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Gateway Policy Explorer: Long-Term Care Series

Massachusetts, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2025

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Massachusetts, USA

In-Kind Benefits

Plan details 1992-2025 * †

Public long-term care (LTC) benefits in Massachusetts are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Massachusetts, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, community care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria.

Since 1992, Massachusetts' Medicaid LTC system has been subject to 2 major policy reforms: the expansion of Medicaid eligibility to cover adults receiving home and community based services (HCBS) with incomes up to 300% of the federal Supplemental Security Income (SSI) benefit amount in 2005, and the expansion of Medicaid eligibility to cover adults with incomes up to 138% of the federal poverty level (FPL) under the Affordable Care Act in 2014.

Key Dates

First law: 1965

Major changes since 1992: 2005, 2014

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† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-2004

Overview

Long-term care (LTC) benefits in Massachusetts are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Massachusetts is administered at the state level by the Massachusetts Division of Medical Assistance until 2003, when responsibilities were transferred to the Executive Office of Health and Human Services (EOHHS).

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Massachusetts are mostly provided through state plan benefit programs (Personal Care Attendant Services - PCA, Home Health Services, Nursing Facility Care) or through federally approved home-and community-based services (HCBS) LTC programs (Frail Elder, Program of All-Inclusive Care for the Elderly - PACE).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PCA Services and Home Health provide home care for beneficiaries that have established medical necessity while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by Frail Elder and PACE are also able to receive a variety of LTC benefits if deemed medically eligible, such as Homemaker services, Home Health Aide services, and Personal Care services.

Benefit programs vary in dependence requirements. PCA Services and Home Health require the individual to have a medical necessity for services, while nursing facility care, Frail Elder, and PACE beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Policy changes during this period:

- (1993) Massachusetts creates the Division of Medical Assistance to administer Medicaid. Prior to 1993, Medicaid was administered by the state's Department of Public Welfare (Blue Cross MA Foundation, 2015).
- (1993) Nursing facilities update clinical eligibility criteria. To be eligible for nursing facility care, individuals must require assistance with at least 1 skilled service daily or require assistance with a total combination of at least 3 qualifying tasks. At least 1 of the 3 tasks must be a nursing service and the others may be some combination of nursing services and assistance with activities of daily living (ADLs). Prior to 1993, assistance with a minimum total of 4 qualifying tasks was required (MA Register p. 76, 1992c).
- (1993) Massachusetts updates Estate Recovery rules, seeking recovery for nursing facility care for those who are permanently institutionalized or for all nursing facility care, HCBS, and related services received after an individual turned 55. Prior to October 1993, the state sought recovery for nursing facility care for those who were permanently institutionalized or for all nursing facility care, HCBS, and related services received after an individual turned 65 (CMR § 515.011, 2023a).
- (1994) Massachusetts implements the Program of All-Inclusive Care for the Elderly (PACE) (EOHHS, 2024).
- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least 5 years after immigration (U.S. Congress, 1996).
- (1997) Massachusetts implements eligibility track 3a (Medically needy aged, blind, or disabled), which allows individuals with income in excess of the Medicaid eligibility threshold to "spend down" their income to the medically needy income limit (MNIL) by incurring qualified medical expenses over a 6-month period (Massachusetts Register p. 319-339, 1997b).
- (2003) The Massachusetts Division of Medical Assistance is disbanded and Medicaid administration responsibilities are transferred to the Executive Office of Health and Human Services (EOHHS) (Blue Cross MA Foundation, 2015).
- (2004) MassHealth creates a managed care plan for adults aged 65 and older called Senior Care Options (EOHHS, 2024). See Box 5 for more information on managed care in Massachusetts.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024c)

Massachusetts Law for Medicaid

- Code of Massachusetts Regulations (CMR), Title 130, Division of Medical Asistance §§ 403.000, 422.000, 456.000, 504.000, 508.000, 516.000, 518.000, 519.000, 520.000
- Code of Massachusetts Regulations (CMR), Title 651, Executive Office of Elder Affairs §§ 3.00, 14.00

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Massachusetts Medicaid spending on beneficiaries in fiscal year 1992 was 50%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Massachusetts Medicaid (MassHealth), followed by additional requirements for specific benefits and programs under Medicaid.

MassHealth

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Massachusetts.

Eligibility for Medicaid in Massachusetts for people needing LTC services is primarily attained by satisfying at least 1 of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - ◇ Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2024a). See Table 2 for historical monthly benefit amounts.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (CMR §520.003, 2024b). This standard has remained the same since 1989 (U.S. Senate, 1996; KFF, 1999).
    - ▪ Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (CMR § 520.019.D, 2024b).[2]
  - ◇ Citizenship/immigration requirements (SSA, 1998): The applicant must be a Massachusetts resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a Massachusetts resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024b) for additional information.[4]
  - ◇ Other requirements
    - ▪ The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 2: Optional Categorically Needy

- 2b. Federal Poverty Level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the FPL. In 1992, this was $568 for an individual and $766 for a couple. See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community (CMR § 519, 2024a).[6] See Table 3 for historical monthly spousal disregards.
  - Asset requirements: Same asset requirements as eligibility track 1a. If an applicant's resources exceed the limit, they may become eligible for MassHealth by participating in Asset Reduction (CMR § 520.004, 2024b). Additional asset disregards exist when a person is institutionalized and has a spouse residing in the community (CMR § 519, 2024a).[7] See Table 3 for historical monthly spousal disregards.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - Applicants must be at least age 65 and may not be institutionalized (CMR § 519.005, 2024a).

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: From 1997, in order to be eligible under the medically needy track, individuals must "spend down" their excess income over a 6-month period to the medically needy income limit, referred to as a "deductible" in Massachusetts. In 1997, this was $522 for an individual and $650 for a couple. For individuals residing in long-term care facilities, the deductible-income limit was $60 per month (Massachusetts Register p. 339, 1997b). Valid expenses include medical care and other types of remedial care. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community.[6] See Table 3 for historical monthly spousal disregards.
  - Asset requirements: Same asset requirements as eligibility track 1a.[7]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid (MassHealth) has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under MassHealth. Additional program criteria (if applicable) is detailed below.

PCA Services, Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Frail Elder

Beyond meeting minimum level of dependence requirements, individuals must be at least age 65 and not institutionalized, or between age 60-64 with a disability (Mass.gov, 2024a).

PACE

Beyond meeting minimum level of dependence requirements, individuals must be at least age 55 and not institutionalized, or between age 55-64 and disabled (EOHHS, 2015).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult day health
- Adult foster care
- Continuous Skilled Nursing (CSN)
- Chronic Disease and Rehabilitation (CDR) Hospitals
- Traumatic Brain Injury Program (HCBS-TBI) —from 2001

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services

PCA provides personal care services, which include (CMR §§ 422.411, 422.419.C., 2023a):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

PCA services may be consumer-directed, which means individuals hire, terminate, schedule and train their attendants, or consumer-delegated meaning a fiscal intermediary is responsible for managing administrative tasks like payroll and distributing checks to attendants (MA Register p.104, 1999a). Individuals are prohibited from hiring spouses or family members as attendants.

From March 15- June 30, 1999, Massachusetts implemented a temporary emergency PCA services plan that allowed individuals who were eligible for PCA services and not Home Health to receive home health aide services. Individuals were eligible for this emergency coverage if they had valid prior authorization for PCA services but did not have access to a personal care attendant on or after January 1, 1999 (EOHHS, 1999).

Home Health Services

Home Health provides (CMR § 403.412, 2022a):

- Nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care such as simple wound care, vital monitoring, and personal care
- Therapy services: Up to 20 visits per year of physical or occupational and up to 35 visits per year of speech/language therapy are covered before a prior authorization is required —from January 2004, coverage includes 8 visits per year of physical or occupational therapy and 15 visits per year of speech/language therapy without a prior authorization (EOHHS, 2004)

Some home health agencies may additionally provide continuous skilled nursing (CSN) services to those who require nursing visits for longer than 2 continuous hours. CSN services provide prior authorization. From 2003, CSN services have a weekly maximum of 112 hours (MA Register p. 201, 2003). Prior to 2003, this service was called private duty nursing.

Nursing Facility Care

Nursing facility care does not provide home care.

Frail Elder

The Frail Elder program provides the following home care services (Medicaid.gov, 2024):

- Chore services: Minor home repair and heavy household chores like floor, window and wall washing, moving of furniture, and other routine home maintenance.
- Homemaker Services: Assistance with IADLs such as personal laundry, light housekeeping, shopping, meal preparation, and medication. This does not include the minor home repairs and maintenance services provided by chore services.
- Home Health Aide: As described above under Home Health services.[8]
- Personal Care: As described above under PCA Services. Unlike state plan personal care benefits, personal care under the Frail Elder program is not consumer-directed (Mass.gov, 2023).
- Supportive Home Care Aide: Provides personal and/or homemaking services, emotional support, socialization, and escort services to participants with Alzheimer's disease and related dementias or behavioral problems.

Frail Elder program services may also be provided to individuals living in congregate housing (Mass.gov, 2024a). Individuals participating in the Frail Elder program may not receive services under consumer directed care (EOEA pg. 2, 2009).

Home Health Aide and Personal Care provided under the Frail Elder program cannot be delivered concurrently due to potential duplication of services.

PACE

The PACE program provides home health aide and personal care services as described above under Frail Elder (Mass.gov, 2024e).

Community care

Community care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services, Home Health Services, Nursing Facility Care

These programs do not provide community care.

Frail Elder

The Frail Elder program provides the following community care services (Medicaid.gov, 2024):

- Adult day health care (ADHC): Called Supportive Day Program in the Frail Elder program; provides center-based daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting
- Assisted Transportation: Assistance and escort of participant to non-medical appointments and community outings

PACE

The PACE program provides (Mass.gov, 2024e):

- ADHC: As described above under Frail Elder (651 CMR § 14, 2017)
- Transportation to and from medically necessary services

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services, Home Health Services, Frail Elder

These programs do not provide residential care.

Nursing Facility Care, PACE

MassHealth and PACE cover residential care in a nursing facility on a short- or long-term basis. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (CFR, 1992a; CMR § 456.000, 2023b). Services may include the following:

- Physician Services
- Room and board
- All general nursing services and routine personal hygiene services
- Medical supplies, equipment, and over-the-counter (OTC) medication
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Massachusetts' 2 largest home and community-based services (HCBS) programs.

MassHealth provides additional benefits related to LTC (Mass.gov, 2018a):

- Durable medical equipment: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health services
- Hospice: Care is available to residents of nursing facilities if that nursing facility is serviced by a hospice provider
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Frail Elder

The Frail Elder program provides the following services in addition to those offered under the state plan, unless otherwise noted (EOEA, 2001): [9]

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care [10]
- Adult Companion: Includes non-medical care, supervision and socialization of participant; does not include hands-on nursing or ADL care but may assist or supervise participants while completing activities like cooking, shopping, and laundry
- Home-Delivered Meals: Planning, preparation and delivery of meals to homes of beneficiaries who are unable to prepare their own meals or have dietary restrictions and lack outside assistance
- Home/environmental accessibility adaptations (Home Modification): Special modifications or improvements to a beneficiary's home for to promote independence, prevent institutionalization, and ensure the individual's health and safety
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant

- Alzheimer's/dementia coaching: Service designed to assist participants in acquiring, retaining and improving self-help socialization and adaptive skills necessary to reside successfully in a home and community-based setting

PACE

PACE provides the following services in addition to those offered under the state plan, unless otherwise noted (CMS, 2011; Dignity Alliance MA, 2023):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care [10]
- Meals: Preparation and provision of nutritious meals meeting dietary restrictions of participants, nutritional support including tube feeding, total parenteral nutrition or peripheral parenteral nutrition
- Nutritional Counseling: Personalized service to educate participants and promote healthy diet and nutritional behaviors
- Behavioral Health: Services and support provided to individuals with behavioral health disorders or who exhibit behaviors that may require interdisciplinary intervention
- Transportation: Provides beneficiaries with access to medically-necessary services and non-medical community services and supports like adult day health, shopping, and counseling
- Respite care: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Social Work: Services may include case management, counseling, care coordination, and connection to community resources

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Massachusetts Executive Office of Health and Human Services (EOHHS) or the Executive Office of Elder Affairs (EOEA). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

PCA Services

Services are provided by personal care attendants based on the care plan created by the Personal Care Management (PCM) agency at intake. Individuals are prohibited from hiring family members as attendants.

Home Health Services

Services are provided by home health agencies and are delivered at the direction of a registered nurse (RN) or therapist supervising a home health aide. Prior authorization may be required for services (CMR § 403.416, 2022a).

Nursing Facility Care

Care is provided by RNs, licensed practical nurses (LPNs), and other auxiliary staff employed by a state registered nursing facility (CMR §456.000, 2023b).

Frail Elder, PACE

The provision of care for program services will vary by authorized service (Medicaid.gov, 2024).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services

PCA services must be medically necessary as prescribed by a physician or ordering non-physician practitioner and the individual may not be institutionalized. To receive PCA services, applicants must require physical assistance with activities of daily living (ADLs) for a minimum of 10 hours per week or require physical assistance with a combination of ADLs and instrumental activities of daily living (IADLs) for a minimum of 14 hours per week (MA Register p. 244, 1992b). Services require prior authorization.

Home Health Services

Home Health services must be medically necessary as prescribed by a physician or ordering non-physician practitioner and the individual must be homebound. This means that either leaving the home is medically unwise or the Medicaid recipient is unable to leave home without the assistance of another person. From 1997, therapy services require prior authorization (MA Register p. 440, 1997; MA Register p. 200, 2003).

Nursing Facility Care

An applicant must meet a nursing facility level of care (NFLOC) to be eligible. To meet an NFLOC, the individual must require at least 1 skilled service daily or have a medical condition that requires assistance with a combined total of at least 4 qualifying tasks (MA Register p. 76, 1992c). At least 1 of the 4 tasks must be a nursing service (required at least 3 times a week) and the rest may be some combination of nursing services and hands-on assistance with ADLs. From 1993, assistance with a combined total of at least 3 qualifying tasks is required (MA Register p. 354, 1993; CMR §456.409.B., 2023b). See Box 1 and Box 2 for a complete list of skilled services, ADLs, and nursing services.

Frail Elder, PACE

To be eligible for Frail Elder and PACE services, an individual must be community dwelling and meet an NFLOC, as described above under Nursing Facility Care (CMR § 519, 2024a). Applicants to Frail Elder must require at least 1 program service per month. Additionally, some PACE services may require prior authorization.

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the 5 largest programs.

MassHealth

Federal law requires states to renew Medicaid eligibility at least every 12 months. MassHealth eligibility may be reviewed sooner if there is a change in circumstances, a change in MassHealth eligibility criteria, or if they have failed to provide verification within the requested time frame (CMR § 516.007, 2017a).

PCA Services

Prior authorization is required annually, however, this period may be extended if the individual is not requesting an increase in the weekly number of PCA services hours and there is no significant change in medical or functional status or living situation (CMR § 422.422, 2023a).

Home Health Services

Prior authorization is required annually. Additionally, the beneficiary's physician or ordering non-physician practitioner must review and/or revise the plan of care every 60 days or more frequently as required by the individual's condition (CMR § 403.420, 2022a).

Nursing Facility Care

Clinical authorization that determines medical necessity for nursing facility care can be for a specified or indefinite length of stay (CMR § 456.407, 2023b). Nursing facilities must notify MassHealth during quarterly reviews if any of their residents have potential for discharge (CMR § 456.411, 2023b).

Frail Elder

Participants must undergo a clinical reassessment annually to determine level of care using the Minimum Data Set - Home Care (MDS-HC) (Medicaid.gov, 2024). Participants become ineligible for the Frail Elder program if they enroll in PACE or no longer meet the clinical and financial requirements for the program.

PACE

Individuals must be reassessed annually using the MDS-HC assessment (EOHHS, 2015).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 5 largest programs.

MassHealth

There is no age requirement for MassHealth. Age would only impact the eligibility track used to qualify for MassHealth (CMR § 519, 2024a; CMR § 520, 2024b).

PCA Services, Home Health Services, Nursing Facility Care

There is no age requirement.

Frail Elder

Individuals must be at least age 60, or aged 60-65 and disabled (Mass.gov, 2024a).

PACE

Individuals must be at least age 55, or aged 55-64 and disabled (EOHHS, 2015).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services

PCA services must be determined medically necessary by the beneficiary's physician or ordering non-physician practitioner. To receive PCA services, applicants must require physical assistance with activities of daily living (ADLs) at least 10 hours per week or require physical assistance with a combination of ADLs and instrumental activities of daily living (IADLs) at least 14 hours per week. Additionally, Medicaid coverage for PCA services requires prior authorization (MA Register p. 244, 1992b).

Home Health Services

Home Health services must be determined medically necessary by the beneficiary's physician or ordering non-physician practitioner and the individual must be homebound. This means that either leaving the home is medically unwise or the Medicaid recipient is unable to leave home without the assistance of another person. From 1997, Medicaid coverage for therapy services requires prior authorization (MA Register p. 440, 1997a; MA Register p. 200, 2003).

Nursing Facility Care

Applicants must meet a nursing facility level of care (NFLOC). This is defined as 1 of the following (MA Register p. 76, 1992c; CMR §456.409.B., 2023b):

- Requiring at least 1 skilled service daily —see Box 1 for a complete list of skilled services
- Requiring assistance with a minimum total combination of 4 qualifying tasks; at least 1 of the 4 tasks must be a nursing service and the rest may be some combination of nursing services and hands-on assistance with ADLs —see Box 2 for a complete list of ADLs and nursing services

From 1993, a minimum total combination of 3 qualifying tasks is required. At least 1 of the 3 tasks must be a nursing service, and the rest may be some combination of nursing services and hands-on assistance with ADLs (MA Register p. 354, 1993).

Frail Elder, PACE

Applicants must meet an NFLOC as defined above under Nursing Facility Care and be able to safely reside in the community. Applicants to Frail Elder must require at least 1 program service per month. Additionally, some PACE services may require prior authorization (Mass.gov, 2024d; Medicaid.gov, 2024).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services

Applicants must obtain prior authorization for PCA services and services must be determined medically necessary by the beneficiary's physician or ordering non-physician practitioner. They must also require physical assistance with activities of daily living (ADLs) at least 10 hours per week or require physical assistance with a combination of ADLs and instrumental activities of daily living (IADLs) at least 14 hours per week (MA Register p. 244, 1992b).

The ADLs assessed include mobility, taking medications, bathing/grooming, dressing or undressing, passive range-of-motion exercises, eating, and toileting. The IADLs assessed include household services, transportation, and special needs including maintenance of adaptive devices or personal care services paperwork.

Author's note: Available sources from this policy period do not detail an explicit evaluation procedure for assessing ADLs and IADLs.

Home Health Services
Applicants must obtain prior authorization for Home Health services. Services must be deemed medically necessary by a licensed physician or ordering non-physician practitioner, however, state regulations do not detail explicit evaluation criteria (MA Register p. 200, 2003).

Nursing Facility Care
Applicants must meet a nursing facility level of care (NFLOC). An NFLOC is determined using the Minimum Data Set - Home Care (MDS-HC). Nursing facility care requires doctor approval and clinical approval —determined by assessing need for skilled services, nursing services, and hands-on assistance with ADLs (MA Register p. 354, 1993; CMR §456.409.B., 2023b).

To meet an NFLOC, applicants must have 1 of the following:

- Require at least 1 skilled service daily
- Require assistance with a combination of at least 4 qualifying tasks (from 1993, at least 3 total tasks) —at least 1 of the tasks must be a nursing service (required at least 3 times a week) and the rest may be some combination of nursing services and hands-on assistance with ADLs

See Box 1 for a list of skilled services and Box 2 for a list of ADLs and nursing services.[11]

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). The PASRR screening helps the state determine whether an incoming nursing facility resident is likely to have a developmental disability or mental illness. Results of the PASRR Level I screening will indicate whether an individual requires PASRR Level II screening to determine if specialized mental health or developmental disability services are needed (42 CFR 483.100-138; UCSF, 2023). A physician licensed to practice in Massachusetts must certify that nursing facility care is medically necessary and must draft a plan of treatment before an individual is admitted (CMR § 456.410, 2023b). See Box 3 for more information on the PASRR, and Box 4 for the MDS.

Frail Elder, PACE
Applicants must meet an NFLOC as described above under Nursing Facility Care and be able to safely reside in the community. Applicants to Frail Elder must require at least 1 program service per month. Additionally, some PACE services may require prior authorization (Medicaid.gov, 2024; Mass.gov, 2024d).[12]

Evaluators

Evaluators vary by health benefit program. The details of the 5 largest programs are summarized below.

PCA Services, Home Health Services, Nursing Facility Care, Frail Elder
Nurses from Aging Services Access Points (ASAPs) conduct clinical eligibility screenings for applicants to determine level of care (UMass Med, 2014).

PACE
A registered nurse from a PACE organization assesses applicants using the Minimum Data Set - Home Care (MDS-HC) form (EOHHS, 2015).

Benefit limitations

Can you mix LTC benefits?

All Massachusetts Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 5 largest programs.

MassHealth

As required by federal law, Massachusetts enforces Estate Recovery. The acceptance of Medicaid (MassHealth) in Massachusetts creates a debt to the state agency in the total amount paid for nursing facility care for those who are permanently institutionalized or for all nursing facility care, HCBS, and related services received after the recipient reached 65 years of age before October 1993 or 55 years of age after October 1993. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (CMR § 515.011, 2023c).

PCA Services, Home Health Services

There are no copayments or similar charges imposed upon participants for program services.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 1992, the PNA was $60 per month and $65 per month for SSI recipients (MA Register p. 99, 1999; NASW, 2012). See Table 4 for historical PNA amounts in Massachusetts.

Frail Elder

There are no copayments or similar charges imposed upon participants for program services (Mass.gov, 2024c).

PACE

PACE does not require a copayment for services. However, a private pay option for PACE is available to non-Medicaid beneficiaries and these participants may be required to pay a monthly premium based on income (Mass.gov, 2024d).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2005-2013

Policy change in 2005
In 2005, Massachusetts expanded Medicaid coverage by implementing a new eligibility track covering individuals receiving home and community-based services (HCBS) at a higher income level, referred to here as eligibility track 2a. (Institutional rules for people receiving LTC). This new track applies to individuals eligible for the Frail Elder program or the Program of All-inclusive Care for the Elderly (PACE) with incomes up to 300% of the federal Supplemental Security Income (SSI) amount (EOHHS, 2005).

Other policy changes during this period:

- (2006) The Deficit Reduction Act of 2005 implements a home equity limit that makes individuals with home equity above $500,0000 ineligible for LTC. States may extend this limit up to a maximum of $750,000. Prior to 2006, in determining an applicant's assets, the value of an individual's home was usually exempt. Under the new law, a person with more than $750,000 in home equity is ineligible for nursing facility care under MassHealth. Homes occupied by a spouse or a disabled or minor child are exempt. From 2011, this figure increases annually with inflation (CMR § 520.007.G.3, 2024b).
- (2006) From July 2006, the community spouse resource allowance (CSRA) includes the combined total countable assets of an institutionalized and community spouse, with a maximum amount of $99,540. Previously, the CSRA was defined as one-half of the combined total countable assets of the institutionalized spouse and the community spouse, within a designated minimum and maximum value (EOHHS, 2007a).
- (2007) Massachusetts increases the personal needs allowance (PNA) from $60 per month ($65 for SSI recipients) to $72.80 per month for all nursing facility residents (EOHHS, 2007b).
- (2007) Home Health Services removes the requirement that an applicant must be homebound to be eligible for services. Instead, individuals must live in a non-institutionalized setting (MA Register p. 184, 2007).
- (2009) Massachusetts begins increasing the look back period for transfers made after February 2006 monthly for all assets by 1 month until the lookback period totaled 60 months for all assets in February 2011 (CMR § 520.019, 2024b).
- (2013) Home Health services removes the 112 hour weekly maximum for continuous skilled nursing (MA Register p. 173, 2013).

Overview

Long-term care (LTC) benefits in Massachusetts are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Massachusetts is administered at the state level by the Executive Office of Health and Human Services (EOHHS).

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Massachusetts are mostly provided through state plan benefit programs (Personal Care Attendant Services - PCA, Home Health Services, Nursing Facility Care) or through federally approved home-and community-based services (HCBS) LTC programs (Frail Elder, Program of All-Inclusive Care for the Elderly - PACE).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PCA Services and Home Health provide home care for beneficiaries that have established medical necessity while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by Frail Elder and PACE are also able to receive a variety of LTC benefits if deemed medically eligible, such as Homemaker services, Home Health Aide services, and Personal Care services.

Benefit programs vary in dependence requirements. PCA Services and Home Health require the individual to have a medical necessity for services, while nursing facility care, Frail Elder, and PACE beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024c)

Massachusetts Law for Medicaid

- Code of Massachusetts Regulations (CMR), Title 130, Division of Medical Asistance §§ 403.000, 422.000, 456.000, 504.000, 508.000, 516.000, 518.000, 519.000, 520.000
- Code of Massachusetts Regulations (CMR), Title 651, Executive Office of Elder Affairs §§ 3.00, 14.00

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Massachusetts Medicaid spending on beneficiaries in fiscal year 2005 was 50%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Massachusetts Medicaid (MassHealth), followed by additional requirements for specific benefits and programs under Medicaid.

MassHealth

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Massachusetts.

Eligibility for Medicaid in Massachusetts for people needing LTC services is primarily attained by satisfying at least 1 of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - ◇ Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2005, the monthly federal benefit amount was $579 for an individual and $869 for a couple (SSA, 2024a). See Table 2 for historical monthly benefit amounts.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (CMR § 520.003, 2024b). This standard has remained the same since 1989 (U.S. Senate, 1996; KFF, 1999).
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (CMR § 520.019.D, 2024b).[13]
    - Home equity limit: From 2006, the equity interest in the individual's home may not exceed $750,000, or else they will be ineligible for LTC services. From 2011, this figure increases annually with inflation (CMR § 520.007.3, 2024b). See Table 5 for historical home equity limits.
  - ◇ Citizenship/immigration requirements (SSA, 1998): The applicant must be a Massachusetts resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024b) for additional information.[4]
  - ◇ Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  Eligibility for Medicaid through this track is limited to individuals accessing HCBS through the Frail Elder program or the Program of All-Inclusive Care for the Elderly (PACE). Individuals requiring Medicaid eligibility to access nursing facility care cannot use this eligibility track to qualify (KFF, 2019).
  - ◇ Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount for individuals receiving HCBS or participating in PACE (EOHHS, 2005). In 2005, this was $1,737 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). If an applicant's resources exceed the limit, they may become eligible for MassHealth by participating in Asset Reduction (CMR § 520.004, 2024b).
    - Asset transfer & home equity limit: Same as eligibility track 1a if participating in Frail Elder or PACE.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be enrolled in the Frail Elder program or PACE.
- 2b. Federal Poverty Level (FPL) aged and disabled
  - ◇ Income requirements: Monthly income may not exceed 100% of the FPL. In 2005, this was $798 for an individual and $1,070 for a couple. See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community (CMR § 519, 2024a).[14] See Table 3 for historical monthly spousal disregards.
  - ◇ Asset requirements: Same asset requirements as eligibility track 1a. If an applicant's resources exceed the limit, they may become eligible for MassHealth by participating in Asset Reduction (CMR § 520.004, 2024b). Additional asset disregards exist when a person is institutionalized and has a spouse residing in the community (CMR § 519, 2024a).[15] See Table 3 for historical monthly spousal disregards.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - Applicants must be at least age 65 and may not be institutionalized (CMR § 519.005, 2024a).

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - ◇ Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a 6-month period to the medically needy income limit, referred to as a "deductible" in Massachusetts. In 2005, this was $522 for an individual and $650 for a couple. For individuals residing in long-term care facilities, the deductible-income limit was $60 per month. This increased to $72.80 in 2007 (Massachusetts Register p. 339, 1997b; EOHHS, 2007b). Valid expenses include medical care and other types of remedial care. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community.[14] See Table 3 for historical monthly spousal disregards.
  - ◇ Asset requirements: Same asset requirements as eligibility track 1a.[15]
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Other Eligibility Tracks
There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid (MassHealth) has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under MassHealth. Additional program criteria (if applicable) is detailed below.

PCA Services, Home Health, Nursing Facility Care
There are no additional benefits for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Frail Elder

Beyond meeting minimum level of dependence requirements, individuals must be at least age 65 and not institutionalized, or between age 60-64 with a disability (Mass.gov, 2024a).

PACE

Beyond meeting minimum level of dependence requirements, individuals must be at least age 55 and not institutionalized, or between age 55-64 and disabled (EOHHS, 2015).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult day health
- Adult foster care
- Continuous Skilled Nursing (CSN)
- Chronic Disease and Rehabilitation (CDR) Hospitals
- Traumatic Brain Injury Program (HCBS-TBI)
- Money Follows the Person - Residential Supports (MFP - RS) —from 2013
- Money Follows the Person - Community Living (MFP - CL) —from 2013

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services

PCA provides personal care services, which include (CMR §§ 422.411, 422.419.C., 2023a):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

PCA services may be consumer-directed, which means individuals hire, terminate, schedule and train their attendants, or consumer-delegated meaning a fiscal intermediary is responsible for managing administrative tasks like payroll and distributing checks to attendants (MA Register p.104, 1999a). Individuals are prohibited from hiring family members as attendants. From March 2006, adult children, daughters-in-law, and sons-in-law of beneficiaries were permitted to serve as personal care attendants (EOHHS, 2006).

Home Health Services

Home Health provides (CMR § 403.412, 2022a):

- Nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse (CMR § 403.415, 2022a)
- Home health aide services: Semi-skilled care such as simple wound care, vital monitoring, and personal care (CMR § 403.416, 2022a)
- Therapy services: From 2005, up to 20 visits per year of physical or occupational and up to 35 visits per year of speech/language therapy are covered before a prior authorization is required (EOHHS, 2004)

Some home health agencies may additionally provide continuous skilled nursing (CSN) services to those who require nursing visits for longer than 2 continuous hours, with a weekly maximum of 112 hours (MA Register p. 201, 2003). This maximum was removed in 2013 (MA Register p. 173, 2013). CSN services require prior authorization.

Nursing Facility Care

Nursing facility care does not provide home care.

Frail Elder

The Frail Elder program provides the following home care services (Medicaid.gov, 2024):

- Chore services: Minor home repair and heavy household chores like floor, window and wall washing, moving of furniture, and other routine home maintenance.
- Homemaker Services: Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication. This does not include the minor home repairs and maintenance services provided by chore services.
- Home Health Aide: As described above under Home Health.[8]
- Personal Care: As described above under PCA Services. Unlike state plan personal care benefits, personal care under the Frail Elder program is not consumer-directed (Mass.gov, 2023).
- Supportive Home Care Aide: Provides personal and/or homemaking services, emotional support, socialization, and escort services to participants with Alzheimer's disease and related dementias or behavioral problems.

Frail Elder program services may also be provided to individuals living in congregate housing (Mass.gov, 2024a). Individuals participating in the Frail Elder program may not receive services under consumer-directed care (EOEA pg. 2, 2009).

Home Health Aide and Personal Care provided under the Frail Elder program cannot be delivered concurrently due to potential duplication of services.

PACE

The PACE program provides home health aide and personal care services as described above under Frail Elder (Mass.gov, 2024e).

Community care

Community care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services, Home Health Services, Nursing Facility Care

These programs do not provide community care.

Frail Elder

The Frail Elder program provides the following community care services (Medicaid.gov, 2024):

- Adult day health care (ADHC): Called Supportive Day Program in the Frail Elder program; provides center-based daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting
- Assisted Transportation: Assistance and escort of participant to non-medical appointments and community outings

PACE

The PACE program provides (Mass.gov, 2024e):

- ADHC: As described above under Frail Elder (651 CMR § 14, 2017)
- Transportation to and from medically necessary services

Residential care

Residential care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services, Home Health Services, Frail Elder

These programs do not provide residential care.

Nursing Facility Care, PACE

MassHealth and PACE cover residential care in a nursing facility on a short- or long-term basis. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (CFR, 1992a; CMR § 456.000, 2023b). Services may include the following:

- Physician Services
- Room and board
- All general nursing services and routine personal hygiene services
- Medical supplies, equipment, and over-the-counter (OTC) medication
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Massachusetts' 2 largest home and community-based services (HCBS) programs.

MassHealth provides additional benefits related to LTC (Mass.gov, 2018a):

- Durable medical equipment: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health services
- Hospice: Care is available to residents of nursing facilities if that nursing facility is serviced by a hospice provider
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Frail Elder

The Frail Elder program provides the following services in addition to those offered under the state plan, unless otherwise noted (Mass.gov, 2018b; Medicaid.gov, 2024):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care [10]
- Adult Companion: Includes non-medical care, supervision and socialization of participant; does not include hands-on nursing or ADL care but may assist or supervise participants while completing activities like cooking, shopping, and laundry
- Alzheimer's/dementia coaching: Service designed to assist participants in acquiring, retaining and improving self-help socialization and adaptive skills necessary to reside successfully in a home and community-based setting
- Medication Dispensing System: Automated system filled and monitored by a participant's caregiver that provides audible/visual cueing for medication compliance
- Home Delivery: Services include grocery shopping, planning, preparation and delivery of meals to homes of beneficiaries who are unable to prepare their own meals or have dietary restrictions and lack outside assistance, and delivery of pre-filled medications to an individual's home
- Home Based wandering response systems: GPS- equipped communication device programmed to emit an alert signal when an individual at risk for wandering goes outside a designated perimeter
- Home/environmental accessibility adaptations (Home Modification): Special modifications or improvements to a beneficiary's home for to promote independence, prevent institutionalization, and ensure the individual's health and safety
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Transitional Assistance: Assistance with the logistics and expenses associated with transitioning out of a nursing facility or other congregate facility into the community

PACE

PACE provides the following services in addition to those offered under the state plan, unless otherwise noted (CMS, 2011; Dignity Alliance MA, 2023):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care [10]
- Meals: Preparation and provision of nutritious meals meeting dietary restrictions of participants, nutritional support including tube feeding, total parenteral nutrition or peripheral parenteral nutrition
- Nutritional Counseling: Personalized service to educate participants and promote healthy diet and nutritional behaviors
- Behavioral Health: Services and support provided to individuals with behavioral health disorders or who exhibit behaviors that may require interdisciplinary intervention
- Transportation: Provides beneficiaries with access to medically-necessary services and non-medical community services and supports like adult day health, shopping, and counseling
- Respite care: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Social Work: Services may include case management, counseling, care coordination, and connection to community resources

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Massachusetts Executive Office of Health and Human Services (EOHHS) or the Executive Office of Elder Affairs (EOEA). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

PCA Services

Services are provided by personal care attendants based on the care plan created by the Personal Care Management (PCM) agency at intake. Individuals are prohibited from hiring family members as attendants. From March 2006, adult children, daughters-in-law, and sons-in-law of beneficiaries were permitted to serve as personal care attendants (EOHHS, 2006).

Home Health Services
Services are provided by home health agencies and are delivered at the direction of a registered nurse (RN) or therapist supervising a home health aide. Prior authorization may be required for services (CMR § 403.416, 2022a).

Nursing Facility Care
Care is provided by RNs, licensed practical nurses (LPNs), and other auxiliary staff employed by a state registered nursing facility (CMR §456.000, 2023b).

Frail Elder, PACE
The provision of care for program services will vary by authorized service (Medicaid.gov, 2024).

Benefit eligibility

Qualifying period
Potential users may apply at any time.

Minimum level of dependence
The minimum level of dependence varies by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services
PCA services must be medically necessary as prescribed by a physician or ordering non-physician practitioner and the individual may not be institutionalized. To receive PCA services, applicants must require hands-on assistance with at least 2 activities of daily living (ADLs). Services require prior authorization (MA Register p. 157, 2006).

Home Health Services
Home Health services must be medically necessary as prescribed by a physician or ordering non-physician practitioner and the individual must be homebound. Services require prior authorization. From 2007, individuals are no longer required to be homebound to receive Home Health services. Instead, they must reside in a non-institutionalized setting (MA Register p. 176-178, 2007).

Nursing Facility Care
An applicant must meet a nursing facility level of care (NFLOC) to be eligible. To meet an NFLOC, the individual must require at least 1 skilled service daily or have a medical condition that requires assistance with a combined total of at least 3 qualifying tasks. At least 1 of the 3 tasks must be a nursing service (required at least 3 times a week) and the rest may be some combination of nursing services and hands-on assistance with ADLs (MA Register p. 354, 1993; CMR §456.409.B., 2023b). See Box 1 and Box 2 for a complete list of skilled services, ADLs, and nursing services.

Frail Elder, PACE
To be eligible for Frail Elder and PACE services, an individual must be community dwelling and meet an NFLOC, as described above under Nursing Facility Care (CMR § 519, 2024a). Applicants to Frail Elder must require at least 1 program service per month. Additionally, some PACE services may require prior authorization.

Duration of benefit
Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the 5 largest programs.

MassHealth
Federal law requires states to renew Medicaid eligibility at least every 12 months. MassHealth eligibility may be reviewed sooner if there is a change in circumstances, a change in MassHealth eligibility criteria, or if they have failed to provide verification within the requested time frame (CMR § 516.007, 2017a).

PCA Services
Prior authorization is required annually, however, this period may be extended if the individual is not requesting an increase in the weekly number of PCA services hours and there is no significant change in medical or functional status or living situation (CMR § 422.422, 2023a).

Home Health Services

Prior authorization is required annually. Additionally, the beneficiary's physician or ordering non-physician practitioner must review and/or revise the plan of care every 60 days or more frequently as required by the individual's condition (CMR § 403.420, 2022a).

Nursing Facility Care

Clinical authorization that determines medical necessity for nursing facility care can be for a specified or indefinite length of stay (CMR § 456.407, 2023b). Nursing facilities must notify MassHealth during quarterly reviews if any of their residents have potential for discharge (CMR § 456.411, 2023b).

Frail Elder

Participants must undergo a clinical reassessment annually to determine level of care using the Minimum Data Set - Home Care (MDS-HC) (Medicaid.gov, 2024). Participants become ineligible for the Frail Elder program if they enroll in PACE or no longer meet the clinical and financial requirements for the program.

PACE

Individuals must be reassessed annually using the MDS-HC assessment (EOHHS, 2015).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 5 largest programs.

MassHealth

There is no age requirement for MassHealth. Age would only impact the eligibility track used to qualify for MassHealth (CMR § 519, 2024a; CMR § 520, 2024b).

PCA Services, Home Health Services, Nursing Facility Care

There is no age requirement.

Frail Elder

Individuals must be at least age 60, or aged 60-65 and disabled (Mass.gov, 2024a).

PACE

Individuals must be at least age 55, or aged 55-64 and disabled (EOHHS, 2015).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services

PCA services must be determined medically necessary by the beneficiary's physician or ordering non-physician practitioner. To receive PCA services, applicants must require hands-on assistance with at least 2 activities of daily living (ADLs). Additionally, Medicaid coverage for PCA services requires prior authorization (MA Register p. 157, 2006).

Home Health Services

Home Health services must be determined medically necessary by the beneficiary's physician or ordering non-physician practitioner and the individual must be homebound. Additionally, Medicaid coverage for Home Health services requires prior authorization. From 2007, individuals are not required to be homebound to receive Home Health services. Instead, they must reside in a non-institutionalized setting (MA Register p. 176-178, 2007).

Nursing Facility Care

Applicants must meet a nursing facility level of care (NFLOC). This is defined as 1 of the following (MA Register p. 354, 1993; CMR §456.409.B., 2023b):

- Requiring at least 1 skilled service daily —see Box 1 for a complete list of skilled services
- Requiring assistance with a minimum total combination of 3 qualifying tasks; at least 1 of the 3 tasks must be a nursing service and the rest may be some combination of nursing services and hands-on assistance with ADLs —see Box 2 for a complete list of ADLs and nursing services

Frail Elder, PACE

Applicants must meet an NFLOC as defined above under Nursing Facility Care and be able to safely reside in the community. Applicants to Frail Elder must require at least 1 program service per month. Additionally, some PACE services may require prior authorization (Mass.gov, 2024d; Medicaid.gov, 2024).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services

Applicants must obtain prior authorization for PCA services and services must be determined medically necessary by the beneficiary's physician or ordering non-physician practitioner. They must also require hands-on assistance with at least 2 activities of daily living (ADLs).

The following ADLs are assessed to determine level of dependence (MA Register p. 163, 2006; CMR §§ 422.410, 2023a):

- Mobility
- Taking Medications
- Bathing/ Grooming
- Dressing or Undressing
- Passive range-of-motion exercises
- Eating
- Toileting

Individuals are also evaluated on their ability to complete instrumental activities of daily living (IADLs) including household services, meal preparation and clean up, transportation, and other special needs, however, state regulations do not detail explicit evaluation criteria for IADLs.

Home Health Services

Applicants must obtain prior authorization for Home Health services. Services must be deemed medically necessary by a licensed physician or ordering non-physician practitioner, however, state regulations do not detail explicit evaluation criteria (MA Register p. 176-178, 2007).

Nursing Facility Care

Applicants must meet a nursing facility level of care (NFLOC). An NFLOC is determined using the Minimum Data Set - Home Care (MDS-HC). Nursing facility care requires doctor approval and clinical approval —determined by assessing need for skilled services, nursing services, and hands-on assistance with ADLs (CMR § 456.409, 2023b).

To meet an NFLOC, applicants must have 1 of the following:

- Require at least 1 skilled service daily
- Require assistance with a combination of at least 3 qualifying tasks —at least 1 of the 3 tasks must be a nursing service (required at least 3 times a week) and the rest may be some combination of nursing services and hands-on assistance with ADLs

See Box 1 for a list of skilled services and Box 2 for a list of ADLs and nursing services.[11]

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). The PASRR screening helps the state determine whether an incoming nursing facility resident is likely to have a developmental disability or mental illness. Results of the PASRR Level I screening will indicate whether an individual requires PASRR Level II screening to determine if specialized mental health or developmental disability services are needed (42 CFR 483.100-138; UCSF, 2023). A physician licensed to practice in Massachusetts must certify that nursing facility care is medically necessary and must draft a plan of treatment before an individual is admitted (CMR § 456.410, 2023b). See Box 3 for more information on the PASRR, and Box 4 for the MDS.

Frail Elder, PACE

Applicants must meet an NFLOC as described above under Nursing Facility Care and be able to safely reside in the community. Applicants to Frail Elder must require at least 1 program service per month. Additionally, some PACE services may require prior authorization (Medicaid.gov, 2024; Mass.gov, 2024d).[12]

Evaluators

Evaluators vary by health benefit program. The details of the 5 largest programs are summarized below.

PCA Services, Home Health Services, Nursing Facility Care, Frail Elder

Nurses from Aging Services Access Points (ASAPs) conduct clinical eligibility screenings for applicants to determine level of care (UMass Med, 2014).

PACE

A registered nurse from a PACE organization assesses applicants using the Minimum Data Set - Home Care (MDS-HC) form (EOHHS, 2015).

Benefit limitations

Can you mix LTC benefits?

All Massachusetts Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 5 largest programs.

MassHealth

As required by federal law, Massachusetts enforces Estate Recovery. The acceptance of Medicaid (MassHealth) in Massachusetts creates a debt to the state agency in the total amount paid for nursing facility care for those who are permanently institutionalized or for all nursing facility care, HCBS, and related services received after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (CMR § 515.011, 2023c).

PCA Services, Home Health Services

There are no copayments or similar charges imposed upon participants for program services.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 2005, the PNA was $60 per month and $65 per month for SSI recipients (MA Register p. 99, 1999; NASW, 2012). This amount increased to $72.80 per month for all nursing facility residents in 2007 (EOHHS, 2007b). See Table 4 for historical PNA amounts in Massachusetts.

Frail Elder

There are no copayments or similar charges imposed upon participants for program services (Mass.gov, 2024c).

PACE

PACE does not require a copayment for services. However, a private pay option for PACE is available to non-Medicaid beneficiaries and these participants may be required to pay a monthly premium based on income (Mass.gov, 2024d).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2014-2025

Policy change in 2014
In 2014, Massachusetts adopted Medicaid expansion following passage of the Affordable Care Act (ACA), creating a new eligibility track covering adults age 19-64 with incomes up to 138% of the federal poverty level (FPL), referred to here as eligibility track 2c (ACA expansion adults). Additionally, adoption of the ACA required states to extend spousal impoverishment rules to community spouses of individuals in the Frail Elder home-and community-based services (HCBS) program under eligibility track 2a (Institutional rules for people receiving LTC) (EOHHS, 2017).

Other policy changes during this period:

- (2016) Massachusetts implements a new exception to the Estate Recovery program that offsets estate recovery claims by the total amount of premiums an individual paid to MassHealth after age 55 (CMR § 515.011, 2023c).
- (2018) The Frail Elder program adds new benefits to the program, including Complex Care Training and Oversight (formerly Skilled Nursing), Home Safety and Independence Evaluations (formerly Occupational Therapy), Personal Emergency Response System (PERS), Orientation and Mobility services, and Peer Support (Mass.gov, 2018b).
- (2022) Home Health Services updates cinical eligibility criteria. From 2022, applicants must require assistance with at least 2 activities of daily living (ADLs) to be eligible for home health aide services (CMR §§ 403.409, 403.416, 202a).
- (2024) Homemaker and Adult Companion services provided under the Frail Elder program can be accessed using the consumer-directed service delivery method (Medicaid.gov, 2024).

Overview

Long-term care (LTC) benefits in Massachusetts are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Massachusetts is administered at the state level by the Executive Office of Health and Human Services (EOHHS).

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Massachusetts are mostly provided through state plan benefit programs (Personal Care Attendant Services - PCA, Home Health Services, Nursing Facility Care) or through federally approved home-and community-based services (HCBS) LTC programs (Frail Elder, Program of All-Inclusive Care for the Elderly - PACE).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PCA Services and Home Health provide home care for beneficiaries that have established medical necessity while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by Frail Elder and PACE are also able to receive a variety of LTC benefits if deemed medically eligible, such as Homemaker services, Home Health Aide services, and Personal Care services.

Benefit programs vary in dependence requirements. PCA Services and Home Health require the individual to have a medical necessity for services, while nursing facility care, Frail Elder, and PACE beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024c)

Massachusetts Law for Medicaid

- Code of Massachusetts Regulations (CMR), Title 130, Division of Medical Asistance §§ 403.000, 422.000, 456.000, 504.000, 508.000, 516.000, 518.000, 519.000, 520.000
- Code of Massachusetts Regulations (CMR), Title 651, Executive Office of Elder Affairs §§ 3.00, 14.00

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Massachusetts Medicaid spending on beneficiaries in fiscal year 2014 was 50%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate. [16]

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Massachusetts Medicaid (MassHealth), followed by additional requirements for specific benefits and programs under Medicaid.

MassHealth

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Massachusetts.

Eligibility for Medicaid in Massachusetts for people needing LTC services is primarily attained by satisfying at least 1 of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - ◇ Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2014, the benefit amount was $721 for an individual and $1,082 for a couple (SSA, 2024a). See Table 2 for historical monthly benefit amounts.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (CMR §520.003, 2024b). This standard has remained the same since 1989 (U.S. Senate, 1996; KFF, 1999).
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (CMR § 520.019.D, 2024b).[17]
    - Home equity limit: The equity interest in an individual's home may not exceed $814,000, or else they will be ineligible for LTC services. This figure increases annually with inflation (CMR § 520.007.3, 2024b). See Table 5 for historical home equity limits.
  - ◇ Citizenship/immigration requirements (SSA, 1998): The applicant must be a Massachusetts resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024b) for additional information.[4]
  - ◇ Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  Eligibility for Medicaid through this track is limited to individuals accessing HCBS through the Frail Elder program or the Program of All-Inclusive Care for the Elderly (PACE). Individuals requiring Medicaid eligibility to access nursing facility care cannot use this eligibility track to qualify (KFF, 2019).
  - ◇ Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount for individuals receiving HCBS or participating in PACE (EOHHS, 2005). In 2014, this was $2,163 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). If an applicant's resources exceed the limit, they may become eligible for MassHealth by participating in Asset Reduction (CMR § 520.004, 2024b). Additional asset disregards exist when a person is participating in an HCBS program and has a spouse residing in the community (EOHHS, 2017; CMR § 520.016, 2024b).[18] See Table 3 for historical monthly spousal disregards.
    - Asset transfer & home equity limit: Same as eligibility track 1a if participating in Frail Elder or PACE.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - Applicants must be enrolled in the Frail Elder program or PACE.
- 2b. Federal Poverty Level (FPL) aged and disabled
  - ◇ Income requirements: Monthly income may not exceed 100% of the federal poverty level(FPL). In 2014, this was $973 for an individual and $1,311 for a couple. See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community (CMR § 519, 2024a).[19] See Table 3 for historical monthly spousal disregards.
  - ◇ Asset requirements: Same asset requirements as eligibility track 1a. If an applicant's resources exceed the limit, they may become eligible for MassHealth by participating in Asset Reduction (CMR § 520.004, 2024b). Additional asset disregards exist when a person is institutionalized and has a spouse residing in the community.[18] See Table 3 for historical monthly spousal disregards.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - Applicants must be at least age 65 and may not be institutionalized (CMR § 519.005, 2024a).
- 2c. Affordable Care Act (ACA) expansion adults
  - ◇ Income requirements: Monthly income may not exceed 138% of the FPL. In 2014, this was $1,342 for an individual and $1,809 for a household of two. See Table 2 for historical income limits.
  - ◇ Asset requirements: There is no asset test for this population (KFF, 2018).
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - Applicants must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - ◇ Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a 6-month period to the medically needy income limit, referred to as a "deductible" in Massachusetts. In 2014, this was $522 per month for an individual and $650 per month for a couple. For individuals residing in long-term care facilities, the monthly deductible-income limit was $72.80 (CMR § 520.030, 2024b). Valid expenses include medical care and other types of remedial care. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community.[19] See Table 3 for historical monthly spousal disregards.
  - ◇ Asset requirements: Same asset requirements as eligibility track 1a.[18]
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid (MassHealth) has been determined, beneficiaries may have to meet additional eligibility criteria in

order to become eligible for specific LTC health benefit programs under MassHealth. Additional program criteria (if applicable) is detailed below.

PCA Services, Home Health, Nursing Facility Care
There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Frail Elder
Beyond meeting minimum level of dependence requirements, individuals must be at least age 65 and not institutionalized, or between age 60-64 with a disability (Mass.gov, 2024a).

PACE
Beyond meeting minimum level of dependence requirements, individuals must be at least age 55 and not institutionalized, or between age 55-64 and disabled (EOHHS, 2015).

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult day health
- Adult foster care
- Continuous Skilled Nursing (CSN)
- Chronic Disease and Rehabilitation (CDR) Hospitals
- Traumatic Brain Injury Program (HCBS-TBI)
- Moving Forward Program - Residential Supports (MFP - RS) (previously "Money Follows the Person" program)
- Moving Forward Program - Community Living (MFP - CL) (previously "Money Follows the Person" program)

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services
PCA provides personal care services, which include (CMR §§ 422.411, 422.419.C., 2023a):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

PCA services are consumer-directed, which means individuals hire, terminate, schedule and train their attendants. A fiscal intermediary is responsible for managing administrative tasks like payroll and distributing checks to attendants (CMR § 422.420.A.6, 2023a). Individuals are prohibited from hiring family members as attendants unless they are the beneficiary's adult children, daughters-in-law, or sons-in-law (EOHHS, 2006).

Home Health Services
Home Health provides (CMR § 403.412, 2022a):

- Nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse (CMR § 403.415, 2022a)
- Home health aide services: Semi-skilled care such as simple wound care, vital monitoring, and personal care (CMR § 403.416, 2022a), with a prior authorization required if services exceed 240 home health aide units in 90 days (from 2016), or if services exceed 240 home health aide units in a calendar year —from 2022 (EOHHS, 2016; CMR § 403.410.C, 2022a)
- Therapy services: Up to 20 visits per year of physical or occupational and up to 35 visits per year of speech/language therapy covered before a prior authorization is required (EOHHS, 2004)

Some home health agencies may additionally provide continuous skilled nursing (CSN) services to those who require nursing visits for longer than 2 continuous hours. CSN services require prior authorization.

Nursing Facility Care
Nursing facility care does not provide home care.

Frail Elder
The Frail Elder program provides the following home care services (Medicaid.gov, 2024):

- Chore services: Minor home repair and heavy household chores like floor, window and wall washing, moving of furniture, and other routine home maintenance.
- Homemaker Services: Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication. This does not include the minor home repairs and maintenance services provided by chore services.
- Home Health Aide: As described above under Home Health.[8]
- Personal Care: As described above under PCA Services. Unlike state plan personal care benefits, personal care under the Frail Elder program is not consumer-directed (Mass.gov, 2023).
- Supportive Home Care Aide: Provides personal and/or homemaking services, emotional support, socialization, and escort services to participants with Alzheimer's disease and related dementias or behavioral problems.

Frail Elder program services may also be provided to individuals living in congregate housing (Mass.gov, 2024a). Individuals participating in the Frail Elder program may not receive services under consumer-directed care (EOEA pg. 2, 2009).

In 2024, Massachusetts added consumer-directed service delivery options to Homemaker and Adult Companion services provided under the Frail Elder program (Medicaid.gov, 2024).

Home Health Aide and Personal Care provided under the Frail Elder program cannot be delivered concurrently due to potential duplication of services.

PACE
The PACE program provides home health aide and personal care services as described above under Frail Elder (Mass.gov, 2024e).

Community care
Community care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services, Home Health Services, Nursing Facility Care
These programs do not provide community care.

Frail Elder
The Frail Elder program provides the following community care services (Medicaid.gov, 2024):

- Adult day health care (ADHC): Called Supportive Day Program in the Frail Elder program; provides center-based daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting
- Assisted Transportation: Assistance and escort of participant to non-medical appointments and community outings

PACE
The PACE program provides (Mass.gov, 2024e):

- ADHC: As described above under Frail Elder (651 CMR § 14, 2017)
- Transportation to and from medically necessary services

Residential care
Residential care benefits vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services, Home Health Services, Frail Elder
These programs do not provide residential care.

Nursing Facility Care, PACE
MassHealth and PACE cover residential care in a nursing facility on a short- or long-term basis. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (CFR, 1992a; CMR § 456.000, 2023b). Services may include the following:

- Physician Services
- Room and board

- All general nursing services and routine personal hygiene services
- Medical supplies, equipment, and over-the-counter (OTC) medication
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Massachusetts' 2 largest home and community-based services (HCBS) programs.

MassHealth provides additional benefits related to LTC (Mass.gov, 2018a):

- Durable medical equipment: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health services
- Hospice: Care is available to residents of nursing facilities if that nursing facility is serviced by a hospice provider (CMR 456.422, 2023)
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy (Mass.gov, 2024c)

Frail Elder

The Frail Elder program provides the following services in addition to those offered under the state plan, unless otherwise noted (Mass.gov, 2018b; Medicaid.gov, 2024):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care [10]
- Adult Companion: Includes non-medical care, supervision and socialization of participant; does not include hands-on nursing or ADL care but may assist or supervise participants while completing activities like cooking, shopping, and laundry —may be delivered up to 100% remotely via telehealth
- Alzheimer's/dementia coaching: Service designed to assist participants in acquiring, retaining and improving self-help socialization and adaptive skills necessary to reside successfully in a home and community-based setting
- Medication Dispensing System: Automated system filled and monitored by a participant's caregiver that provides audible/visual cueing for medication compliance
- Home Delivery: Services include grocery shopping, planning, preparation and delivery of meals to homes of beneficiaries who are unable to prepare their own meals or have dietary restrictions and lack outside assistance, and delivery of pre-filled medications to an individual's home
- Home Based wandering response systems: GPS- equipped communication device programmed to emit an alert signal when an individual at risk for wandering goes outside a designated perimeter
- Home/environmental accessibility adaptations (Home Modification): Special modifications or improvements to a beneficiary's home for to promote independence, prevent institutionalization, and ensure the individual's health and safety
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Transitional Assistance: Assistance with the logistics and expenses associated with transitioning out of a nursing facility or other congregate facility into the community
- Home Safety and Independence Evaluations (formerly Occupational Therapy) (from 2018): Service provided periodically by an occupational therapist to identify home safety risks; cannot be received concurrently with Goal Engagement Program
- Complex Care Training and Oversight (formerly Skilled Nursing) (from 2018): Medication management and development, management, and evaluation of the home health aide plan of care provided by a registered nurse or licensed practical nurse
- Personal Emergency Response System (PERS) (from 2018): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Orientation and Mobility Services (from 2018): Training and education service provided to participants who are visually impaired or legally blind to help them navigate their home and community safely and independently
- Peer Support (from 2018): Support and advising from peers to promote self-advocacy and encourage community living

From 2023, Telehealth was added as a service delivery option for multiple Frail Elder benefits including Alzheimer's/Dementia coaching, Adult Companion, and Peer Support (Mass.gov, 2023).

PACE

PACE provides the following services in addition to those offered under the state plan, unless otherwise noted (CMS, 2011; Dignity Alliance MA, 2023):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care [10]

- Meals: Preparation and provision of nutritious meals meeting dietary restrictions of participants, nutritional support including tube feeding, total parenteral nutrition or peripheral parenteral nutrition
- Nutritional Counseling: Personalized service to educate participants and promote healthy diet and nutritional behaviors
- Behavioral Health: Services and support provided to individuals with behavioral health disorders or who exhibit behaviors that may require interdisciplinary intervention
- Transportation: Provides beneficiaries with access to medically-necessary services and non-medical community services and supports like adult day health, shopping, and counseling
- Respite care: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Social Work: Services may include case management, counseling, care coordination, and connection to community resources

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Massachusetts Executive Office of Health and Human Services (EOHHS) or the Executive Office of Elder Affairs (EOEA). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

PCA Services

Services are provided by personal care attendants based on the care plan created by the Personal Care Management (PCM) agency at intake. Individuals are prohibited from hiring family members as attendants unless they are the adult children, daughters-in-law, or sons-in-law of beneficiaries (EOHHS, 2006).

Home Health Services

Services are provided by home health agencies and are delivered at the direction of a registered nurse (RN) or therapist supervising a home health aide. Prior authorization may be required for services (CMR § 403.416, 2022a).

Nursing Facility Care

Care is provided by RNs, licensed practical nurses (LPNs), and other auxiliary staff employed by a state registered nursing facility (CMR §456.000, 2023b).

Frail Elder, PACE

The provision of care for program services will vary by authorized service (Medicaid.gov, 2024).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services

PCA services must be medically necessary as prescribed by a physician or ordering non-physician practitioner and the individual may not be institutionalized. To receive PCA services, applicants must require hands-on assistance with at least 2 activities of daily living (ADLs). Services require prior authorization (MA Register p. 157, 2006).

Home Health Services

Home Health services must be medically necessary as prescribed by a physician or ordering non-physician practitioner and the individual may not be institutionalized. Services require prior authorization (MA Register p. 176-178, 2007).

From 2019, eligible individuals were permitted to receive home health aide services without the requirement of concurent skilled nursing or therapy services (EOHHS, 2019).

From 2022, applicants must require hands-on assistance with at least 2 ADLs to receive home health aide services (CMR §§ 403.409, 403.416, 2022a).

Nursing Facility Care

An applicant must meet a nursing facility level of care (NFLOC) to be eligible. To meet an NFLOC, the individual must require at least 1 skilled service daily or have a medical condition that requires assistance with a combined total of at least 3 qualifying tasks. At least 1 of the 3 tasks must be a nursing service (required at least 3 times a week) and the rest may be some combination of nursing services and hands-on assistance with ADLs (MA Register p. 354, 1993; CMR §456.409.B., 2023b). See Box 1 and Box 2 for a complete list of skilled services, ADLs, and nursing services.

Frail Elder, PACE

To be eligible for Frail Elder and PACE services, an individual must be community dwelling and meet an NFLOC, as described above under Nursing Facility Care (CMR § 519, 2024a). Applicants to Frail Elder must require at least 1 program service per month. Additionally, some PACE services may require prior authorization.

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the 5 largest programs.

MassHealth

Federal law requires states to renew Medicaid eligibility at least every 12 months. MassHealth eligibility may be reviewed sooner if there is a change in circumstances, a change in MassHealth eligibility criteria, or if they have failed to provide verification within the requested time frame (CMR § 516.007, 2017a).

PCA Services

Prior authorization is required annually, however, this period may be extended if the individual is not requesting an increase in the weekly number of PCA services hours and there is no significant change in medical or functional status or living situation (CMR § 422.422, 2023a).

Home Health Services

Prior authorization is required annually. Additionally, the beneficiary's physician or ordering non-physician practitioner must review and/or revise the plan of care every 60 days or more frequently as required by the individual's condition (CMR § 403.420, 2022a).

Nursing Facility Care

Clinical authorization that determines medical necessity for nursing facility care can be for a specified or indefinite length of stay (CMR § 456.407, 2023b). Nursing facilities must notify MassHealth during quarterly reviews if any of their residents have potential for discharge (CMR § 456.411, 2023b).

Frail Elder

Participants must undergo a clinical reassessment annually to determine level of care using the Minimum Data Set - Home Care (MDS-HC) (Medicaid.gov, 2024). Participants become ineligible for the Frail Elder program if they enroll in PACE or no longer meet the clinical and financial requirements for the program.

PACE

Individuals must be reassessed annually using the MDS-HC assessment (EOHHS, 2015).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by LTC health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 5 largest programs.

MassHealth

There is no age requirement for MassHealth. Age would only impact the eligibility track used to qualify for MassHealth (CMR § 519, 2024a; CMR § 520, 2024b).

PCA Services, Home Health Services, Nursing Facility Care

There is no age requirement.

Frail Elder
Individuals must be at least age 60, or aged 60-65 and disabled (Mass.gov, 2024a).

PACE
Individuals must be at least age 55, or aged 55-64 and disabled (EOHHS, 2015).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services
PCA services must be determined medically necessary by the beneficiary's physician or ordering non-physician practitioner. To receive PCA services, applicants must require hands-on assistance with at least 2 activities of daily living (ADLs). Additionally, Medicaid coverage for PCA services requires prior authorization (MA Register p. 157, 2006).

Home Health Services
Home Health services must be determined medically necessary by the beneficiary's physician or ordering non-physician practitioner. Addiitonally, Medicaid coverage for Home Health services requires prior authorization (MA Register p. 176-178, 2007).

From 2022, applicants must require hands-on assistance with at least 2 activties of daily living (ADLs) to receive home health aide services (CMR § 403.409, 2022a, MassHealth Help, 2024a).

Nursing Facility Care
Applicants must meet a nursing facility level of care (NFLOC). This is defined as 1 of the following (MA Register p. 354, 1993; CMR §456.409.B., 2023b):

- Requiring at least 1 skilled service daily —see Box 1 for a complete list of skilled services
- Requiring assistance with a minimum total combination of 3 qualifying tasks; at least 1 of the 3 tasks must be a nursing service and the rest may be some combination of nursing services and hands-on assistance with ADLs —see Box 2 for a complete list of ADLs and nursing services

Frail Elder, PACE
Applicants must meet an NFLOC as defined above under Nursing Facility Care and be able to safely reside in the community. Applicants to Frail Elder must require at least 1 program service per month. Additionally, some PACE services may require prior authorization (Mass.gov, 2024d; Medicaid.gov, 2024).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the 5 largest programs are summarized below.

PCA Services
Applicants must obtain prior authorization for PCA services and services must be determined medically necessary by the beneficiary's physician or ordering non-physician practitioner. They must also require hands-on assistance with at least 2 activities of daily living (ADLs).

The following ADLs are assessed to determine level of dependence (MA Register p. 163, 2006; CMR §§ 422.410, 2023a):

- Mobility
- Taking Medications
- Bathing/ Grooming
- Dressing or Undressing
- Passive range-of-motion exercises
- Eating
- Toileting

Individuals are also evaluated on their ability to complete instrumental activities of daily living (IADLs) including household services, meal preparation and clean up, transportation, and other special needs, however, state regulations do not detail explicit evaluation criteria for IADLs.

Home Health Services

Applicants must obtain prior authorization for Home Health services. Services must be deemed medically necessary by a licensed physician or ordering non-physician practitioner (MA Register p. 176-178, 2007). From 2022, applicants must require hands-on assistance with at least 2 ADLs to receive home health aide services, as described above under PCA services (CMR §§ 403.410, 403, 416, 2022a). Passive range-of-motion exercises and taking medications are ADLs that are assessed to determine level of dependence for PCA services only, not home health aide services.

Nursing Facility Care

Applicants must meet a nursing facility level of care (NFLOC). An NFLOC is determined using the Minimum Data Set - Home Care (MDS-HC). Nursing facility care requires doctor approval and clinical approval —determined by assessing need for skilled services, nursing services, and hands-on assistance with ADLs (CMR § 456.409, 2023b).

To meet an NFLOC, applicants must have 1 of the following:

- Require at least 1 skilled service daily
- Require assistance with a combination of at least 3 qualifying tasks —at least 1 of the 3 tasks must be a nursing service (required at least 3 times a week) and the rest may be some combination of nursing services and hands-on assistance with ADLs

See Box 1 for a list of skilled services and Box 2 for a list of ADLs and nursing services.[11]

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). The PASRR screening helps the state determine whether an incoming nursing facility resident is likely to have a developmental disability or mental illness. Results of the PASRR Level I screening will indicate whether an individual requires PASRR Level II screening to determine if specialized mental health or developmental disability services are needed (42 CFR 483.100-138; UCSF, 2023). A physician licensed to practice in Massachusetts must certify that nursing facility care is medically necessary and must draft a plan of treatment before an individual is admitted (CMR § 456.410, 2023b). See Box 3 for more information on the PASRR, and Box 4 for the MDS.

Frail Elder, PACE

Applicants must meet an NFLOC as described above under Nursing Facility Care and be able to safely reside in the community. Applicants to Frail Elder must require at least 1 program service per month. Additionally, some PACE services may require prior authorization (Medicaid.gov, 2024; Mass.gov, 2024d).[12]

Evaluators

Evaluators vary by health benefit program. The details of the 5 largest programs are summarized below.

PCA Services, Home Health Services, Nursing Facility Care, Frail Elder

Nurses from Aging Services Access Points (ASAPs) conduct clinical eligibility screenings for applicants to determine level of care (UMass Med, 2014).

PACE

A registered nurse from a PACE organization assesses applicants using the Minimum Data Set - Home Care (MDS-HC) form (EOHHS, 2015).

Benefit limitations

Can you mix LTC benefits?

All Massachusetts Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 5 largest programs.

MassHealth

As required by federal law, Massachusetts enforces Estate Recovery. The acceptance of Medicaid (MassHealth) in Massachusetts creates a debt to the state agency in the total amount paid for nursing facility care for those who are permanently institutionalized or for all nursing facility care, HCBS, and related services received after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (CMR § 515.011, 2023c). During this policy period, a few notable changes to estate recovery were implemented:

- MassHealth offsets claims of estate recovery by the total amount of premiums paid on behalf of the member from age 55 to their death if the date of death was after December 31, 2016.
- For dates of death on or after May 14, 2021 the debt will not be enforced if the value of the individual's probate estate is $25,000 or less.
- From December 2024, estate recovery is no longer required for beneficiaries receiving PCA services (Mass Legal Services, 2024).

PCA Services, Home Health Services

There are no copayments or similar charges imposed upon participants for program services.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 2014 the PNA was $72.80 (MassHealth Help, 2024b). See Table 4 for historical PNA amounts in Massachusetts.

Frail Elder

There are no copayments or similar charges imposed upon participants for program services (Mass.gov, 2024c).

PACE

PACE does not require a copayment for services, however, a private pay option for PACE is available to non-Medicaid beneficiaries and these participants may be required to pay a monthly premium based on income (Mass.gov, 2024d).

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Massachusetts Federal Medical Assistance Percentage (FMAP) for Medicaid (1992-2025)

Fiscal Year	FMAP
1992	50.00%
1993	50.00
1994	50.00
1995	50.00
1996	50.00
1997	50.00
1998	50.00
1999	50.00
2000	50.00
2001	50.00
2002	50.00
2003	51.48
2004	52.21
2005	50.00
2006	50.00
2007	50.00
2008	50.00
2009	59.84
2010	61.59
2011	56.81
2012	50.00
2013	50.00
2014	50.00
2015	50.00
2016	50.00
2017	50.00
2018	50.00
2019	50.00
2020	54.65
2021	56.20
2022	56.20
2023	54.98
2024	50.38
2025	50.00

Source: Congress.gov (2020), U.S. DHHS (2023)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period.

Table 2: Massachusetts Medicaid Income Limits (1992-2025)

Year	SSI (Individual)	SSI (Couple)	100% FPL (Individual)	100% FPL (Couple)	300% SSI (Individual)	138% FPL (Individual)	138% FPL (Couple)
1992	$422	$633	$568	$766			
1993	434	652	581	786			
1994	446	669	614	820			
1995	458	687	623	836			
1996	470	705	645	864			
1997	484	726	658	885			
1998	494	741	671	905			
1999	500	751	687	922			
2000	513	769	696	938			
2001	531	796	716	968			
2002	545	817	739	995			
2003	552	829	749	1,010			
2004	564	846	776	1,041			
2005	579	869	798	1,070	$1,737		
2006	603	904	817	1,100	1,809		
2007	623	934	851	1,141	1,869		
2008	637	956	867	1,167	1,911		
2009	674	1,011	903	1,215	2,022		
2010	674	1,011	903	1,215	2,022		
2011	674	1,011	908	1,226	2,022		
2012	698	1,048	931	1,261	2,094		
2013	710	1,066	958	1,293	2,130		
2014	721	1,082	973	1,311	2,163	$1,342	$1,809
2015	733	1,100	981	1,328	2,199	1,354	1,832
2016	733	1,100	990	1,335	2,199	1,367	1,843
2017	735	1,103	1,005	1,354	2,205	1,387	1,868
2018	750	1,125	1,012	1,372	2,250	1,397	1,893
2019	771	1,157	1,041	1,410	2,313	1,437	1,945
2020	783	1,175	1,064	1,437	2,349	1,468	1,983
2021	794	1,191	1,074	1452	2,382	1,482	2,004
2022	841	1,261	1,133	1,526	2,523	1,564	2,106
2023	914	1,371	1,215	1,643	2,742	1,677	2,268
2024	943	1,415	1,255	1,703	2,829	1,732	2,352
2025	967	1,450	1,304	1,763	2,901	1,800	2,432

Source: Massachusetts Register (1997b), CRS (2002), CRS (2011), SSA (2024b), CMS (2024), Mass.gov (2025)

Notes: Supplemental Security Income (SSI) and federal poverty level (FPL) amounts for individuals and couples are monthly. Income limits at 300% SSI and 138% of the FPL begin in 2005 and 2014 respectively, corresponding to Massachusetts' implementation of this track. Income of individuals who qualify for MassHealth through the 300% SSI track is evaluated independently from the applicant's spouse or other dependents. From 1997, non-institutionalized individuals with monthly income greater than 100% of the FPL may become eligible for MassHealth through the Medically Needy track by spending down income to a medically needy income limit called the "MassHealth deductible-income standard" over a 6-month period. The income standard is $522 for an individual and $650 for a couple. This has remained the same since 1997. The deductible-income standard for institutionalized individuals with income greater than the standard rate for nursing facility services was $60 from 1997-2007 and $72.80 from 2007-2024.

Table 3: Massachusetts Spousal Impoverishment Standards (1992-2025)

Year	Minimum MMNA	Maximum MMNA	Minimum CSRA	Maximum CSRA
1992	$984.20	$1,718.00	$13,740.00	$68,700.00
1993	1,148.75	1,769.00	14,148.00	70,740.00
1994	1,178.75	1,817.00	14,532.00	72,660.00
1995	1,230.00	1,871.00	14,964.00	74,820.00
1996	1,253.75	1,919.00	15,348.00	76,740.00
1997	1,295.00	1,976.00	15,804.00	79,020.00
1998	1,326.25	2,019.00	16,152.00	80,760.00
1999	1,356.25	2,049.00	16,392.00	81,960.00
2000	1,382.50	2,103.00	16,824.00	84,120.00
2001	1,406.25	2,175.00	17,400.00	87,000.00
2002	1,451.25	2,232.00	17,856.00	89,280.00
2003	1,492.50	2,266.50	18,132.00	90,660.00
2004	1,515.00	2,319.00	18,552.00	92,760.00
2005	1,561.25	2,377.50	19,020.00	95,100.00
2006	1,603.75	2,488.50	19,908.00	99,540.00
2007	1,650.00	2,541.00	20,328.00	101,640.00
2008	1,711.25	2,610.00	20,880.00	104,400.00
2009	1,750.00	2,739.00	21,912.00	109,560.00
2010	1,821.25	2,739.00	21,912.00	109,560.00
2011	1,838.75	2,739.00	21,912.00	109,560.00
2012	1,891.25	2,841.00	22,728.00	113,640.00
2013	1,939.00	2,898.00	23,184.00	113,640.00
2014	1,966.25	2,931.00	23,448.00	115,920.00
2015	1,991.25	2,980.50	23,844.00	117,240.00
2016	2,002.50	2,980.50	23,844.00	119,220.00
2017	2,030.00	3,022.50	24,180.00	120,900.00
2018	2,057.00	3,090.00	24,720.00	123,600.00
2019	2,113.75	3,160.50	25,284.00	126,420.00
2020	2,155.00	3,259.50	25,728.00	128,640.00
2021	2,177.50	3,259.50	26,076.00	130,380.00
2022	2,288.75	3,435.00	27,480.00	137,400.00
2023	2,465.00	3,715.50	29,724.00	148,620.00
2024	2,555.00	3,853.50	30,828.00	154,140.00
2025	2,555.00	3,948.00	31,584.00	157,920.00

Source: CMS (2024), MassHealth Help (2024b), Mass.gov (2025)

Notes: State sources were not found for years prior to 1998, but they are subject to the federal minimum and maximum standards. Federal law requires states to set the minimum monthly maintenance needs allowance (MMNA) standard at 150% of the federal poverty level (FPL) for a couple, increasing each year with inflation, except for FY 1992, which was set at 133% of the FPL. MMNAs are calculated using FPLs for each year and are validated by state and federal sources. Some states round to the dollar, which may lead to minor variations between the calculated federal amounts and state-specific standards. For Community Spouse Resource Allowances (CSRAs), the minimum was set at $12,000 and the maximum at $60,000 as of September 30, 1989, increasing each year with inflation. CSRAs are calculated using the Consumer Price Index for urban consumers (CPI-U).

Box 1: Massachusetts Nursing Facility Level of Care Eligibility Criteria —Skilled Services (1992–2025)

To qualify for nursing facility care, applicants must require daily assistance with at least 1 of the skilled services listed below or require hands-on assistance with a combination of at least 3 of the tasks detailed in Box 2. At least 1 of those 3 tasks must be a nursing service (performed at least 3 times a week):

- Injections: Intravenous, intramuscular, or subcutaneous injection, or intravenous feeding
- Tube feeding: Nasogastric-tube, gastrostomy, or jejunostomy feeding
- Tracheostomy care: Nasopharyngeal aspiration and tracheostomy care, however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services
- Treatment and/or application of dressings when the physician or PCP has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions)
- Oxygen: Administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema)
- Observation and evaluation: Skilled nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure)
- Care plan management: Skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety
- Catheter care: Insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter (not including urethral catheters placed for convenience or for control of incontinence) as an adjunct to the active treatment of disease of the urinary tract. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection)
- Gait evaluation and training: Administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting
- Range-of-motion exercise: Certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record)
- Therapeutic heat treatment: Hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications
- Therapy: Physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician or PCP and be designed to achieve specific goals within a given time frame

Source: MA Register p. 354 (1993), CMR § 456.409 (2023)

Notes: To qualify for a nursing facility level of care (NFLOC), an individual must require at least 1 skilled service daily or require hands-on assistance with a total combination of at least 3 of the tasks detailed in Box 2. At least 1 of the 3 tasks must be a nursing service required at least 3 times a week. The remaining 2 tasks may be any combination of assistance with activities of daily living (ADLs) and nursing services.

Box 2: Massachusetts Nursing Facility Level of Care Eligibility Criteria —ADL and Nursing Services (1992–2025)

To qualify for nursing facility care, applicants must require at least 1 skilled service (see Box 1) daily or require assistance with a total combination of at least 3 of the tasks detailed below. At least 1 of the 3 tasks must be a nursing service required at least 3 times a week. The remaining 2 tasks may be any combination of nursing services and hands-on assistance with activities of daily living (ADLs).

ADLs

- Bathing: Individual requires either direct care or attendance or constant supervision during the entire activity
- Dressing: Individual requires either direct care or attendance or constant supervision during the entire activity
- Toileting, Bladder, or Bowel: Individual is incontinent of bladder or bowel function day and night, or requires scheduled assistance or routine catheter or colostomy care
- Transfers: Individual must be assisted or lifted to another position
- Mobility/Ambulation: Individual must be physically steadied, assisted, or guided in ambulation, or be unable to propel a wheelchair alone without assistance of another person
- Eating: Individual requires constant intervention, individual supervision, or direct physical assistance

Nursing Services

- Any physician- or primary care provider (PCP)-ordered skilled service specified in 130 CMR 456.409(A) —see Box 1
- Positioning while in bed or a chair as part of the written care plan
- Measurement of intake or output based on medical necessity
- Administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions
- Staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental health professional —from 1993
- Physician- or PCP-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals) —from 1993
- Physician- or PCP-ordered nursing observation and/or vital-signs monitoring, specifically related to the written care plan and the need for medical or nursing intervention —from 1993
- Treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician or PCP orders, or routine changing of dressings that require nursing care and monitoring —from 1993

Source: MA Register p. 354 (1993), CMR § 456.409 (2023)
Notes: To qualify for nursing facility care, applicants must require at least 1 skilled service (see Box 1) daily or require assistance with a total combination of at least 3 of the qualifying tasks detailed in this box. At least 1 of the 3 tasks must be a nursing service required at least 3 times a week. The remaining 2 tasks may be any combination of nursing services and hands-on assistance with activities of daily living (ADLs).

Box 3: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 4: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: Mass.gov (1999), UCSF (2023)

Table 4: Massachusetts Personal Needs Allowances (PNA) (1992-2025)

Year	PNA (monthly)
1992-2006	$60
2007-2025	72.80

Source: EOHHS (2007b), LTC Ombudsman (2010), NASW (2012), Mass.gov (2025)
Notes: Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). Authors have not yet verifed the PNAs for all Fiscal Years (FYs) but sources indicate that Massachusetts increased the PNA from $60 to $72.80 in 2007 and this amount has not increased as of 2025. Prior to 2007, SSI recipients recieved a higher PNA amount of $65 per month.

Box 5: Massachusetts Managed Care Programs for Older Adults and Long-Term Care Recipients

MassHealth operates using 2 health care delivery systems: fee-for-service and managed care. Enrolling in a managed care plan is required for many MassHealth beneficiaries under age 65. Individuals older than age 65 and individuals receiving long-term care may choose to voluntarily enroll in a managed care plan if they are eligible.

The 3 managed care plans available to older adults in Massachusetts are:

- One Care —from 2013
- Senior Care Options (SCO) —from 2004
- Program of All-Inclusive Care for the Elderly (PACE) —from 1994

<u>One Care</u>
One Care is available for adults younger than 64 who are eligible for and participating in both MassHealth and Medicare. Applicants cannot participate in One Care if they are not already enrolled in Medicare. An individual enrolled in One Care may stay in the program after turning 65 if they are still eligible for MassHealth. It provides coverage for all services that are normally available through MassHealth and Medicare, including long-term care. Individuals must live within the service area of a One Care provider to be eligible.

<u>SCO</u>
SCO is available to individuals at least age 65 living in the community or residing in a long-term care facility. It provides coverage for all services that are normally available through MassHealth and Medicare, including long-term care and services provided under the Frail Elder home and community-based services (HCBS) program. Individuals must live within the service area of a senior care organization to be eligible.

<u>PACE</u>
PACE is available to adults at least age 55 who meet a nursing facility level of care (NFLOC) and are not institutionalized. Further information on financial requirements, clinical eligibility criteria, and services covered under PACE are provided throughout this document.

Source: CMR (2018), EOHHS (2024)
Notes: Managed care plans in Massachusetts that target older adults and individuals receiving long-term care are often referred to as "Integrated Care Plans" because they integrate services and financing from both Medicare and Medicaid.

Table 5: Massachusetts Home Equity Limits (2006-2025)

Year	Home equity limit
2006	$750,000
2007	750,000
2008	750,000
2009	750,000
2010	750,000
2011	750,000
2012	786,000
2013	802,000
2014	814,000
2015	828,000
2016	828,000
2017	840,000
2018	858,000
2019	878,000
2020	892,000
2021	906,000
2022	955,000
2023	1,033,000
2024	1,071,000
2025	1,097,000

Source: CMR (2024), SSA (2024e), Mass.gov (2025)

Notes: The limit was $750,000 from January 2006 to 2011, after which the equity limit began increasing annually with inflation. Home equity limits are calculated using Social Security Cost-of-Living Adjustments (COLAs) and are validated by state and federal sources.

Sources

This section records key sources consulted when we collected the institutional details reported in this document. Archived versions of these sources are available at the Gateway Policy Explorer website (http://g2aging.org/policy-explorer).

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): A community-based long-term care benefit that provides comprehensive health care services in a congregate day setting. Services include daytime supervision, social, rehabilitative, recreational, personal care, and sometimes meal services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary. This service is referred to as "Supportive Day Program" under the Frail Elder HCBS program. Beneficiaries can access adult day health care through PACE and Frail Elder.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably is the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Aging Service Access Points (ASAPs) : A collection of agencies statewide that provide care coordination, home care, LTC services, and care planning services for Massachusetts Medicaid beneficiaries. Nurses within ASAPs administer level of care evaluations for individuals applying for HCBS.

Asset reduction: Asset spend-down program allowing MassHealth applicants whose countable assets exceed the asset limit for MassHealth Standard, Family Assistance, and Limited plans to become eligible for MassHealth. These individuals must be otherwise eligible for MassHealth. Individuals participating in asset reduction may be eligible to MassHealth beginning on (1) the date they have successfully reduced their assets to the acceptable limit without violating transfer of resources rules for nursing facility residents or (2) the date (within 30 days of receiving an asset reduction notice) that the applicant incurs medical bills equivalent to the amount of excess assets, thus reducing assets below the limit. Unlike other states, Massachusetts allows applicants an offset for incurred medical expenses.

Chronic Disease and Rehabilitation (CDR) Hospital: Institutional benefit providing inpatient and outpatient services for individuals recovering from stroke, spinal cord injury, or other chronic conditions. CDR hospitals also provide oncology services, complex care medical management, and more.

Community Spouse Resource Allowance (CSRA): Amount of countable assets a spouse residing in the community can retain if their spouse is institutionalized or requires home and community-based long-term care. In Massachusetts, the CSRA may be referred to as the "community spouse asset allowance."

Comprehensive Data Set (CDS): Long-term care assessment tool used by ASAPs to determine eligibility for the state Home Care Program. This tool contains in its entirety the MDS-HC which is used to determine eligibility for most LTC benefits in Massachusetts.

Congregate Housing: Shared, affordable living for older adults and individuals with disabilities. Living arrangements include private bedroom and shared ameneties including restrooms, kitchens, and dining space.

Consumer-delegated: Care delivery option that allows MassHealth PCA services beneficiaries to choose, manage, and direct attendants of their choice, while delegating certain employer-required tasks like paryoll management, prior authorization verifcation, and distribution of attendants' checks to a fiscal intermediary. Beneficiaries chose between the consumer-delegated and consumer-directed options when receiving PCA services until at least 2001. Though authors have been unable to confirm the exact date this care delivery

option was removed, this option does not exist in state legislature in 2025. Instead, PCA services are consumer-directed and a fiscal intermediary automatically completes administrative tasks. See MA Register (1999) for more information.

Consumer-directed: Care delivery option that allow MassHealth long-term care beneficiaries to choose, manage, and direct attendants of their choice to provide personal care, homemaker, and supportive home care aide services. Prior to 2024, Frail Elder program participants were not permitted to receive consumer-directed PCA services. Massachusetts regulations may occasionally refer to consumer-directed care as "participant-directed" care.

Continuous Skilled Nursing (CSN): Skilled nursing services provided by a registered nurse or licensed practical nurse to beneficiaries who need more than 2 hours of continuous nursing services daily. Until 2003, this service was called "private duty nursing (PDN)." These services must be deemed medically necessary and require a prior authorization. See CMR 438.000 for more information.

Critical Unmet Needs: Unmet needs of an applicant in the following categories: any activity of daily living (ADL), meal preparation, grocery shopping, medication management, medical transportation, respite care, and Home Health services. Critical unmet needs and functional impairment levels as defined by state Home Care Program regulations (651 CMR 3.00) are considered when developing a plan of care for Frail Elder program participants.

Deductible: Applicants with income in excess of the Medicaid financial eligibility threshold must spend-down their income to meet a deductible if they are seeking Medicaid eligibility through eligibility track 3a (Medically needy aged, blind, or disabled). Typically this standard is very low. Massachusetts refers to this standard as the "MassHealth deductible-income standard", though it is more commonly known as the "Medically Needy Income Limit (MNIL)."

Deficit Reduction Act of 2005: Federal legislation that established home equity limits. Massachusetts implemented a home equity limit of $750,000 beginning in 2006. From 2011, this amount increased annually with inflation.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that generally automatically results in Medicaid coverage for individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with low income and assets.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300% of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2b. Federal Poverty Level (FPL) Aged and Disabled: Optional coverage group under Medicaid that allows for expanded income limits, up to 100 percent of the federal poverty level, for individuals that are at least age 65 or disabled.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. Until 2024, Massachusetts pursued reimbursement for more than the federal required minimum scope of services. For dates of death after August 1, 2024, PCA services are exempt from estate recovery. See CMR (2024a) and Mass Legal Services (2024) for more information.

Executive Office of Elder Affairs (EOEA): State agency that administers programs and resources for older adults, including the state Home Care Program. They collaborate with regional non-profit and municipal agencies to support older adults, caregivers, and providers across Massachusetts.

Executive Office of Health and Human Services (EOHHS): State agency that administers the Medicaid state plan (MassHealth) to all eligible persons in Massachusetts.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent. The standard FMAP applies to most Medicaid spending on benefits, while the administrative rate nationwide is 50 percent with exceptions for some administrative activities such as training and compensation of skilled professionals (75 percent) and preadmission screening and resident review (75 percent).

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100% of the FPL would qualify based on financial eligibility.

Fee-for-service: A health care delivery system where providers are paid for each service performed. This was the primary system of providing Medicaid-covered services before managed care systems entered widespread use.

Fiscal Intermediary: Organization contracted by MassHealth to manage administrative tasks like payroll and federal tax witholding for consumers who employ and self-direct their attendants under consumer-directed long-term care benefits including PCA Services.

Functional impairment level (FIL): A four level scale characterized by an individual's need for assistance completing ADLs and IADLs.Critical unmet needs and functional impairment levels as defined by state Home Care Program regulations (651 CMR 3.00) are considered when developing a plan of care for Frail Elder program participants.

Homebound: An individual is considered homebound if they are confined to their place of residence. This means that either leaving the home is medically unwise or the Medicaid recipient is unable to leave home without the assistance of another person.

Home Care Program: State funded home care service available to Massachusetts residents. Services include those in the Frail Elder program as well as other supportive services including counseling, peer support, and caregiver education. The Home Care Program is available to all residents at least age 60, or younger than 60 with Alzheimer's regardless of eligibility for MassHealth. While MassHealth beneficiaries and participants of Frail Elder do not pay for services, payment for other participants is determined using a sliding scale based on income. See CMR (2017b) for more information.

Home Health Agency: Main provider of long-term home health services including skilled nursing services from registered nurses (RN) or licensed practical nurses (LPN), homemaking and personal care services provided by home health aides, and physical or occupational therapy provided by therapists.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Home-and Community-Based Services for Frail Elders: HCBS program providing home care services, community care, and respite care for community-dwelling adults aged 60 and older. In 2005, financial eligibility for applicants to this program increased from 100 percent of the federal poverty level to 300 percent of the federal benefit rate.

Homemaker Services: In-home support service available to eligible Medicaid beneficiaries that provides assistance with general

household activities like meal preparation, laundry, and housekeeping.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services and HCBS through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. Massachusetts offers multiple managed care plans for elderly beneficiaries, including One Care, Senior Care Options (SCO) and Program of All-Inclusive Care for the Elderly (PACE). One Care targets individuals aged 21-64 who are dually eligible for both Medicare and Medicaid, and enrollment in both programs is required for participation in One Care. An individual may choose to stay in the One Care program after they turn 65, given they are still eligible for MassHealth. SCO targets individuals aged 65 and older who are dually eligible for Medicare and Medicaid, however enrollment in Medicare is not required for participation in SCO. Participants in Senior Care Options are eligible to receive benefits of the Frail Elder HCBS program. PACE targets individuals aged 55 and older who are eligible for Medicaid. Both programs provide coverage for a wide range of primary care and long-term care services. See Box 5 for more information.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available. Massachusetts' Medicaid state plan is commonly known as MassHealth.

Medical necessity: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

Medically Needy Income Limit (MNIL): The income standard that a Medicaid applicant must spend-down to meet if they are seeking Medicaid eligibility through eligibility track 3a (Medically needy aged, blind, or disabled). Typically, this standard is very low. Massachusetts refers to the MNIL as the "deductible-income standard", which has remained the same for individuals living in the community since 1997.

Minimum Data Set - Home Care (MDS-HC): Minimum Data Set – Home Care (MDS-HC) is the comprehensive level of care assessment and screening tool used for most MassHealth long-term care services for community-dwelling older adults.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Moving Forward Program - Community Living (MFP-CL): HCBS program designed to help MassHealth beneficiaries transition from an institutional setting (nursing facility, CDR hospital or psychiatric hospital) to the community. The community living program is for individuals who are able to receive services in their own home or the home of someone else. Prior to 2017, this program was named "Money Follows the Person."

Moving Forward Program - Residential Supports (MFP-RS): HCBS program designed to help MassHealth beneficiaries transition from an institutional setting (nursing facility, CDR hospital or psychiatric hospital) to the community. The residential supports program is for individuals who need 24-hour assistance, 7 days a week in a provider-operated residence. Prior to 2017, this program was named

"Money Follows the Person."

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Nursing services: Nursing services include procedures or physician-ordered skilled services performed at least three times a week. Some services include measurement and administration of medication, behavioral intervention, vital monitoirng, and occupational, physical, or speech/language therapy. See Box 4 for more details.

One Care: Managed care program in Massachusetts available to adults younger than 64 who are dually-eligible and enrolled in both MassHealth and Medicare. An individual may remain in the program after they turn 65 if they continue to meet eligibility requirements for MassHealth. Individuals must live within the service area of a One Care provider to be eligible. See Box 5 for more information.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care, and more.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Attendant (PCA) Services: Personal care attendants provide up to 50 hours per week of assistance with ADLs and IADLs to individuals whose permanent or chronic disabilities prevent them from completing at least 2 or more ADLs without physical assistance. See CMR 422.000 for more information.

Personal Care Management (PCM) Agency: State contracted agency that supports beneficiaries of personal care attendant (PCA) services. PCMs evaluate applicants' eligibility for the program, provide skills training and support managing one's personal care attendant, and submits prior authorization requests for services.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency. Massachusetts added this service to the Frail Elder program in 2018, and called it the Enhanced Technology/Cellular Personal Emergency Response System (ET/CPERS).

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Prior authorization: An approval that is sometimes required before a service may be provided. Specifically, prior authorization is a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

Program of All-inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to some older adults living in the community. Most of the participants who are in PACE are dually eligible for both Medicare and Medicaid. Enrollment in PACE

programs is typically capped at a relatively low number of participants. In Massachusetts, PACE is offered in specific counties across the state, referred to as "service areas." These counties include: Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester. At the time of publishing, PACE is not available in Barnstable, Dukes, and Nantucket counties.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Section 1115 Demonstration Program: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations.

Senior Care Options: Managed care program in Massachusetts available to adults at least age 65 living in the community or in a long-term care facility who are dually-eligible for both MassHealth and Medicare, however enrollment in Medicare is not required. Individuals must live within the service area of a senior care organization to be eligible. See Box 5 for more information.

Skilled Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more. In Massachusetts, an individual must require at least 1 skilled service daily to meet a nursing facility level of care (NFLOC). See Box 3 for more information.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. cash assistance program for aged, blind, and disabled persons of limited means.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. See SSA (2011) for more information.
2. From 1993, the look back period is 36 months prior to the date of application for all assets.
3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).
4. Individuals who do not meet the citizenship/immigration standards listed may still be eligible for Medicaid coverage in Massachusetts. See 130 CMR 504 for information on applicable coverage types for non-citizens.
5. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2024d) for more information on these requirements.
6. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the minimum MMNA in Massachusetts was $984.20 per month, and the maximum was $1,718.00. This standard increases annually with inflation. See Table 3 for historical MMNAs.

7. Spousal considerations for assets: The community spouse is able to keep 50% of the couple's countable assets with a minimum of $13,740 and a maximum of $68,700 in 1992. This is referred to as the Community Spouse Resource Allowance (CSRA). Spouses are able to retain the maximum CSRA unless total combined countable assets are below $27,480, in which case they will retain the minimum ($13,740). See Massachusetts Register p.43 (1992) for more information. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

8. Home Health Aide services under the Frial Elder program differ from state plan Home Health benefits because participating agencies do not have to meet Medicare requirements. Additionally, services can be received even when the participant is not receiving other skilled nursing or therapy services. This service may not be delivered at the same time as PCA or Supportive Home Care Aide services.

9. Authors have not yet verified "other services" provided under the Frail Elder program prior to 2001. Sources confirm that at least the following services were active benefits under the program since 2001.

10. Administrative operations for the Frail Elder program and PACE, including case management, are provided by Aging Services Access Points (ASAPs).

11. The MDS-HC tests more activities of daily living (ADLs) than are relevant to meeting a nursing facility level of care (NFLOC), or to qualify for Home Health and PCA services. The assessment tool also evaluates level of assistance required with IADLs to help determine the plan of care for participants.

12. The Medicaid 1915(c) application for the Frail Elder program mentions that an applicant's functional impairment level (FIL) and critical unmet needs are evaluated using the criteria listed in 651 CMR 3.03 during the assessment process. However, the application also specifically states that clinical eligibility for the Frail Elder program is only determined using the regulations for nursing facility eligibility, which we have detailed in this section. For this reason, we do not detail FIL and critical needs requirements. See 651 CMR 3.03 for more information.

13. From 2009, Massachusetts began increasing the look back period for transfers made after February 2006 monthly for all assets by one month until the look back period totaled 60 months in February 2011. See 130 CMR 520.019 for more information.

14. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2005, the minimum MMNA in Massachusetts was $1,561.25 per month, and the maximum was $2,377.50. This standard increases annually with inflation. See Table 3 for historical MMNAs.

15. Spousal considerations for assets: The community spouse is also able to keep 50% of the couple's countable assets with a minimum of $19,020 and a maximum of $95,100 in 2005. This is referred to as the Community Spouse Resource Allowance (CSRA). Spouses are able to retain the maximum CSRA unless total combined countable assets are below $38,040, in which case they will retain the minimum ($19,020). From 2007, the community spouse may retain the couple's countable assets up to a maximum of $99,540. See EOHHS (2007). Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

16. The Affordable Care Act (ACA) provides 100% matching funds for newly eligible adults with incomes up to 138% of the Federal Poverty Level between 2014-2016, gradually declining to 90% in 2020 where it remains indefinitely (ASPE, 2014).

17. The look back period is 60 months prior to the date of application for all assets.

18. Spousal considerations for assets: The community spouse may retain the couple's countable assets up to a maximum of $115,920 in 2014. This is referred to as the Community Spouse Resource Allowance (CSRA). Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

19. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or enrolled in HCBS programs and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2014, the minimum MMNA in Massachusetts was $1,966.25 per month, and the maximum was $2,931.00. This standard increases annually with inflation. See Table 3 for historical MMNAs.

Version information

Current Version: 1.0 (April 2025)

Version History

- 1.0 (April 2025): First version.