	3						
SNCP-DSRIP	4		$18,617,796		$51,727,421		Added expenditures from DSRIP row of Schedule C
SNCP-DSRIP-ACO	5						
SNCP-DSRIP-CP	6						
SNCP-DSRIP-SWI	7						
SNCP-DSRIP-Operations	8						
SNCP-PHTII	9						
SNCP-DSH-HSNTF	10					$107,898,926	Added expenditures from SNCP-DSH-HSNTF row of Schedule C
SNCP-DSH-IMD	11						
SNCP-DSH-CPE	12						
SNCP-UCC	13						
SNCP-OTHER	14	$200,210,000	$197,002,584	$283,147,297	$179,814,872	$9,462,750	Added SFY 18,19,20, 21, 22 SNPP and SFY 18, 19, 20,21 Public Service Hospital Safety Net Care Payments
DSHP-Health Connector Subsidies	15						
DSHP-CSR	16						
Provisional Eligibility	17						
TANF/EAEDC	18	$285,515	$265,952	$171,617	$53,155	$56,032	Added EADC expenditures - Not receiving FFP for these expenditures
End of Month Coverage	19						
Continuous Eligibility	20						
SUD	21						
Hypothetical 1 Per Capita							
CommonHealth	1						
CommonHealth XXI	2						
Hypothetical 2 Per Capita							
Out-of-state Former Foster Care Youth	1	$128,577	$376,448	$425,545	$416,789	$526,571	Added FFCY expenditures (Expenditures are reported under Base Families on Schedule C)
Hypothetical 3 Per Capita							
New Adult Group	1						

WW Soendino - Actual

Total Computable

		DEMONSTRATION YEARS (DY)																					
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Medicaid Per Capita																										
Base Families	1					$12,197	$18,950	$472,232	$90,387,621	$1,858,065,692	$1,950,432,163	$2,099,630,570	$2,215,557,457	$2,403,134,261	$2,346,599,383	$2,515,038,962	$2,542,350,812	$2,606,362,814	$2,926,851,268	$2,967,818,807	$2,865,313,197	$2,929,238,321	$2,987,714,552	$3,081,540,527	$3,509,260,248	$3,737,191,444
Base Disabled/MCB	2					$707,476	$388,868	$1,671,804	$192,729,141	$1,544,511,841	$1,866,269,426	$1,782,204,044	$1,886,678,743	$1,927,983,302	$2,270,456,995	$2,118,047,021	$2,153,546,645	$2,264,315,788	$2,446,269,945	$2,412,655,017	$2,444,577,757	$2,446,176,835	$2,619,136,014	$2,668,522,845	$2,863,050,115	$2,875,463,695
1902 (r) 1 Children	3					($508)	$458	$13,651	$1,898,971	$49,012,288	$61,430,644	$42,855,783	$30,574,860	$44,627,298	($18,102,938)	$55,470,735	$58,390,366	$70,087,243	$66,009,954	$117,709,687	$141,918,629	$96,111,748	$78,885,190	$74,062,550	$104,966,617	$118,941,729
1902 (r) 2 Disabled	4					($4,601)	$15,036	$155,368	$6,151,729	$62,693,624	$48,163,994	$43,957,808	$57,551,950	$52,179,985	$52,587,197	$49,658,669	$51,173,267	$52,381,558	$46,440,458	$53,769,595	$58,814,966	$55,827,299	$60,241,888	$62,816,443	$70,075,090	$76,007,239
1902 (r) 3 BCCDP	5							$456,737	$2,121,926	$4,268,583	$4,811,448	$3,962,474	$4,585,808	$6,043,172	$4,753,489	$3,922,931	$3,583,595	$3,041,682	$3,973,804	$5,402,585	$6,876,704	$9,790,964	$13,496,847	$14,058,230	$13,450,633	$14,697,140
Base Families 21 RO	6																									
1902 (r) 3 RO	7																									
Medicaid Accroeate - WW only																										
e-Family Assistance	1							$7	$42,938	$3,503,369	$3,919,053	$5,809,164	$6,884,268	$11,672,531	$13,420,464											
e-HIV/PA	2					$15,818	$1,332	($7,824)	$874,100	$14,500,059	$16,346,143	$18,350,702	$19,735,876	$23,747,195	$24,861,045	$24,483,693	$26,098,717	$18,355,909	$8,063,523	$7,691,151	$8,151,752	$9,629,813	$11,732,401	$11,210,206	$11,783,925	$13,757,008
SBE	3																		$810,248			$22,687	$9,182			
SNCP-DSRIP	4																					$289,823,537	$303,997,383	$204,984,685	$120,135,935	$53,847,117
SNCP-DSRIP-ACO	5																									
SNCP-DSRIP-CF	6																									
SNCP-DSRIP-SWI	7																									
SNCP-DSRIP-Operations	8																									
SNCP-PHTI	9																			$130,391,551	$163,997,778	$309,000,000	$240,000,000	$120,000,000	$66,250,000	$70,000,000
SNCP-DSH-HIV/TF	10														$41,781,976	$77,698,623	$128,214,687	$156,211,424	$169,210,251	$149,686,790	$144,717,613	$229,621,717	$238,157,886	$241,564,300	$253,803,311	$226,922,540
SNCP-DSH-IMD	11																		$1,256	$1,410,664	$47,208,948	$28,954,675	$28,855,997	$28,345,352	$34,403,761	$32,342,642
SNCP-DSH-CTE	12																				$136,988,216	$185,000,217	$164,362,366	$187,347,991	$153,385,459	$135,987,192
SNCP-UCC	13																									
SNCP-OTHER	14															($41,531)	$3,113	($4,947,550)	$157,412,572	$201,778,502	$22,118,742	$200,210,000	$197,002,584	$283,147,297	$179,814,872	$9,462,750
DSHP-Health Connector Subsidies	15																		$31,385,699	$56,692,956	$110,987,289	$108,947,889	$132,579,163	$144,486,079	$111,173,205	$11,782,323
DSHP-CSR	16																				$62,054,086	$101,287,543	$134,790,876	$134,030,016	$99,282,637	$59,091,694
Provisional Eligibility	17																									
TANF/EAEDC	18																					$285,515	$285,952	$171,617	$53,155	$56,032
End of Month Coverage	19														($1,140)	($588)		$162,178,153	$478,093,137	$615,371						
Continuous Eligibility	20																									
SUD	21																									
Hypothetical 1 Per Capita																										
CommonHealth	1	$13,275,330	$31,100,435	$63,328,380	$82,314,235	$105,196,783	$130,398,289	$131,231,034	$132,491,136	$109,818,022	$96,428,950	$89,839,385	$87,197,017	$72,429,915	$78,417,273	$78,521,528	$83,146,677	$92,468,150	$92,216,505	$101,222,460	$110,664,637	$117,655,822	$131,752,414	$139,219,849	$134,206,500	$133,107,578
CommonHealth XXI	2																									
Hypothetical 2 Per Capita																										
Out-of-state Former Foster Care Youth	1																					$128,577	$376,448	$425,545	$416,789	$526,571
Hypothetical 3 Per Capita																										
New Adult Group	1																	$1,147,573,447	$1,338,193,728	$2,052,948,026	$2,081,965,524	$2,193,383,012	$2,191,529,747	$2,193,697,541	$2,919,875,876	$3,185,626,991
TOTAL		**$13,275,330**	**$31,100,435**	**$63,328,380**	**$82,314,235**	**$105,936,865**	**$130,822,883**	**$133,943,019**	**$426,697,582**	**$3,646,373,488**	**$3,947,621,823**	**$4,096,979,930**	**$4,309,135,979**	**$4,542,117,459**	**$4,614,663,738**	**$4,922,606,043**	**$5,046,517,882**	**$6,568,699,616**	**$7,787,832,148**	**$8,301,788,982**	**$8,496,355,838**	**$9,281,065,971**	**$9,535,636,670**	**$9,589,617,145**	**$10,673,510,076**	**$10,754,711,629**

WW Spending - Projected

Enter projected spending for the demonstration which includes the remaining quarters of the current DY and all future DYs.
Enter the projected annual expenditures for each DY per MEG for the active DYs.
For the current DY, only future quarters should have projected spending information. Do not include expenditures that were reported as actuals.

Total Computable

		21	22	23	24	25
Medicaid Per Capita						
Base Families	1					$160,056,505
Base Disabled/MCB	2					$84,949,175
1902 (r) 2 Children	3					$3,715,395
1902 (r) 2 Disabled	4					$4,034,229
1902 (r) 2 BCCDP	5					$562,467
Base Families 21 RO	6					
1902 (r) 2 RO	7					
Medicaid Aggregate - WW only						
e-Family Assistance	1					
e-HIV/FA	2					$393,827
SBE	3					
SNCP-DSRIP	4	$77,176,463	$100,922,967	$121,240,587	$154,838,922	$65,604,291
SNCP-DSRIP-ACO	5					
SNCP-DSRIP-CP	6					
SNCP-DSRIP-SWI	7					
SNCP-DSRIP-Operations	8					
SNCP-PHTII	9					$27,400,000
SNCP-DSH-HSNTF	10					
SNCP-DSH-IMD	11					
SNCP-DSH-CPE	12					
SNCP-UCC	13					
SNCP-OTHER	14		$182,360	$583,736	$1,294,514	$153,757,250
DSHP-Health Connector Subsidies	15					
DSHP-CSR	16					
Provisional Eligibility	17					
TANF/EAEDC	18					
End of Month Coverage	19					
Continuous Eligibility	20					
SUD	21					
Hypothetical 1 Per Capita						
CommonHealth	1					$6,123,680
CommonHealth XXI	2					
Hypothetical 2 Per Capita						
Out-of-state Former Foster Care Youth	1					
Hypothetical 3 Per Capita						
New Adult Group	1					$90,549,674

WW Spending - Total

Total Computable

		21	22	23	24	25
Medicaid Per Capita						
Base Families	1	$2,929,238,321	$2,987,714,552	$3,081,540,527	$3,509,280,248	$3,897,247,948
Base Disabled/MCB	2	$2,446,176,835	$2,619,136,014	$2,668,522,845	$2,863,050,115	$2,960,412,830
1902 (r) 2 Children	3	$96,111,748	$78,885,190	$74,062,550	$104,988,617	$122,657,124
1902 (r) 2 Disabled	4	$55,827,299	$60,241,888	$62,816,443	$70,075,090	$80,041,468
1902 (r) 2 BCCDP	5	$9,790,964	$13,496,847	$14,058,230	$13,430,633	$15,259,607
Base Families 21 RO	6					
1902 (r) 2 RO	7					
Medicaid Aggregate - WW only						
e-Family Assistance	1					
e-HIV/FA	2	$9,629,813	$11,732,401	$11,210,206	$11,783,925	$14,150,835
SBE	3	$22,687	$9,182			
SNCP-DSRIP	4	$367,000,000	$404,920,350	$326,225,272	$274,974,857	$119,451,408
SNCP-DSRIP-ACO	5					
SNCP-DSRIP-CP	6					
SNCP-DSRIP-SWI	7					
SNCP-DSRIP-Operations	8					
SNCP-PHTII	9	$309,000,000	$243,000,000	$120,000,000	$96,250,000	$97,400,000
SNCP-DSH-HSNTF	10	$229,621,717	$238,157,666	$241,564,300	$253,903,311	$226,822,527
SNCP-DSH-IMD	11	$28,954,675	$26,855,997	$28,345,352	$34,403,761	$32,342,649
SNCP-DSH-CPE	12	$155,000,217	$164,302,366	$187,347,061	$153,385,409	$155,987,192
SNCP-UCC	13					
SNCP-OTHER	14	$200,210,000	$197,184,944	$283,731,033	$181,109,386	$163,220,000
DSHP-Health Connector Subsidies	15	$108,917,689	$132,579,163	$144,480,079	$111,173,205	$11,782,323
DSHP-CSR	16	$101,287,543	$134,790,876	$134,033,016	$99,282,637	$59,091,684
Provisional Eligibility	17					
TANF/EAEDC	18	$285,515	$265,952	$171,617	$53,155	$56,032
End of Month Coverage	19					
Continuous Eligibility	20					
SUD	21					
Hypothetical 1 Per Capita						
CommonHealth	1	$117,655,822	$131,752,414	$139,219,849	$134,206,500	$139,231,258
CommonHealth XXI	2					
Hypothetical 2 Per Capita						
Out-of-state Former Foster Care Youth	1	$128,577	$376,448	$425,545	$416,789	$526,571
Hypothetical 3 Per Capita						
New Adult Group	1	$2,193,383,012	$2,191,529,747	$2,193,687,541	$2,919,875,876	$3,256,176,665
TOTAL		**$9,358,242,434**	**$9,636,931,998**	**$9,711,441,466**	**$10,831,643,515**	**$11,351,858,121**

Member Months - Actual

Enter actual member months (number of beneficiaries times the number of enrolled months) for quarters to date for each active DY.
For the reported quarter, add the actual number of member months per each MEG to the previous actual number. The number should equal the total of ALL actual member months.
Note: Depending of the specifics of the state, you can use Total member months or Average monthly unduplicated counts. Whichever definition is used, it must be applied consistently.
Helpful Hint: When updating a DY, remember to enter actual member months for the reported quarter along with actuals for prior quarter(s). Retroactive adjustments may affect the entries.

		21	22	23	24	25
Medicaid Per Capita						
Base Families	1	9,716,592	9,322,892	9,338,342	10,154,297	11,440,193
Base Disabled/MCB	2	2,837,893	2,767,468	2,717,453	2,741,809	2,756,704
1902 (r) 2 Children	3	209,813	187,116	147,490	254,960	321,803
1902 (r) 2 Disabled	4	227,903	212,794	214,326	215,394	217,666
1902 (r) 2 BCCDP	5	14,877	13,659	13,337	13,767	15,331
Base Families 21 RO	6	-				
1902 (r) 2 RO	7	-				
Hypothetical 1 Per Capita						
CommonHealth	1	332,041	363,258	384,086	388,214	382,296
CommonHealth XXI	2	-				
Hypothetical 2 Per Capita						
Out-of-state Former Foster Care Youth	1	495	1,069	1,047	1,148	1,357
Hypothetical 3 Per Capita						
New Adult Group	1	4,079,702	3,812,337	3,859,266	4,643,300	5,372,611

Member Months - Projected

Enter/adjust projected member months based on reported actuals.
Enter projected number of member months for each active DY per MEG for the demonstration.
For the current DY, enter only the number that reflects projections for future quarters of the DY.
Do not include member months for either the current reporting quarter or past quarters.

		21	22	23	24	25
Medicaid Per Capita						
Base Families	1					
Base Disabled/MCB	2					
1902 (r) 2 Children	3					
1902 (r) 2 Disabled	4					
1902 (r) 2 BCCDP	5					
Base Families 21 RO	6					
1902 (r) 2 RO	7					
Hypothetical 1 Per Capita						
CommonHealth	1					
CommonHealth XXI	2					
Hypothetical 2 Per Capita						
Out-of-state Former Foster Care Youth	1					
Hypothetical 3 Per Capita						
New Adult Group	1					

Member Months - Total

		21	22	23	24	25
Medicaid Per Capita						
Base Families	1	9,716,592	9,322,892	9,338,342	10,154,297	11,440,193
Base Disabled/MCB	2	2,837,893	2,767,468	2,717,453	2,741,809	2,756,704
1902 (r) 2 Children	3	209,813	187,116	147,490	254,960	321,803
1902 (r) 2 Disabled	4	227,903	212,794	214,326	215,394	217,666
1902 (r) 2 BCCDP	5	14,877	13,659	13,337	13,767	15,331
Base Families 21 RO	6					
1902 (r) 2 RO	7					
Medicaid Per Capita - WOW only						
Hypothetical 1 Per Capita						
CommonHealth	1	332,041	363,258	384,086	388,214	382,296
CommonHealth XXI	2					
Hypothetical 2 Per Capita						
Out-of-state Former Foster Care Youth	1	495	1,069	1,047	1,148	1,357
Hypothetical 3 Per Capita						
New Adult Group	1	4,079,702	3,812,337	3,859,266	4,643,300	5,372,611

Budget Neutrality Summary

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year.
By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality.
Selecting the 'Reset to Defaults' button will reset the Reporting DY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start DY	**21**
Budget Neutrality Reporting End DY	**25**

Actuals + Projected

Without-Waiver Total Expenditures

			21	22	23	24	25	Total
Medicaid Per Capita								
Base Families	1	**Total**	$ 7,317,565,524	$ 7,287,890,817	$ 7,577,317,084	$ 8,552,456,589	$ 10,001,702,844	
		PMPM	$753.10	$781.72	$811.42	$842.25	$874.26	
		Mem-Mon	9,716,592	9,322,892	9,338,342	10,154,297	11,440,193	
Base Disabled/MCB	2	**Total**	$ 4,675,400,032	$ 4,741,751,673	$ 4,842,311,368	$ 5,081,147,506	$ 5,313,106,623	
		PMPM	$1,647.49	$1,713.39	$1,781.93	$1,853.21	$1,927.34	
		Mem-Mon	2,837,893	2,767,468	2,717,453	2,741,809	2,756,704	
1902 (r) 2 Children	3	**Total**	$ 125,262,390	$ 115,733,102	$ 94,508,377	$ 169,254,929	$ 221,320,174	
		PMPM	$597.02	$618.51	$640.78	$663.85	$687.75	
		Mem-Mon	209,813	187,116	147,490	254,960	321,803	
1902 (r) 2 Disabled	4	**Total**	$ 292,847,926	$ 283,277,988	$ 295,587,629	$ 307,755,336	$ 322,197,194	
		PMPM	$1,284.97	$1,331.23	$1,379.15	$1,428.80	$1,480.24	
		Mem-Mon	227,903	212,794	214,326	215,394	217,666	
1902 (r) 2 BCCDP	5	**Total**	$ 73,320,056	$ 69,743,686	$ 70,548,493	$ 75,448,248	$ 87,041,663	
		PMPM	$4,928.56	$5,105.99	$5,289.81	$5,480.24	$5,677.53	
		Mem-Mon	14,877	13,659	13,337	13,767	15,331	
Base Families 21 RO	6	**Total**	$ -	$ -	$ -	$ -	$ -	
		PMPM	$753.10	$781.72	$811.42	$842.25	$874.26	
		Mem-Mon						
1902 (r) 2 RO	7	**Total**	$ -	$ -	$ -	$ -	$ -	
		PMPM	$597.02	$618.51	$640.78	$663.85	$687.75	
		Mem-Mon						
Medicaid Aggregate - WOW only								
DSH	1	**Total**	$ 680,109,699	$ 695,930,159	$ 710,007,363	$ 720,822,506	$ 731,802,391	

TOTAL			$ 13,164,505,625	$ 13,194,327,423	$ 13,590,280,314	$ 14,906,885,113	$ 16,677,170,888	$ 71,533,169,363

With-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Medicaid Per Capita								
Base Families	1		$ 2,929,238,321	$ 2,987,714,552	$ 3,081,540,527	$ 3,509,280,248	$ 3,897,247,948	$45,793,067,983
Base Disabled/MCB	2		$ 2,446,176,835	$ 2,619,136,014	$ 2,668,522,845	$ 2,863,050,115	$ 2,960,412,830	$38,664,312,454
1902 (r) 2 Children	3		$ 96,111,748	$ 78,885,190	$ 74,062,550	$ 104,988,617	$ 122,657,124	$1,227,742,013
1902 (r) 2 Disabled	4		$ 55,827,299	$ 60,241,888	$ 62,816,443	$ 70,075,090	$ 80,041,468	$965,112,791
1902 (r) 2 BCCDP	5		$ 9,790,964	$ 13,496,847	$ 14,058,230	$ 13,430,633	$ 15,259,607	$123,530,999
Base Families 21 RO	6		$ -	$ -	$ -	$ -	$ -	
1902 (r) 2 RO	7		$ -	$ -	$ -	$ -	$ -	
Medicaid Aggregate - WW only								
e-Family Assistance	1		$ -	$ -	$ -	$ -	$ -	$45,231,794
e-HIV/FA	2		$ 9,629,813	$ 11,732,401	$ 11,210,206	$ 11,783,925	$ 14,150,835	$269,776,371
SBE	3		$ 22,687	$ 9,182	$ -	$ -	$ -	$842,117
SNCP-DSRIP	4		$ 367,000,000	$ 404,920,350	$ 326,225,272	$ 274,974,857	$ 119,451,408	$1,492,571,887
SNCP-DSRIP-ACO	5		$ -	$ -	$ -	$ -	$ -	
SNCP-DSRIP-CP	6		$ -	$ -	$ -	$ -	$ -	
SNCP-DSRIP-SWI	7		$ -	$ -	$ -	$ -	$ -	
SNCP-DSRIP-Operations	8		$ -	$ -	$ -	$ -	$ -	
SNCP-PHTII	9		$ 309,000,000	$ 243,000,000	$ 120,000,000	$ 96,250,000	$ 97,400,000	$1,160,039,329
SNCP-DSH-HSNTF	10		$ 229,621,717	$ 238,157,666	$ 241,564,300	$ 253,903,311	$ 226,822,527	$2,057,592,885
SNCP-DSH-IMD	11		$ 28,954,675	$ 26,855,997	$ 28,345,352	$ 34,403,761	$ 32,342,649	$199,523,302
SNCP-DSH-CPE	12		$ 155,000,217	$ 164,302,366	$ 187,347,061	$ 153,385,409	$ 155,987,192	$953,010,461
SNCP-UCC	13		$ -	$ -	$ -	$ -	$ -	
SNCP-OTHER	14		$ 200,210,000	$ 197,184,944	$ 283,731,033	$ 181,109,386	$ 163,220,000	$1,401,779,211
DSHP-Health Connector Subsidies	15		$ 108,917,689	$ 132,579,163	$ 144,480,079	$ 111,173,205	$ 11,782,323	$749,988,303
DSHP-CSR	16		$ 101,287,543	$ 134,790,876	$ 134,033,016	$ 99,282,637	$ 59,091,684	$590,539,842
Provisional Eligibility	17		$ -	$ -	$ -	$ -	$ -	
TANF/EAEDC	18		$ 285,515	$ 265,952	$ 171,617	$ 53,155	$ 56,032	$832,272
End of Month Coverage	19		$ -	$ -	$ -	$ -	$ -	$640,884,927
Continuous Eligibility	20		$ -	$ -	$ -	$ -	$ -	
SUD	21		$ -	$ -	$ -	$ -	$ -	
TOTAL			**$ 7,047,075,023**	**$ 7,313,273,389**	**$ 7,378,108,531**	**$ 7,777,144,350**	**$ 7,955,923,627**	**$ 37,471,524,919**

Savings Phase-Down

Medicaid Per Capita			21	22	23	24	25	TOTAL
		Savings Phase-Down						
Base Families	1	**Without Waiver**	$ 7,317,565,524	$ 7,287,890,817	$ 7,577,317,084	$ 8,552,456,589	$ 10,001,702,844	
		With Waiver	$ 2,929,238,321	$ 2,987,714,552	$ 3,081,540,527	$ 3,509,280,248	$ 3,897,247,948	
Difference			$ 4,388,327,203	$ 4,300,176,264	$ 4,495,776,557	$ 5,043,176,341	$ 6,104,454,895	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 3,291,245,402	$ 3,225,132,198	$ 3,371,832,418	$ 3,782,382,255	$ 4,578,341,171	
		Savings Phase-Down						

Base Disabled/MCB	2	**Without Waiver**	$ 4,675,400,032	$ 4,741,751,673	$ 4,842,311,368	$ 5,081,147,506	$ 5,313,106,623	
		With Waiver	$ 2,446,176,835	$ 2,619,136,014	$ 2,668,522,845	$ 2,863,050,115	$ 2,960,412,830	
Difference			$ 2,229,223,197	$ 2,122,615,659	$ 2,173,788,523	$ 2,218,097,391	$ 2,352,693,793	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 1,671,917,398	$ 1,591,961,744	$ 1,630,341,393	$ 1,663,573,043	$ 1,764,520,344	
		Savings Phase-Down						
1902 (r) 2 Children	3	**Without Waiver**	$ 125,262,390	$ 115,733,102	$ 94,508,377	$ 169,254,929	$ 221,320,174	
		With Waiver	$ 96,111,748	$ 78,885,190	$ 74,062,550	$ 104,988,617	$ 122,657,124	
Difference			$ 29,150,642	$ 36,847,912	$ 20,445,827	$ 64,266,312	$ 98,663,050	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 21,862,981	$ 27,635,934	$ 15,334,370	$ 48,199,734	$ 73,997,287	
		Savings Phase-Down						
1902 (r) 2 Disabled	4	**Without Waiver**	$ 292,847,926	$ 283,277,988	$ 295,587,629	$ 307,755,336	$ 322,197,194	
		With Waiver	$ 55,827,299	$ 60,241,888	$ 62,816,443	$ 70,075,090	$ 80,041,468	
Difference			$ 237,020,627	$ 223,036,100	$ 232,771,186	$ 237,680,246	$ 242,155,726	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 177,765,470	$ 167,277,075	$ 174,578,389	$ 178,260,184	$ 181,616,795	
		Savings Phase-Down						
1902 (r) 2 BCCDP	5	**Without Waiver**	$ 73,320,056	$ 69,743,686	$ 70,548,493	$ 75,448,248	$ 87,041,663	
		With Waiver	$ 9,790,964	$ 13,496,847	$ 14,058,230	$ 13,430,633	$ 15,259,607	
Difference			$ 63,529,092	$ 56,246,839	$ 56,490,263	$ 62,017,615	$ 71,782,056	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 47,646,819	$ 42,185,129	$ 42,367,697	$ 46,513,211	$ 53,836,542	
		Savings Phase-Down						
Base Families 21 RO	6	**Without Waiver**	$ -	$ -	$ -	$ -	$ -	
		With Waiver	$ -	$ -	$ -	$ -	$ -	
Difference			$ -	$ -	$ -	$ -	$ -	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ -	$ -	$ -	$ -	$ -	
		Savings Phase-Down						
1902 (r) 2 RO	7	**Without Waiver**	$ -	$ -	$ -	$ -	$ -	
		With Waiver	$ -	$ -	$ -	$ -	$ -	
Difference			$ -	$ -	$ -	$ -	$ -	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ -	$ -	$ -	$ -	$ -	
Total Reduction			**$ 5,210,438,070**	**$ 5,054,192,080**	**$ 5,234,454,267**	**$ 5,718,928,428**	**$ 6,652,312,140**	**$ 27,870,324,985**

BASE VARIANCE			**$ 906,992,532**	**$ 826,861,954**	**$ 977,717,516**	**$ 1,410,812,335**	**$ 2,068,935,121**	**$ 6,191,319,459**
Excess Spending from Hypotheticals								$ -
1115A Dual Demonstration Savings (state preliminary estimate)								$ -
1115A Dual Demonstration Savings (OACT certified)								$ -
Carry-Forward Savings From Prior Period								
NET VARIANCE								**$ 6,191,319,459**

Cumulative Target Limit

			21	**22**	**23**	**24**	**25**	

Cumulative Target Percentage (CTP)			2.0%	1.5%	1.0%	0.5%		
Cumulative Budget Neutrality Limit (CBNL)			$ 7,954,067,555	$ 16,094,202,899	$ 24,450,028,945	$ 33,637,985,630	$ 43,662,844,378	
Allowed Cumulative Variance (= CTP X CBNL)			$ 159,081,351	$ 241,413,043	$ 244,500,289	$ 168,189,928	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (906,992,532)	$ (1,733,854,486)	$ (2,711,572,002)	$ (4,122,384,337)	$ (6,191,319,459)	
Is a Corrective Action Plan needed?								

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Hypothetical 1 Per Capita								
CommonHealth	1	**Total**	$ 257,690,691	$ 295,448,569	$ 327,383,157	$ 346,783,413	$ 357,890,252	
		PMPM	$776.08	$813.33	$852.37	$893.28	$936.16	
		Mem-Mon	332,041	363,258	384,086	388,214	382,296	
CommonHealth XXI	2	**Total**	$ -	$ -	$ -	$ -	$ -	
		PMPM	$776.08	$813.33	$852.37	$893.28	$936.16	
		Mem-Mon						
TOTAL			**$257,690,691**	**$295,448,569**	**$327,383,157**	**$346,783,413**	**$357,890,252**	**$1,585,196,083**

With-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Hypothetical 1 Per Capita								
CommonHealth	1		$117,655,822	$131,752,414	$139,219,849	$134,206,500	$139,231,258	
CommonHealth XXI	2							
TOTAL			**$ 117,655,822**	**$ 131,752,414**	**$ 139,219,849**	**$ 134,206,500**	**$ 139,231,258**	**$ 662,065,843**

HYPOTHETICALS VARIANCE 1			**$ 140,034,869**	**$ 163,696,155**	**$ 188,163,308**	**$ 212,576,913**	**$ 218,658,994**	**$ 923,130,239**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Hypothetical 2 Per Capita								
Out-of-state Former Foster Care Youth	1	**Total**	$ 173,453	$ 390,698	$ 399,106	$ 456,422	$ 562,721	
		PMPM	$350.41	$365.48	$381.19	$397.58	$414.68	
		Mem-Mon	495	1,069	1,047	1,148	1,357	

TOTAL			**$ 173,453**	**$ 390,698**	**$ 399,106**	**$ 456,422**	**$ 562,721**	**$ 1,982,400**

With-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Hypothetical 2 Per Capita								
Out-of-state Former Foster Care Youth	1		$ 128,577	$ 376,448	$ 425,545	$ 416,789	$ 526,571	
TOTAL			**$ 128,577**	**$ 376,448**	**$ 425,545**	**$ 416,789**	**$ 526,571**	**$ 1,873,930**

HYPOTHETICALS VARIANCE 2			**$ 44,876**	**$ 14,251**	**$ (26,439)**	**$ 39,633**	**$ 36,150**	**$ 108,470**

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Hypothetical 3 Per Capita								
New Adult Group	1	**Total**	$ 2,291,487,278	$ 2,233,381,627	$ 2,358,088,818	$ 2,959,128,793	$ 3,571,174,223	
		PMPM	$561.68	$585.83	$611.02	$637.29	$664.70	
		Mem-Mon	4,079,702	3,812,337	3,859,266	4,643,300	5,372,611	
TOTAL			**$ 2,291,487,278**	**$ 2,233,381,627**	**$ 2,358,088,818**	**$ 2,959,128,793**	**$ 3,571,174,223**	**$ 13,413,260,739**

With-Waiver Total Expenditures

			21	22	23	24	25	TOTAL
Hypothetical 3 Per Capita								
New Adult Group	1		$ 2,193,383,012	$ 2,191,529,747	$ 2,193,687,541	$ 2,919,875,876	$ 3,256,176,665	
TOTAL			**$ 2,193,383,012**	**$ 2,191,529,747**	**$ 2,193,687,541**	**$ 2,919,875,876**	**$ 3,256,176,665**	**$ 12,754,652,841**

HYPOTHETICALS VARIANCE 3			**$ 98,104,266**	**$ 41,851,880**	**$ 164,401,277**	**$ 39,252,917**	**$ 314,997,559**	**Excluded**

Yes No
Yes
No

Per Capita or Aggregate
Per Capita
Aggregate

Phase-Down
No Phase-Down
Savings Phase-Down

Actuals and Projected
Actuals Only
Actuals + Projected

MAP ADM
MAP+ADM Waivers
MAP Waivers Only

Waiver List
MAP WAIVERS
Not Applicable
\115-CMHLTH
111-MHSPY
1115 BASIC
1115 BPHC
1115 CMHLTH
1115 CPHC
1115 LIMITD
1115 STNDRT
1115-BASIC
1115-BPHC
1115-CMHLTH
1115-CPHC
1115-IRP
1115-LIMITD
1115-MHSPY
1115-MSP
1115-STNDRD
115-STNDRD
1902(r)(2) Children
1902(r)(2) Disabled
Base Childless Adults (19-20)
Base Childless Adults (Care Plus)
Base Childless Adults (Standard ABP)
Base Disabled
Base Families
Base MCB
BASIC
BPHC
CommCare-133
CommCare-19-20
COMMONHEALTH
CPHC
DSH
DSHP-CommCare Transition
DSHP-CSR
DSHP-Health Connector subsidies
DSHP-Temporary Coverage
e-Family Assistance
e-HIV/FA
IRP
LIMITED
Mass Health Basic
Mass Health BPHC
Mass Health Commonhealth
Mass Health CPHC
Mass Health DSH
Mass Health IRP
Mass Health Limited
Mass Health MHSPY
Mass Health MSP
Mass Health Standard
MassHealth - Basic
MassHealth - BPHC
MassHealth - CommonHealth
MassHealth - CPHC
MassHealth - DSH
MassHealth - IRP
MassHealth - Limited
MassHealth - MHSPY
MassHealth - MSP

Demonstration Reporting Start DY 21
Demonstration Reporting End DY 25

Reporting Net Variance
$ 6,191,319,459

MassHealth - Standard
MassHealth Basic
MassHealth BPHC
MassHealth Commonhealth
MassHealth CPHC
MassHealth DSH
MassHealth IRP
MassHealth Limited
MassHealth MHSPY
MassHealth MSP
MassHealth Standard
MassHealth-Basic
MassHealth-BCCTP
MassHealth-BPHC
MassHealth-CommonHealth
MassHealth-CPHC
MassHealth-DSH
MassHealth-Essential
MassHealth-IRP
MassHealth-Limited
MassHealth-MHSPY
MassHealth-MSP
MassHealth-Standard
MassHeath-MSP
MHSPY
MSP
Safety Net Provider Payments
SBE-PA
SNCP
SNCP DSTI
SNCP-CommCare
SNCP-CPE
SNCP-DSHP
SNCP-DSRIP
SNCP-HSNTF
SNCP-IMD
SNCP-Other
SNCP-PHTII
FFCY
Provisional Eligibility
SNCP-UCC
SNCP-DSRIP-ACO
SNCP-DSRIP-CP
SNCP-DSRIP-SWI
SNCP-DSRIP-Operations
Continuous Eligibility
SUD
Base Fam XXI RO
1902 (r)(2) XXI RO
CommonHealth XXI
STANDARD

ADM WAIVERS